NRC Form 366 (9-65)							ENSEE EVENT REPORT (LER)						U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88					
FACILITY	NAME (1	1						-				DOCKET NUMBER	(2)	-	PAC	GE (3)		
Palo Verde Unit 1											0 15 10 10	10151	0151218		012			
TITLE (4)	410 1	0100	C/41.2	<u> </u>				-	-					-10		1016		
P	erson	ne1	Erro	r Resul	ts in	Miss	ed Ch	anne	Che	ck on	Two Rad	iation Mor	itore					
	NT DATE		LILLO	LER NUMI		111.00		AT DATE		CR OII		FACILITIES INVO						
MONTH DAY YEAR			VEAR SEQUENTIAL			REVISION				FACILITY NAMES			DOCKET NUMBER(S)					
			NUMBER		ER	NUMBER		-		N/A			0 5 0 0		101 1 1	1. 1		
0 5	3 1	8 6	8 6	0 3	8	0 0	0 6	3 0	8 6	N/A	-	1.	0 5	0 1 0	101			
	RATING	1.	THIS R	EPORT IS SUBN	HTTED PU	REUANT T	O THE REC	UIREME	NTS OF 10	CFR & /	Check one or more	of the following) (1	1)					
MODE (8)		1	20	20.402(b)			20.405(c)				50.73(a)(2)(iv)		73,7	73,71(b)				
POWER			20	20.406(a)(1)(i)			50.38(c)(1)				50.73(a)(2)(v)		73.71(c)					
1101 11010			20	20.405(a)(1)(ii)				50.36(c)(2)			50.73(a)(2)(vii)	OTHER (Specify in Abstract						
			20	1.405(a)(1)(iii)		X	50.73(a)(2	27(1)			50.73(s)(2)(viii)	(A)	3664		7881, 1979	C Furm		
			20	20.406(a)(1)(iv)			50.73(a)(2)(ii)				50.73(a)(2)(viii)	(B))					
			20	20.405(a)(1)(v)				50.73(a)(2)(iii)			50,73(a)(2)(x)							
						L	ICENSEE C	ONTACT	FOR THIS	LER (12)								
NAME													TELEPHON	E NUMB	IER			
									AREA CODE									
Thomas R. Bradish, Compliance Su				uperv	pervisor (Ext. 6936)				61012	9131	21-	1513	1010					
				COMP	ETE ONE	LINE FOR	EACH CON	PONENT	FAILURE	DESCRIBE	D IN THIS REPO	RT (13)						
CAUSE	SYSTEM	СОМР	ONENT	MANUFA(TURER		ORTABLE NPRDS			CAUSE	SYSTEM	COMPONENT	MANUFAC TURER	REPORT TO NP					
			1 1	11								1 1 1						
			-hh			-		********	1			1						
	1	1	1. 1	1.1					1		1.1.1	1 1 1 1						
			-	SUPP	LEMENTA	LREPORT	EXPECTED	(14)		-				MONTH	DAY	YEAR		
Tyes	ilt one o	omniete A		NOISSIMBLIS C	DATE		v	l No				SUBMISSI DATE (1	ON	-				

At 1025 on June 3, 1986, Palo Verde Unit 1 was in Mode 1 (POWER OPERATION) at 100 percent power when a radiation protection lead technician discovered that the Flow Rate Monitor and the Sampler Flow Rate Measuring Device daily channel checks had not been performed on the Condenser Evacuation System radiation monitor (RU-141), and on the Plant Vent System radiation monitor (RU-143) May 31, June 1, and June 2, 1986. The omission was discovered during an independent evaluation by the lead technician, of completed surveillance tests.

The root cause of the missed surveillance test was a cognitive personnel error in that a radiation protection technician did not recognize the actual plant conditions and status of the radiation monitor.

To prevent recurrence, the radiation protection technicians were counseled on verbatim compliance with approved procedures. A caution is being added to the applicable procedure as an enhancement to clarify the definition of operability for the radiation monitor.

There have been no previous similar events.

ABSTRACT (Limit to 1400 spaces i.e. approximately fifteen single space typewritten in

8607100168 860630 FDR ADOCK 05000528 TERL

NRC Form 364A (9.83) LICENS		U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104 EXPIRES: 8/31/88					
FACILITY NAME (1)	DOCKET NUMBER (2)		L	ER NUMBER (6)	PAGE (3)		
		YEAR		SEQUENTIAL NUMBER	MEVISION NUMBER		
Palo Verde Unit 1	0 5 0 0 0 5 2 8	816	_	01318	- 010	012 OF	012

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

P.O. BOX 52034 . PHOENIX, ARIZONA 85072-2034

June 30, 1986 ANPP-00006-JGH/TDS/JHT/96.03

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

cc: J. B. Martin (all w/a)

R. P. Zimmerman

A. L. Hon

E. A. Licitra

A. C. Gehr

INPO Records Center

E. E. Van Brunt, Jr.