

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)												DOCKET NUMBER (2)			PAGE (3)	
Palo Verde Unit 1												0 5 0 0 0 5 2 8			1 OF 0 3	

TITLE (4)

Inadvertant Control Room Essential Ventilation Actuation Signal Actuation

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 NUMBER(S)		
0 1 1 3 8 5	8 5 -	0 0 1 -	0 0 0 2 1 2 8 5						0 5 0 0 0			0 5 0 0 0		

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 0 0	20.402(b)	20.408(c)	X	50.14(a); 2 (iv)		73.71(b)						
		20.406(a)(1)(i)	50.38(c)(1)		50.73(a)(a),(v)		73.71(c)						
		20.406(a)(1)(ii)	50.38(c)(2)		50.73(a)(2)(vii)								
		20.406(a)(1)(iii)	50.73(a)(2)(ii)		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)(ii)		50.73(a)(2)(x)								

LICENSEE CONTACT FOR THIS LER (12)													
NAME											TELEPHONE NUMBER		
William F. Quinn (extension 6087)											AREA CODE	6 0 2 9 4 3 - 7 2 0 0	

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPPDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPPDS	

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

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

An inadvertant actuation of the Control Room Essential Filtration Signal (CREFAS) occurred during routine surveillance testing. The surveillance procedure called for the operator to reset a Containment Purge Isolation Actuation Signal (CPIAS) which was actuated as part of the surveillance. However, the surveillance procedure did not provide specific information regarding signal resetting. The operator pressed the wrong push button and actuation of CREFAS occurred. All components associated with the CREFAS functioned properly. The CPIAS and CREFAS circuitry was functionally tested and the surveillance procedure was revised to provide specific instruction on resetting action signals.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
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TEXT If more space is required, use additional NRC Form 386A's (17)

On January 13, 1985, Palo Verde Unit 1 was in Mode 6. Initial fuel loading had been completed, and Train B of shutdown cooling was in operation. Surveillance testing was being performed to verify proper operation of Containment Purge Isolation Actuation Signal (CPIAS) Train A. CPIAS Train A was manually actuated per the surveillance procedure, and component actuation was verified as satisfactory.

The surveillance procedure then required the operator to reset the CPIAS Train A signal without providing the details of how the signal resetting was to be accomplished. The CPIAS modules, where the reset is performed, has two reset push buttons, a "Trip Reset" and a "Manual Reset". The "Manual Reset" push button should have been pressed. However, without specific instruction from the surveillance procedure, the operator pressed the "Trip Reset" push button. Pushing the "Trip Reset" push button does not by itself cause a CREFAS actuation. However, the "Test" push button is located directly beneath the "Trip Reset" push button. Due to the size and location of the "Trip" and "Trip Reset" push buttons, the operator inadvertently pressed the "Test" push button when the "Trip Reset" push button was also pressed. The accidental pressing of the "Test" push button caused a cross logic trip of CPIAS Train B and an actuation of Train A and B of CREFAS. The inadvertent actuation occurred at 0237.

All components associated with Train B of CPIAS and Train A and B of CREFAS actuated properly. The Containment Purge Train B isolation valves closed on the cross logic trip from CPIAS Train A. The Control Room Ventilation realigned from its normal mode to its essential mode. The actuation signals were properly reset and the equipment not required to support plant conditions was shutdown. The NRC was notified at 0252 to comply with the 4 hour notification requirement.

The surveillance procedure used was revised during the shift to provide specific instruction on how to properly reset a CPIAS signal.

At the time of the incident, it could not be determined that the "Test" push button had been accidentally pressed, causing the CPIAS cross logic and CREFAS actuation. The CPIAS and CREFAS circuitry was tested to determine if sneak circuits or spurious signals existed. The testing revealed that the circuitry functioned properly. As part of the test, the system was placed into the condition existing at the time of the incident. The "Trip Reset" push button was tested and it functioned properly, a CPIAS cross logic and CREFAS actuation did not occur.

Based on the results of the retesting it has been concluded that the "Test" push button, located directly beneath the "Trip Reset" push button, was also pressed when the "Trip Reset" push button was pressed.

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The procedural inadequacy that led to the actuation has been corrected. The Balance of Plant Engineered Safety Features Actuation System functioned properly. Thus, as this event was not caused by equipment failure, and because an essential system did not fail to start, the safety margin of the plant was not impaired.

LER 85-002-00 contains additional information.