

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 5 2 8	PAGE (3) 1 OF 0 2
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TITLE (4)  
Personnel Error Results in Missed Channel Check on a Radiation Monitor

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		
0	6	1	8	6	0	0	7	0	N/A		
4	8	6	8	6	0	0	8	8	DOCKET NUMBER(S) 0 5 0 0 0		
6	8	6	8	6	0	0	8	8	N/A		
6	8	6	8	6	0	0	8	8	0 5 0 0 0		

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

OPERATING MODE (9) 1	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 1 0 0	20.406(a)(1)(i)	50.36(e)(1)	50.73(a)(2)(v)	73.71(c)
	20.406(a)(1)(ii)	50.36(e)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
	20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Thomas R. Bradish, Compliance Supervisor (Ext. 6936)	TELEPHONE NUMBER 6 0 2 9 3 2 - 5 3 0 0
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRDOS

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (if yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15) MONTH:    DAY:    YEAR:
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1300 on June 16, 1986, Palo Verde Unit 1 was in Mode 1 (POWER OPERATION) at 100 percent power when a Radiation Protection Lead 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) on June 14 and June 15, 1986. The omission was discovered by the lead during an independent evaluation 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 also being added to the applicable procedure as an enhancement to clarify the definition of operability for the radiation monitor.

A similar event occurred on May 31, 1986 and was reported in LER-86-038.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Palo Verde Unit 1	DOCKET NUMBER (2)  0 5 0 0 0 5 2 8 8 6 - 0 4 1 - 0 0	LER NUMBER (8)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 6	0 4 1	0 0	0 2	OF	0 2

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

At 1300 on June 16, 1986, Palo Verde Unit 1 was in Mode 1 (POWER OPERATION) at 100 percent power when a (non-licensed utility) Radiation Protection Lead discovered 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) on June 14 and June 15, 1986. The omission was discovered by the lead during an independent evaluation of completed surveillance tests. The approximate elapsed time between required channel checks was 59 hours and 20 minutes.

Channel checks are required daily by Technical Specification 4.3.3.9 on 3 channels of RU-141. The 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 functioning. Prior to the event, the Noble Gas Activity Monitor had been declared inoperable so that specific daily channel check was not required. However, the technician (non-licensed utility) 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. Therefore, the channel checks on the Flow Rate Monitor and the Sampler Flow Rate Measuring Device were not performed as 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. He did not realize that the Flow Rate Monitor and the Sampler Flow Rate Measuring Device would be operable with the Noble Gas Activity Monitor inoperable. 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 the radiation monitor. 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 monitoring unit was within its calibration frequency. Therefore, 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 also reminded that one monitoring channel can be inoperable and the remaining 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.

A similar event occurred on May 31, 1986 and was reported in LER 86-038. At the time of this event, corrective action specified in LER-86-038 had not been completed.



## Arizona Nuclear Power Project

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

July 8, 1986  
ANPP-00011-JGH/TDS/ESP/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-86-041-00  
File: 86-006-216

Dear Sirs:

Attached please find Licensee Event Report (LER) No.86-041-00 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 T. R. Bradish, Compliance Supervisor at (602)932-5300 Ext.6936.

Very truly yours,

J. G. Haynes  
Vice President  
Nuclear Production

JGH/ESP/dh

Attachment

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