

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 4
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TITLE (4) **TS SR violation resulting from an inadequate procedural impact review of a TS amendment**

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	DOCKET NUMBERS
0	5	2	8	9	7	9	7	-	0	0
				5	-	0	0		1	2
							2		2	9
							7			

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)				
POWER LEVEL (10) 1 0 0	<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)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
	<input checked="" type="checkbox"/> 20.405(a)(1)(iii)	<input 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 Daniel G. Marks, Section Leader, Nuclear Regulatory Affairs	TELEPHONE NUMBER AREA CODE 6 0 2 3 9 3 - 6 4 9 2
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS

SUPPLEMENTAL REPORT EXPECTED (14)	EXPECTED SUBMISSION DATE (15)	MONTH DAY YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO		

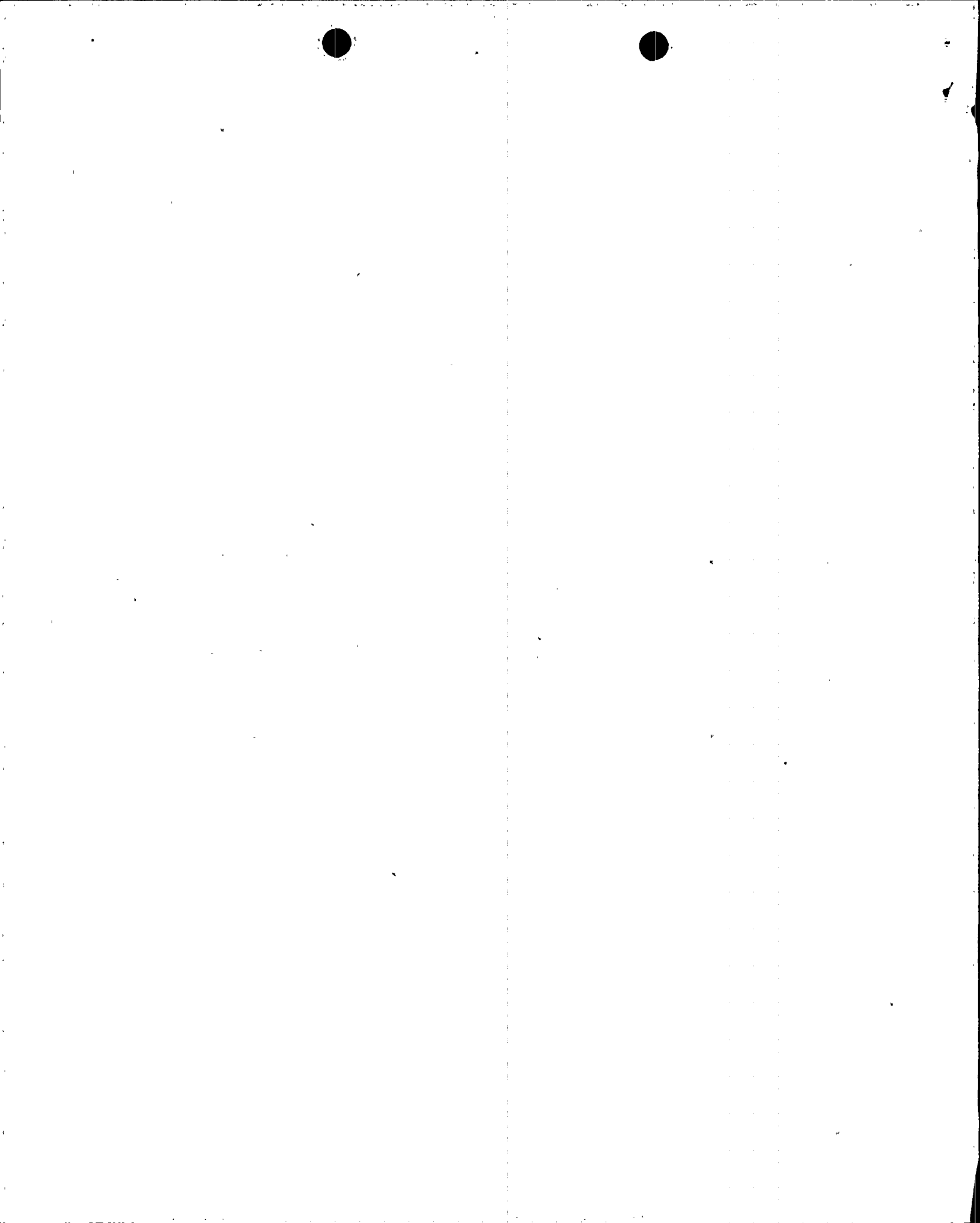
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On September 23, 1997, at approximately 0500 MST, Palo Verde Units 1 and 3 were in Mode 1 (POWER OPERATION), operating at approximately 100 percent power and Unit 2 was in a refueling outage, with fuel off-loaded to the spent fuel pool, when Unit 3 Operations personnel discovered that the containment cleanliness inspection procedure did not appropriately implement Technical Specifications Surveillance Requirement (TS SR) 4.5.2.c.2 for daily containment debris inspection. On November 20, 1997, during an evaluation of the condition, Nuclear Regulatory Affairs personnel discovered that the TS SR for daily checks was not met in Unit 1 between May 27, 1997 and May 29, 1997 during containment entries when CONTAINMENT INTEGRITY was established. Therefore, the procedural discrepancy led to a reportable event under 10 CFR 50.73. A containment inspection was satisfactorily performed on May 29, 1997, prior to final containment closeout.

The cause of the procedural discrepancy was attributed to an inadequate procedural impact review of a TS amendment approved on September 2, 1994. As corrective action, appropriate procedures were revised and additional TS changes were reviewed to verify proper procedural implementation.

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

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME	DOCKET NUMBER	LER NUMBER			PAGE		
Palo Verde Unit 1		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		97	- 005	- 00			
05000528		97 - 005 - 00			02	of	04

TEXT

1. REPORTING REQUIREMENT:

This LER 528/97-005-00 reports an event that resulted in the plant being operated in a condition prohibited by the Technical Specifications (TS) as specified by 10CFR50.73(a)(2)(i)(B).

Specifically, at approximately 0500 MST on September 23, 1997, Palo Verde Units 1 and 3 were in Mode 1 (POWER OPERATION), operating at approximately 100 percent power and Unit 2 was in a refueling outage, with fuel off-loaded to the spent fuel pool, when Unit 3 Operations personnel discovered that the containment cleanliness inspection procedure did not appropriately implement the emergency core cooling systems (ECCS) TS surveillance requirement (SR) 4.5.2.c.2. On November 20, 1997, during an evaluation of the event, Nuclear Regulatory Affairs personnel discovered that the TS SR was not met in Unit 1 between May 27, 1997 and May 29, 1997 during containment entries when CONTAINMENT INTEGRITY was established. Therefore, the procedural discrepancy led to a reportable event under 10 CFR 50.73.

2. EVENT DESCRIPTION:

At approximately 0500 MST on September 23, 1997, Unit 3 Operations personnel (utility-licensed operator) were reviewing the requirement of TS SR 4.5.2.c.2, for Emergency Core Cooling System (ECCS) (BP, BQ) operability requirements, during a containment (NH) entry with CONTAINMENT INTEGRITY established. They discovered that the appropriate containment cleanliness inspection procedure did not properly implement TS SR 4.5.2.c.2. TS SR 4.5.2.c.2 requires a visual inspection which verifies that no loose debris (i.e., rags, trash, clothing, etc.) is present in the containment which could be transported to the containment sump and cause restriction of pump suction during loss of coolant accident (LOCA) conditions. This visual inspection is required to be performed at least once daily if the containment has been entered that day and when the final containment entry is made. Contrary to TS SR 4.5.2.c.2, the approved procedure only required the inspection to be performed when all the work within containment had been completed and that no further containment entries were scheduled. A condition report/disposition request (CRDR) document was initiated and assigned to Nuclear Regulatory Affairs personnel to perform an investigation. On November 20, 1997, during an evaluation of the event, Nuclear Regulatory Affairs personnel discovered that the TS SR was not met during containment entries made following a Unit 1 reactor trip on May 27, 1997, and through May 29, 1997, when the final containment cleanliness inspection was completed. Therefore, the procedural discrepancy led to a reportable event under 10 CFR 50.73.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME	DOCKET NUMBER	LER NUMBER			PAGE		
Palo Verde Unit 1		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		97	- 005	- 00	03	of	04

TEXT

There were no safety system actuations and none were required.

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

The purpose of the containment inspection SR is to ensure that no loose debris (rags, trash, clothing, etc.) is present which could be transported to the containment recirculation sumps and cause a restriction of ECCS and Containment Spray (CS) (BE) pump suction. There are two sumps, one for each train of ECCS and CS pumps. If the sumps were to become clogged, the ECCS and CS pumps, which are required to mitigate a LOCA event, would be rendered INOPERABLE.

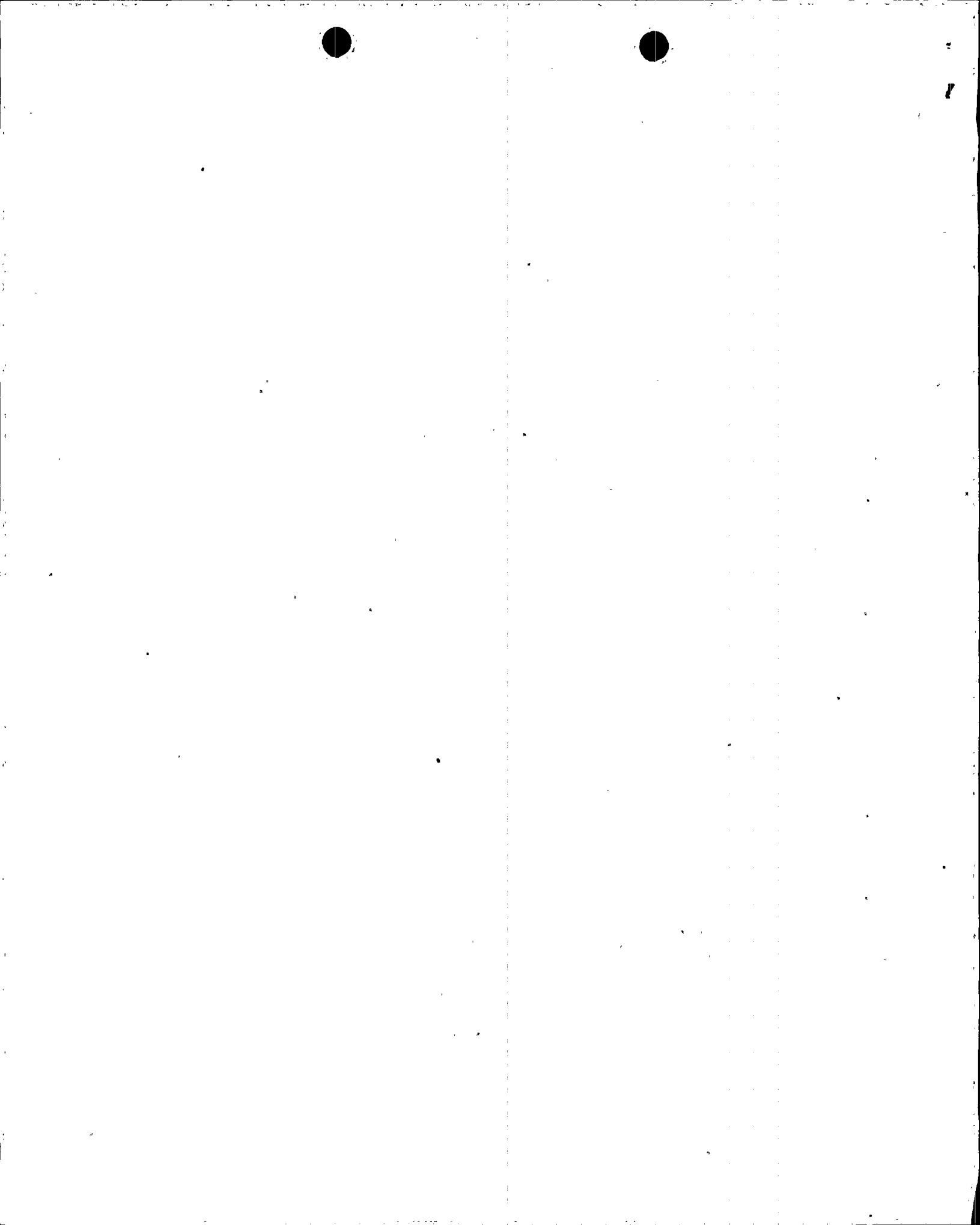
On May 27, 1997 at approximately 0607 MST a containment entry was made for the purpose of trouble shooting instrumentation problems and to seal a steam leak on a secondary side valve. The maintenance activities were completed and the containment inspection was completed on May 29, approximately 56 hours after initial containment entry. It is indeterminate how much "loose debris" was in containment during the 56-hour period. The normal work practice at PVNGS is to limit the amount of material taken into the radiological controlled area.

The event did not result in any challenges to the fission product barriers or result in any release of radioactive materials. In addition, no event occurred which required the use of the containment sumps. Therefore, there were no adverse safety consequences or implications as a result of this event. This event did not adversely affect the safe operation of the plant or health and safety of the public.

4. CAUSE OF THE EVENT:

On September 2, 1994, the NRC issued TS amendments 79, 66, and 51 to Units 1, 2, and 3 respectively. These amendments were requested by APS in response to Generic Letter (GL) 93-05, "Line-Item Technical Specification Improvements to Reduce Surveillance Requirements for Testing During Power Operation". These amendments included changes to TS SR 4.5.2.c.2 (GL 93-05, Item 7.5). A Nuclear Regulatory Affairs (NRA) responsible engineer (other utility personnel) performed a procedural impact review of the TS SR 4.5.2.c.2 change and believed that the change was a relaxation of existing requirements. He therefore determined that existing procedures met the TS amendment request and that no impact review nor procedure changes were required (SALP Cause Codes: A: Personnel Error).

No unusual characteristics of the work location (e.g., noise, heat, poor lighting) directly contributed to this event.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME	DOCKET NUMBER	LER NUMBER			PAGE	
Palo Verde Unit 1		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		9 7	- 0 0 5	- 0 0	0 4	of 0 4

TEXT

5. STRUCTURES, SYSTEMS, OR COMPONENTS INFORMATION:

There are no indications that any structures, systems, or components were inoperable at the start of the event that contributed to this event. No component or system failures were involved. No failures of components with multiple functions were involved. No failures that rendered a train of a safety system inoperable were involved.

6. CORRECTIVE ACTIONS TO PREVENT RECURRENCE:

On September 24, 1997, a night order was issued for Units 1, 2, and 3 to inform Operations personnel that the containment cleanliness inspection procedures did not properly reflect TS SR 4.5.2.c.2. The containment cleanliness inspection surveillance procedure and the containment entry procedure were revised on September 24, 1997 to reflect the performance requirements for TS SR 4.5.2.c.2. In addition, other TS changes associated with the TS amendments were reviewed and verified to have proper procedural implementation. This event was reviewed with NRA personnel to reemphasize the importance of the TS amendment impact review, which is a requirement in the TS amendment processing procedure.

7. PREVIOUS SIMILAR EVENTS:

Although previous events have been reported pursuant to 10CFR50.73 in the past three years for missing TS surveillance requirements, the causes discussed in the previous events have not been similar to this event. Therefore, the corrective actions of the previous events would not have prevented this event.

