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ABSTRACT

On December 11, 1987, with the plant in Mode 1 (POWER OPERATION), Radiation Protection Personnel discovered that the particulate filter paper media required to filter particulate from the exhaust sample stream during an accident scenario was missing from the Standby Gas Treatment System high range radioactivity monitor. The filter paper was immediately installed. The cause of the event is attributed to personnel error; however, the responsible organization or individual and the date when the event occurred could not be determined. The last documented verification of filter presence in the monitor was July 11, 1987. The monthly channel check surveillance procedure for the monitor has been revised to require signature verification of filter media presence to prevent a recurrence from going undetected for longer than a month. The event will be reviewed with all appropriate Control and Instrumentation, Chemistry, and Radiation Protection personnel. The event was assessed as not safety significant since the charcoal cartridge (which was in place) of the monitor is analyzed to determine offsite dose assessment to the public during or after a severe accident. This event is reportable under the provisions of 10CFR50.73(a)(2)(1)(B).

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DESCRIPTION OF EVENT

On December 11, 1987, at 1125 hours, with the plant in Mode 1 (POWER OPERATION), at approximately 47% reactor [RCT] power, Radiation Protection (RP) personnel discovered that the particulate filter [FLT] paper media required to filter particulate from the exhaust sample stream during an accident scenario was missing from the Standby Gas Treatment System [BH] high range radioactivity monitor [IP] [MON]. The condition was identified during monitor inspection to resolve a nonconformance document. The RP personnel potified Chemistry of the condition at 1135 hours on December 11, and the filter paper was immediately installed. The Heating Ventriating and Air Conditioning (HVAC) Common Stack [VL] high range radioactivity monitor was also checked and the filter media was present.

No other equipment or components were inoperable at the time of this event hat contributed to this event. No automatic or manually initiated safety system responses were necessary to place the plant in a safe and stable condition.

CAUSE OF EVENT

The cause of this event is attributed to personnel error by an unknown person. The filter paper media was last vorified to be in place on July 11, 1967, in response to a similar condition described in LER 87-040-00, in which the filter paper media and the charcoal cartridge were found missing from the HVAC Common Stack high range radioactivity monitor on July 10, 1987. Chemistry supervision contacted the individual who had verified the filter paper media to be in place on July 11, 1987, and assured that the correct monitor was checked and that the individual checked the filter paper media itself, not just the seal. Review of maintenance history showed that no maintenance was performed on this monitor between July 11, 1987 and December 11, 1987, and monthly channel checks of the BH system monitor do not require verification of the filter media or walkdown of the monitor system. Therefore, determination of the responsible organization or individual and the date when the event actually occurred is not possible. Additionally, a management review concluded that based on the high visibility of the equipment location and the required knowledge level to correctly disassemble and reassemble the equipment, it is unlikely that this event was caused by de_iberate wrongdoing.

CORRECTIVE ACTIONS

The monthly channel check surveillance procedure for the HVAC Common Stack high range radioactivity monitor and the BH high range radioactivity monitor has been revised to require signature recification of filter media presence during the monthly channel check surveillance. This action will assure that the problem cannot so unnoticed for longer than a month.

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A review of this event will be presented to all appropriate Control and Instrumentation, Chemistry, and Radiation Protection personnel. The review will stress the Technical Specification requirements for radiation monitor operability and the lessons learned as a result of this event. This activity is scheduled to be complete by approximately March 2, 1988.

ANALYSIS OF EVENT

This event is reportable under the provisions of 10CFR50.73(a)(2)(1)(B) due to an operation prohibited by the plant's Technical Specifications. Review of the event indicates that the Standby Gas Treatment System high range radioactivity monitor became inoperable some time after July 11, 1987 and was inoperable until installation of filter paper at approximately 1135 hours on December 11, 1987. During this period, the plant was in Mode 1, Mode 2 (STARTUP), Mode 3 (HOT SHUTDOWN) and Mode 4 (COLD SHUTDOWN) and was at power levels from zero to one hundred percent power.

Assessment of the safety consequences and implications of this event indicates that the event was not safety significant for existing plant conditions or other plant modes. At no time during the period of inoperability was the plant in a condition which would have required the monitor to perform its function. Not being cognizant of the missing particulate filter paper media would not adversely impact Illicois Power Company's capability for offsite dose assessment to the public during or after a severe accident since the charcoal cartridge of the monitor, which was in place, is analyzed for iodine activity to determine dose to the public.

ADDITIONAL INFORMATION

LER 87-040-00 discussed a violation of the plant's Technical Specifications due to collection media missing from the particulate/iodine sampler of the HVAC Common Stock high range radioactivity monitor.

For further information regarding this event, contact D. W. Hillyer, Director-Plant Radiation Protection at (217) 935-8881, extension 3233.

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ILLINOIS POWER COMPANY

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CLINTON POWER STATION P.O. BOX 678, CLINTON, ILLINOIS 61727

January 13, 1988 10CFK50.73

Docket No. 50-461

U.S. Nuclear Regulatory Commission Document Control Desk Washington, D.C. 20555

Subject: Clinton Power Station - Unit 1 Licensee Event Report No. 87-068-00

Dear Sir:

Please find enclosed Licensee Event Report No. 87-068-00: Error by Indeterminable Person Results in Inoperable Standby Gas Treatment System High Range Radioactivity Monitor Due to Missing Particulate Filter Paper. This report is being submitted in accordance with the requirements of 10CFR50.73.

Sincerely yours, F. A. Spangenber Manager VLicensing and Safety

RSF/krm

Enclosure

cc: NRC Resident Office NRC Region III, Regional Administrator INPO Records Center Illinois Department of Nuclear Safety NRC Clinton Licensing Project Manager