

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1): Joseph M. Farley - Unit 1  
DOCKET NUMBER (2): 0500031481 OF 012

TITLE (4): Technical Specification Action Statements Not Met When A and B Train Post-Accident Hydrogen Analyzers on Both Units Were Inoperable

EVENT DATE (8)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (9)					
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES			DOCKET NUMBER(S)		
02	14	86	86	002	00	03	14	86	J. M. Farley-Unit 2			05000364		

OPERATING MODE (5):  
POWER LEVEL (10): 0.99

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11):

<input type="checkbox"/> 20.402(a)	<input type="checkbox"/> 20.406(a)	<input type="checkbox"/> 20.73a(2)(ii)	<input type="checkbox"/> 73.71a)
<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 20.406(a)(1)	<input type="checkbox"/> 20.73a(2)(iv)	<input type="checkbox"/> 73.71a)
<input type="checkbox"/> 20.406(a)(1)(ii)	<input checked="" type="checkbox"/> 20.406(a)(2)	<input checked="" type="checkbox"/> 20.73a(2)(v)	<input type="checkbox"/> OTHER (Specify in Abstract; Show and in Text, NRC Form 206A)
<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 20.73a(2)(i)	<input type="checkbox"/> 20.73a(2)(vi)(A)	
<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 20.73a(2)(ii)	<input type="checkbox"/> 20.73a(2)(vi)(B)	
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 20.73a(2)(iii)	<input type="checkbox"/> 20.73a(2)(v)(a)	

LICENSEE CONTACT FOR THIS LER (12):  
NAME: J. D. Woodard  
TELEPHONE NUMBER: AREA CODE 205, 899-5156

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13):

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC
A	I/P	H/S	C499	N					

SUPPLEMENTAL REPORT EXPECTED (14):  
 YES (If yes, complete EXPECTED SUBMISSION DATE: )  NO  
EXPECTED SUBMISSION DATE (15): MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces; i.e., approximately 17 lines single-space typewritten text) (16)

On 02-14-86, it was discovered that the A and B train post-accident hydrogen analyzers on both units were inoperable because they would have read low by a factor of approximately 0.83 due to an inappropriate design change. On 01-25-86, a design change was performed on the Unit 1 post-accident hydrogen analyzers to admit reagent gas (air) to the flow stream during the sample mode of operation. This design change had been made on recommendation of the equipment vendor during a maintenance and design review initiated by FNP. A similar design change was performed on the Unit 2 analyzers on 01-26-86. Subsequently, on 02-14-86, this design change was found to be inappropriate and the post-accident hydrogen analyzers were declared to be inoperable. Following discovery on 02-14-86, the analyzers were rewired to the original configuration and returned to service by 02-16-86.

This event was caused by personnel error. Based on misunderstanding of analyzer operation and incorrect recommendations from the equipment vendor (engineering staff and technical representative), Alabama Power Company incorrectly determined that the design change was necessary. The health/safety of the public was not affected by this event. Alternate sampling capabilities were available should the analyzers have been determined to be inoperable during an accident.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Joseph M. Farley - Unit 1	DOCKET NUMBER (2)  0   5   0   0   0   3   4   8   8   6	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8   6	-   0   0   2	-   0   0	0   2	OF	0   2

TEXT (If more space is required, use additional NRC Form 366A's) (17)

The post-accident hydrogen analyzers at FNP are capable of being used with either an inerted (nitrogen-filled) containment or an air-filled containment. When these analyzers are used with an inerted containment, it is necessary that the containment atmosphere sample be combined with a reagent gas containing oxygen (e.g., compressed air) so that recombination can take place. When in use with an air-filled containment as at FNP, the reagent gas is not essential for recombination. The presence of the reagent gas is only necessary for calibration of the analyzers.

In January 1986, during preventive maintenance and a maintenance and design review initiated by FNP, with a vendor representative present, it was noted that the reagent gas was not being admitted during containment sampling. At that time it was believed that this was an error and that this error caused the analyzers to be calibrated incorrectly. The internal wiring of the analyzers was changed, upon incorrect recommendation of the vendor engineering staff, to admit the reagent gas during sampling. The Unit 1 analyzers were modified on 01-25-86 and the Unit 2 analyzers were modified on 01-26-86.

It was not recognized at the time that the absence of reagent gas flow in the sample mode was being compensated for during calibration. Subsequently, while reviewing the as-found conditions for potential reportability under 10CFR21, it was discovered that the design change was not necessary. The design change, without a compensating revision to the calibration technique, resulted in the hydrogen analyzer reading low by a factor proportional to sample flow (about 250 cc/min) divided by sample plus reagent flow (about 300 cc/min), or about 0.83. Thus, the analyzers had been inoperable since the implementation of the design change in late January.

Following discovery of the error on 02-14-86, the analyzers were restored to their original configuration and functionally tested for proper flows during all modes of operation. All analyzers except the Unit 2 B Train analyzer were declared operable on 02-15-86. The Unit 2 B Train analyzer was declared operable at 1038 on 02-16-86.

This event was caused by personnel error. Based on misunderstanding of analyzer operation and incorrect recommendations from the equipment vendor (engineering staff and technical representative), Alabama Power Company incorrectly determined that the design change was necessary. As a result of this event, a task force, including Alabama Power Company, the architect-engineer and vendor personnel, has been formed to review the hydrogen analyzer design, application, documentation and maintenance. The health/safety of the public was not affected by this event because the post-accident hydrogen analyzers are needed only after a loss of reactor coolant accident. Alternate sampling capabilities were available should the analyzers have been determined to be inoperable during an accident.

**Mailing Address**

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**R. P. McDonald**  
Senior Vice President  
Flintridge Building



Alabama Power  
*the southern electric system*

March 14, 1986

Docket No. 50-348

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

Joseph M. Farley Nuclear Plant - Unit 1  
Licensee Event Report No. LER 86-002-00

Dear Sir:

Joseph M. Farley Nuclear Plant, Unit 1, Licensee Event Report No. LER 86-002-00 is being submitted in accordance with 10CFR50.73.

If you have any questions, please advise.

Yours very truly,

R. P. McDonald

RPM/JAR:ddb-D-LER  
Enclosure

cc: IE, Region II

IE22  
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