NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

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 2

TITLE (4)
Automatic Actuation of Balance of Plant Engineered Safety Feature System

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 5 0 0 0
0 2	0 6	8 5	8 5	–	0 1 1	–	0 0	0 3	0 8	8 5		0 5 0 0 0

OPERATING MODE (9)	5	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)	20.406(c)	X	50.73(a)(2)(iv)		73.71(b)
		20.406(a)(1)(i)	50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
		20.406(a)(1)(ii)	50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.406(a)(1)(iii)	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)(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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
X YES (If yes, complete EXPECTED SUBMISSION DATE)	NO		0 6	3 0	8 5

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

Automatic actuation of the Control Room Essential Filtration Actuation Signal occurred due to a spurious high radiation alarm on the radiation monitoring unit. All attendant equipment actuated satisfactorily. Spurious actuation was verified by sampling.

The root cause and final corrective action regarding this event are still under investigation and will be addressed in a supplement to this report.

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

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

On February 6, 1985, at 2035 Palo Verde Unit 1 was in Mode 5. Train "A" of Shutdown Cooling was in operation when the Control Room Essential Filtration unit was automatically operated by a spurious alarm/actuation from the control room ventilation radiation monitor. All attendant equipment operated satisfactorily.

The Control Room Essential Filtration unit is actuated from the Balance of Plant Engineered Safety Features Actuation System which receives a signal from the control room ventilation radiation monitoring unit. The signal will operate from either a high radiation signal or an equipment failure signal. The system computer identified that high radiation caused the trip; the radiation level indicated 2.19E-06 microcuries per milliliter with a setpoint of 2.20E-06 after the trip. The duration of the alarm was less than 18 seconds.

During investigation it was identified that the radiation alarm setpoint was greater than allowed by the Technical Specifications. The setpoint that was in effect was the default value which is stored in the radiation monitor's microcomputer software. The radiation monitor restores the default value for setpoints after a loss of power. The plant's redundant radiation monitor was operable with setpoints consistent with the Technical Specifications and the minimum channels needed to be operable per the Technical Specifications was satisfied.

The following action was taken: the high radiation alarm setpoint was adjusted to be conservative with the Technical Specifications and a plant change request has been generated to modify the microcomputer software default values to be consistent with the Technical Specifications. Plant procedures are in effect to verify that setpoints are in compliance with the Technical Specifications.

The cause of the high radiation signal was not identified. The range of the instrument is 1E-06 to 1E-01 microcuries per milliliter. The setpoint of 2E-06 is near the lower end of the range of the detector. Subsequent random spikes of indicated radiation levels have been observed on this monitor. Routine radiological surveys have not detected airborne radiation above naturally occur ing background levels. It is, therefore, believed that these random spikes of radiation levels are due to electronic circuit noise. Although none of the spikes have been of sufficient magnitude to cause a high alarm/actuation, this actuation is considered random and has not occurred since February 6, 1985.

LER 85-003-00 was also concerned with the automatic actuation of the Control Room Essential Filtration Actuation Signal due to a spurious high radiation alarm on the radiation monitoring unit.

The root cause and final corrective action regarding this event are still under investigation and will be addressed in a supplement to this report.

Arizona Nuclear Power Project
P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

ANPP-32098-EEVB/WFQ/GEC
March 8, 1985

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, License No. NPF-34
Licensee Event Report
File: 85-056-026; G.1.01.10

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 85-011-00 prepared and submitted pursuant to 10 CFR 50.73. By copy of this letter we are also forwarding a copy of the LER to the Regional Administrator of the Region V Office.

If you have any questions or concerns, please contact me.

Very truly yours,

E. E. Van Brunt

E. E. Van Brunt, Jr.
Executive Vice President
Project Director

EEVB/GEC/mb
Attachment

cc: J. B. Martin
R. P. Zimmerman
E. A. Licitra
A. C. Gehr
INPO Records Center

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