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ACCESSION NBR: 9210090295 DOC. DATE: 92/10/05 NOTARIZED: NO DOCKET #
 FACIL: STN-50-530 Palo Verde Nuclear Station, Unit 3, Arizona Public 05000530
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 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 92-003-00: on 920930, determined that Train B LPSIP breaker may have been inoperable since 920815. Caused by procedural deficiency. Subj breaker replaced applicable operations procedures revised. W/921005 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 10
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: Standardized plant.

05000530/

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INTERNAL:	ACNW		2	2	ACRS		2	2	
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	AEOD/ROAB/DSP		2	2	NRR/DET/EMEB 7E		1	1	
	NRR/DLPQ/LHFB10		1	1	NRR/DLPQ/LPEB10		1	1	
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	RGN5 FILE 01		1	1					
EXTERNAL:	EG&G BRYCE, J.H		2	2	L ST LOBBY WARD		1	1	
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PALO VERDE NUCLEAR GENERATING STATION
P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

192-00802-JML/TRB/KR
October 5, 1992

JAMES M. LEVINE
VICE PRESIDENT
NUCLEAR PRODUCTION

U. S. Nuclear Regulatory Commission
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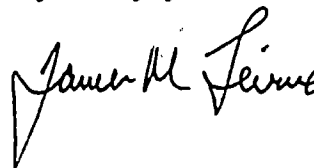
Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 3
Docket No. STN 50-530 (License No. NPF-74)
Licensee Event Report 92-003-00
File: 92-020-404

Attached please find Licensee Event Report (LER) 92-003-00 prepared and submitted pursuant to 10CFR50.73. This LER reports that the OPERABILITY requirements for Technical Specification (TS) Limiting Condition for Operation (LCO) 3.3.3.5 ACTION b (Remote Shutdown System Instrumentation), TS LCO 3.5.2 ACTION a (Emergency Core Cooling Systems Subsystems - Reactor Coolant System Cold Leg Temperature Greater Than or Equal To 350 Degrees Fahrenheit), and TS LCO 3.7.11 ACTION a (Shutdown Cooling System) may not have been met. On August 31, 1992, the Train B Low Pressure Safety Injection (LPSI) pump failed to start from the Control Room during the performance of the Post Accident Sampling System functional testing. The Train B LPSI pump may have been inoperable since August 15, 1992. The Train B LPSI pump was last started for the performance of the LPSI operability surveillance testing on August 15, 1992. In addition, whenever Train A ECCS TS LCOs were entered between August 15, 1992 and August 31, 1992, TS LCO 3.0.3 requirements may not have been met when the Train B LPSI pump may have been inoperable. In accordance with 10CFR50.73(d), a copy of this LER is being forwarded to the Regional Administrator, NRC Region V.

If you have any questions, please contact T. R. Bradish, Compliance Manager, at (602) 393-5421.

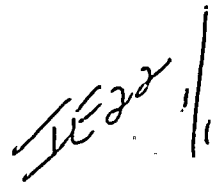
Very truly yours,



JML/TRB/KR

Attachment

9210090295 921005
PDR ADDCK 05000530
S PDR





cc: W. F. Conway (all with attachment)
J. B. Martin
J. A. Sloan
INPO Records Center



LICENSEE EVENT REPORT (LER)

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TITLE (4)
Train B Low Pressure Safety Injection Pump Breaker Inoperable

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		
									N/A		
0 9	0 3	9 2	9 2	0 0 3	0 0	1 0	0 5	9 2	N/A		
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)								
POWER LEVEL (10) 0 9 2			<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)					
			<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)					
			<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)					
			<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)						
			<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)						
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)									

LICENSEE CONTACT FOR THIS LER (12)

NAME Thomas R. Bradish, Compliance Manager	TELEPHONE NUMBER 6 0 2 3 9 3 - 5 4 2 1
--	--

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

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)

On September 3, 1992, at approximately 2100 MST, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION), operating at approximately 92 percent power when APS Plant Engineering personnel determined that the Train B Low Pressure Safety Injection (LPSI) pump breaker may have been inoperable since August 15, 1992. The Train B LPSI pump was last started for the performance of the LPSI operability surveillance testing on August 15, 1992. On August 31, 1992, the Train B LPSI pump failed to start from the Control Room during the performance of the Post Accident Sampling System (PASS) functional testing. Since the Train B LPSI pump may have been inoperable since August 15, 1992, the ACTION requirements for Technical Specification (TS) Limiting Conditions for Operation (LCO) 3.3.3.5 ACTION b, 3.5.2 ACTION a, and 3.7.11 ACTION a may not have been met. In addition, whenever Train A ECCS TS LCOs were entered between August 15, 1992 and August 31, 1992, TS LCO 3.0.3 requirements may not have been met when the Train B LPSI pump may have been inoperable.

The cause of the event was determined to be procedural deficiency in that the procedure did not provide adequate guidance to verify that the breaker was installed correctly. As corrective action, the Train B LPSI pump breaker and the Control Room handswitch were quarantined pending troubleshooting. The Train B LPSI pump breaker was replaced. The replacement breaker was verified to be installed correctly.

There have been no previous similar events reported pursuant to 10CFR50.73.



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I. DESCRIPTION OF WHAT OCCURRED:

A. Initial Conditions:

At 2100 MST on September 3, 1992, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION), operating at approximately 92 percent power.

B. Reportable Event Description (Including Dates and Approximate Times of Major Occurrences):

Event Classification: Condition prohibited by the plant's Technical Specifications.

At approximately 2100 MST on September 3, 1992, APS Plant Engineering personnel (utility, non-licensed) determined that the Train B Low Pressure Safety Injection (LPSI) pump breaker (BRK)(P)(BP) (PBB-S04F) may have been inoperable since August 15, 1992. The Train B LPSI pump was last started for the performance of the LPSI operability surveillance testing on August 15, 1992. On August 31, 1992, the Train B LPSI pump failed to start from the Control Room (NA) during the performance of the Post Accident Sampling System (PASS)(IP) functional testing. Since the Train B LPSI pump may have been inoperable since August 15, 1992, the ACTION requirements for Technical Specification (TS) Limiting Conditions for Operation (LCO) 3.3.3.5 ACTION b (Remote Shutdown System Instrumentation), TS LCO 3.5.2 ACTION a [Emergency Core Cooling Systems (ECCS) (BP/BQ) Subsystems - Reactor Coolant System (RCS) Cold Leg Temperature Greater Than or Equal To 350 Degrees Fahrenheit], and TS LCO 3.7.11 ACTION a (Shutdown Cooling System) (BP) may not have been met. In addition, whenever Train A ECCS TS LCOs were entered between August 15, 1992 and August 31, 1992, TS LCO 3.0.3 requirements may not have been met when the Train B LPSI pump may have been inoperable.

Prior to the event, on August 11, 1992, the Train B LPSI pump breaker was scheduled for routine replacement by maintenance personnel (utility & contractor, non-licensed). At approximately 1032 MST, the Shift Supervisor (utility, licensed) entered TS LCO 3.3.3.5 ACTION b, TS LCO 3.5.2 ACTION a, and TS LCO 3.7.11 ACTION a. Following the breaker replacement in accordance with an approved maintenance procedure (Maintenance of Medium Voltage Circuit Breakers Type AM-4.16-250), the Train B LPSI pump was started and satisfactorily function tested. At approximately 1510 MST, TS LCO 3.3.3.5 ACTION b, TS LCO 3.5.2 ACTION a, and TS LCO 3.7.11 ACTION a were exited.

At approximately 0343 MST on August 15, 1992, the Train B LPSI pump was started for the performance of the surveillance



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requirement to ensure the LPSI pump is operable pursuant to TS 4.0.5 (Section XI of the ASME Boiler and Pressure Vessel Code). The surveillance requirements were satisfied and the Train B LPSI pump was stopped at approximately 0355 MST.

At approximately 1459 MST on August 31, 1992, the Train B ECCS was declared inoperable to support the PASS functional testing (i.e., the LPSI valves are realigned to miniflow and LPSI pumps are started to get safety injection flow to the PASS sample point) and the Shift Supervisor entered TS LCO 3.5.2 ACTION a. At approximately 1506 MST, in accordance with the PASS functional surveillance testing procedure, Control Room personnel attempted to start the Train B LPSI pump from the Control Room. When the handswitch was taken to the start position, the Train B LPSI pump failed to start, no alarms were received, and no abnormal indications existed at the breaker cubicle located at the 100 foot elevation of the Train B Switchgear Room in the Control Building (NA). The Shift Supervisor quarantined the Train B LPSI pump breaker and the Control Room handswitch pending troubleshooting and an equipment root cause of failure analysis (ERCFA). In addition, the Shift Supervisor entered TS LCO 3.3.3.5 ACTION b and TS LCO 3.7.11 ACTION a.

During the ERCFA, APS Plant Engineering personnel observed that the Train B LPSI pump breaker's positive interlock roller was resting against the upper half of the upper "V" notch on the interlock cam plate. The positive interlock roller is connected through a mechanical linkage (i.e., interlock shaft) to the positive interlock switch arm. The elevated position of the positive interlock roller prevented the positive interlock switch arm from fully depressing the plunger on the positive interlock switch. [NOTE: When the positive interlock roller is centered in the upper "V" notch on the interlock cam plate, the positive interlock switch arm fully depresses the plunger on the positive interlock switch.] The partially depressed plunger on the positive interlock switch did not allow full contact with the switch used for the breaker closing circuitry. This resulted in a high resistance connection in the positive interlock switch. During the ERCFA, the contact of the positive interlock switch was found in the marginally open position and therefore prevented the breaker from closing when Control Room personnel attempted to start the Train B LPSI pump from the Control Room.

The Train B LPSI pump was last started (i.e., successful breaker closure) for the performance of the LPSI operability surveillance testing on August 15, 1992. On September 3, 1992, APS Plant Engineering personnel determined that the August 15, 1992 closure of the Train B LPSI pump breaker may have caused the contact of

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the positive interlock switch to marginally open, preventing further electrical closure of the Train B LPSI pump breaker. Therefore, the Train B LPSI pump may have been inoperable between August 15, 1992 and August 31, 1992 and the ACTION requirements for Technical Specification (TS) Limiting Conditions for Operation (LCO) 3.3.3.5 ACTION b, TS LCO 3.5.2 ACTION a, and TS LCO 3.7.11 ACTION a may not have been met.

The Train B LPSI pump breaker was replaced on September 1, 1992. The replacement breaker's positive interlock roller was verified to be centered in the upper "V" notch, the positive interlock switch arm was verified to be fully depressing the plunger on the positive interlock switch, and the replacement breaker was successfully closed twice. At approximately 0325 MST on September 2, 1992, the Train B LPSI was declared operable and the Shift Supervisor exited TS LCO 3.3.3.5 ACTION b, TS LCO 3.5.2 ACTION a, and TS LCO 3.7.11 ACTION a.

At approximately 2202 MST on August 25, 1992, and at approximately 0410 on August 27, 1992, several TS LCOs, including TS LCO 3.5.2 ACTION a (ECCS or specifically, Train A LPSI), were momentarily entered and exited when the control power disconnect on the Train A Essential Chilled Water System (KM) (i.e., support system that provides Engineered Safety Features room cooling during Design Basis Accident conditions) was momentarily opened and then closed after starting the Essential Chilled Water circulation pump. In addition, between 1258 MST and 1454 MST on August 31, 1992 (approximately 2 hours), the Train A ECCS was declared inoperable to support the PASS functional testing and the Shift Supervisor entered and exited TS LCO 3.5.2 ACTION a. As a result, whenever Train A ECCS TS LCOs were entered between August 15, 1992 and August 31, 1992, the TS LCO 3.0.3 requirements may not have been met when the Train B LPSI pump may have been inoperable.

- C. Status of structures, systems, or components that were inoperable at the start of the event that contributed to the event:

Other than the Train B LPSI breaker that may have been inoperable as discussed in Section I.B, no structures, systems, or components were inoperable at the start of the event which contributed to this event.

- D. Cause of each component or system failure, if known:

Not applicable - no component or system failures were involved.



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E. Failure mode, mechanism, and effect of each failed component, if known:

Not applicable - no component failures were involved.

F. For failures of components with multiple functions, list of systems or secondary functions that were also affected:

Not applicable - no failures of components with multiple functions were involved.

G. For a failure that rendered a train of a safety system inoperable, estimated time elapsed from the discovery of the failure until the train was returned to service:

Not applicable - no failures that rendered a train of a safety system inoperable were involved.

H. Method of discovery of each component or system failure or procedural error:

The procedural deficiency discussed in Section I.I was discovered during the investigation.

I. Cause of Event:

An investigation was initiated in accordance with the APS Incident Investigation Program. As part of the investigation, a review of existing procedural controls was performed. On August 11, 1992, the Train B LPSI pump breaker was replaced in accordance with an approved maintenance procedure (Revision 0 of Maintenance of Medium Voltage Circuit Breakers Type AM-4.16-250). The investigation determined that the maintenance procedure used to install the breaker into the cubicle (Revision 0 of Maintenance of Medium Voltage Circuit Breakers Type AM-4.16-250) did not provide adequate guidance to verify that the breaker was installed correctly when in the racked up position. On August 19, 1992, a complete rewrite of the maintenance procedure used to install the breaker into the cubicle (Revision 1 of the Maintenance of Medium Voltage Circuit Breakers Type AM-4.16-250) became effective. Revision 1 of the maintenance procedure included an additional step in the appendices addressing the installation of the breaker. The procedure step states that the positive interlock roller should be centered in the upper "V" notch. In addition, the procedure states that the interlock roller should have approximately 1/16-inch clearance to the stationary interference plate underneath it. The investigation determined that if the breaker had been installed in accordance with Revision 1 of the



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maintenance procedure, the event would not have occurred. A procedural weakness was determined to have caused the event (SALP Cause Code D: Defective Procedures).

No unusual characteristics of the work location (e.g., noise, heat, poor lighting) directly contributed to this event. There were no personnel errors which contributed to this event.

J. Safety System Response:

Not applicable - there were no safety system responses and none were necessary..

K. Failed Component Information:

There were no component failures related to this event. The Magna Blast Air Circuit Breaker was manufactured by General Electric. The model number is Type AM-4.16-250-9H.

II. ASSESSMENT OF THE SAFETY CONSEQUENCES AND IMPLICATIONS OF THIS EVENT:

The OPERABILITY of two separate and independent ECCS subsystems with the RCS temperatures greater than or equal to 350 degrees Fahrenheit ensures that sufficient emergency core cooling capability will be available in the event of a Loss of Coolant Accident (LOCA) assuming the loss of one subsystem through any single failure consideration. A safety injection actuation signal (SIAS) is initiated by receipt of 2-out-of-4 low pressurizer pressure or 2-out-of-4 high containment pressure signals. The LPSI pump will automatically start upon receipt of a SIAS or containment spray actuation signal (CSAS). A CSAS is initiated by receipt of 2-out-of-4 high-high containment pressure signal.

The investigation determined that the Train B LPSI pump may have been inoperable between August 15, 1992 and August 31, 1992, and therefore, may not have automatically started on a SIAS/CSAS. In addition, on August 31, 1992, for approximately 2 hours, the Train A ECCS was declared inoperable to support the PASS functional testing. In the event of a SIAS/CSAS, a safety equipment actuated status (SEAS) alarm would have alerted Control Room personnel that the Train B LPSI pump did not start. The Emergency Operating Procedures direct Control Room personnel to manually actuate the components (i.e., LPSI pumps) to the required position. This would entail manually closing the Train B LPSI pump breaker (manual closure of the Train B LPSI pump breaker was not affected by the open contact on the positive interlock switch) or manually realigning Train A LPSI valve position. LPSI pumps would not inject borated water into the RCS unless RCS pressure dropped to 250 pounds per square inch absolute (psia). In the event of a large break



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LOCA and both LPSI pumps unavailable, the Functional Recovery procedures direct Control Room personnel to realign one train of the Containment Spray System to inject borated water into the RCS.

During safety injection, the LPSI pumps inject large volumes of borated water into the RCS for an emergency involving a large pipe rupture. For safety analysis, it is assumed that only one of the LPSI pumps is available following an accident and that 50 percent of the flow is lost through spillage. A probabilistic risk assessment (PRA) evaluating the impact on core damage when both LPSI pumps are inoperable for a period of 2 hours was performed. The PRA results indicate that the core damage probability was increased by approximately 5.0E-8 over a baseline value of 2.0E-8 for the 2 hour period. As a point of reference, the increase in the probability of core damage associated with the Train A Auxiliary Feedwater pump being inoperable for 72 hours as allowed by TS is approximately 1.0E-5. Therefore, from a risk perspective, the potential risks imposed on health and safety of the public is judged to be minimal. The event did not result in any challenges to the fission product barriers or result in any releases of radioactive materials.

III. CORRECTIVE ACTION:

A. Immediate:

The Shift Supervisor quarantined the Train B LPSI pump breaker and the Control Room handswitch pending troubleshooting and an equipment root cause of failure analysis (ERCFA). Following troubleshooting and ERCFA, the Train B LPSI pump breaker was replaced. The replacement breaker was verified to be installed correctly.

Applicable Operations procedures have been revised to ensure that Control Room personnel verify that the positive interlock roller, positive interlock switch arm, and the positive interlock switch are in their correct positions.

B. Action to Prevent Recurrence:

The Non-Class and Class 1E 4.16 kV (EA and EB) and Non-Class 1E 13.8kV (EA) Magne Blast breakers are currently being inspected in all three units under an approved inspection plan and work authorization documents. Because some breakers are required to remain closed due to plant conditions, the breaker inspection will be completed in Unit 1 and Unit 2 during their next refueling outage and in Unit 3 prior to completion of the current refueling



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outage. The breaker inspection will be tracked to completion under the PVNGS Commitment Action Tracking System.

IV. PREVIOUS SIMILAR EVENTS:

No other previous events have been reported pursuant to 10CFR50.73.

