| NBC Form 366 | | | | | | | | | | | |
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

PAGE (3)

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APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

NUMBER

LER NUMBER (6)

YEAR

817

SEQUENTIAL

01011

FACILITY NAME (1)

NAC Form 366A

Joseph M. Farley - Unit 1 TEXT (If more spece is required, use edditional NRC Form 366A(s) (17)

Plant and System Identification:

Westinghouse - Pressurized Water Reactor Energy Industry Identification System codes are identified in the text as [XX].

DOCKET NUMBER (2)

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Summary of Event

At 0730 on 1-5-87 during normal plant operations at 100% reactor power, it was discovered that the containment atmosphere particulate radioactivity monitor (R-11) [IL] was inoperable due to improper valve alignment. Investigation revealed that R-11 had been inoperable since approximately 1225 on 12-31-86. Since it had not been realized at the time that R-11 was inoperable, the Technical Specification 3.4.7.1 requirement to obtain and analyze samples of the containment atmosphere once per twenty-four hours was not met. Upon discovery on 1-5-87, R-11 was returned to service.

Description of Event

At approximately 0730 on 1-5-87, it was discovered that the containment atmosphere particulate radioactivity monitor (R-11) had been inoperable from 12-31-86 until 1-5-87 due to improper valve alignment. Since it had not been realized at the time that R-11 was inoperable, the Technical Specification 3.4.7.1 requirement to obtain and analyze samples of the containment atmosphere once per twenty-four hours was not met.

During a routine log review by Health Physics (HP) Supervision on 1-5-87, it was observed that the R-11 reading had decreased from approximately 5000 counts per minute on 12-30-86 to approximately 2000 counts per minute on 12-31-86 and had remained at approximately 2000 counts per minute. Upon investigation, it was found that the valve V-1 (the R-11 bypass valve) was open and V-2 (the R-11 inlet valve) was closed which made R-11 inoperable.

Further investigation revealed that procedure FNP-1-STP-227.2B had been performed by Instrumentation and Controls (I&C) personnel on 12-31-86. Apparently, the valves had not been restored to the proper position following performance of the STP. Upon completion of the STP on 12-31-86, the shift supervisor had noticed the reduced R-11 reading. He requested HP personnel to verify the valve positions on R-11. This verification was completed at 2030 on 12-31-86 and the shift supervisor was informed that R-11 was operating properly. Apparently, the HP technicians performing the valve alignment verification had not detected the valve alignment problem. HP personnel reasoned that the reduced count rate was due to changes in the environmental conditions.

R-11 was restored to proper operation and declared operable at 0901 on 1-5-87.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | PAGE (3) | |
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| | | YEAR SEQUENTIAL REVISION NUMBER NUMBER | | |
| Joseph M. Farley - Unit 1 | 0 5 0 0 0 3 4 8 | 8 8 7 - 0 0 1 - 0 0 | 013 OF 0 13 | |

Cause of Event

NRC Form 366A

The inoperability of R-11 was due to errors committed by I&C personnel in conducting an STP (FNP-1-STP-227.2B). A contributing cause was that the procedure grouped several actions, including the manipulation of V-1 and V-2, into one step. Apparently, HP personnel subsequently committed the same errors in conducting the lineup verification specifically requested by the Shift Supervisor although the HP verification was documented by individual valve steps.

Reportability Analysis and Safety Assessment

This event is reportable because of the failure to meet the Technical Specification 3.4.7.1 requirement to obtain and analyze samples of the containment atmosphere once per twenty-four hours. However, containment atmosphere particulate monitor R-12 was not affected by this event. No radiological hazards were associated with this event and therefore the health and safety of the public were not affected by this event.

Corrective Action

The I&C technician and the HP technicians involved in this event have been counseled for failure to properly follow approved procedures. The I&C procedures for R-11 will be revised to place valve manipulations in separate steps.

Additional Information

LER 86-001-00 reported Technical Specifications action statements not being met when R-11 was inoperable, although the cause of this previous event was unrelated to the cause of the current event.

No components failed during this event.

Alabama Power Company 600 North 18th Street Post Office Box 2641 Birmingham, Alabama 35291-0400 Telephone 205 250-1835



R. P. McDonald Senior Vice President

February 3, 1987

Docket No. 50-348

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

Dear Sir:

Joseph M. Farley Nuclear Plant - Unit 1 Licensee Event Report No. LER 87-001-00

Joseph M. Farley Nuclear Plant, Unit 1, Licensee Event Report No. LER 87-001-00 is being submitted in accordance with 10CFR50.73.

If you have any questions, please advise.

Respectfully submitted,

R. P. McDonald

RPM/JAR:dst-D-LER

Enclosure

cc: IE, Region II