

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/88

FACILITY NAME (1) Palo Verde Unit 1	DOCKET NUMBER (2) 0500052886	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 365A's) (17)

At 1025 on June 3, 1986, Palo Verde Unit 1 was in Mode 1 (POWER OPERATION) at 100 percent power when a (non-licensed utility) lead radiation protection technician identified that the Flow Rate Monitor (FI) and the Sampler Flow Rate Measuring Device (FI) daily channel checks had not been performed on the Condenser Evacuation System (SH) radiation monitor (RU-141)(IL), and on the Plant Vent System (VL) radiation monitor (RU-143)(IL) May 31, June 1, and June 2, 1986. The omission was discovered during an independent evaluation being conducted by the lead technician. The approximate elapsed time between required channel checks was 81 hours and 20 minutes.

Channel checks are required daily by Technical Specification 4.3.3.9 on 3 channels of RU-141 and RU-143. The sole purpose of the daily checks is to verify that the Noble Gas Activity Monitor, the Flow Rate Monitor, and the Sampler Flow Rate Measuring Device are all functioning. Prior to the event the Noble Gas Activity Monitor had been declared inoperable so its daily channel check was not required.

A (non-licensed utility) radiation protection technician did not perform the channel checks on the Flow Rate Monitor and the Sampler Flow Rate Measuring Device as required. The technician assumed that since the Noble Gas Activity Monitor was inoperable, the entire radiation monitor was inoperable, and that the flow instrument channel checks were not required.

The root cause of the missed surveillance test was a cognitive personnel error in that the technician did not recognize the actual plant conditions. The technician did not realize that the Flow Rate Monitor and the Sampler Flow Rate Measuring Device were operable. This action was contrary to an approved surveillance test procedure. There were no unusual characteristics of the work location that contributed to the error.

Sample flow is recorded on a strip chart recorder for both of the radiation monitors. Since a review of the sample flow charts showed that the Flow Rate Monitor and the Sampler Flow Rate Measuring Device were both operating throughout the event, that no abnormal radiation levels existed, and the radiation monitor was within its calibration frequency, this event had no effect on the health and safety of the public.

There were no automatically or manually initiated safety system responses.

To prevent recurrence, the radiation protection technicians were counseled on verbatim compliance with approved procedures. The technicians were reminded that one monitoring channel can be inoperable and the rest of the channels may still be operable and require testing, maintenance, etc. A caution will be added to the applicable procedure as an enhancement to clarify the fact that individual channels may be declared inoperable without declaring the entire instrument inoperable.

There have been no previous similar events.



Arizona Nuclear Power Project

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

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 1
Docket No. STN 50-528
Licensee Event Report-86-038-00
File: 86-006-216

Dear Sirs:

Attached please find Licensee Event Report (LER) No.86-038-00 prepared and submitted pursuant to 10 CFR 50.73. In accordance with 10 CFR 50.73(d), we are herewith forwarding a copy of the LER to the Regional Administrator of the Region V Office.

If you have any questions, please contact Thomas R. Bradish, Compliance Supervisor at (602)932-5300 Ext.6936.

Very truly yours,

J. G. Haynes
Vice President
Nuclear Production

JGH/JHT/dh

Attachment

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