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 2	0 5 0 0 0 5 2 9	1 OF 0 2

TITLE (4)
Inadvertent Actuation of CPIAS and CREFAS Due to Personnel Error

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	2 4	8 6	8 6	– 0 0 4 –	0 0	0 2	2 0	8 6		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): 5
POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER AREA CODE	
William F. Quinn, Manager - Nuclear Licensing (Extension 4087)	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)

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)

On January 24, 1986, at 18[illegible], Palo Verde Unit 2 was in Mode 5 (COLD SHUTDOWN) when a Containment Purge Isolation Actuation Signal (CPIAS) and Control Room Essential Filtration Actuation Signal (CREFAS) were received on both channels.

Two utility Instrument and Control (I&C) Technicians were performing the radiation monitoring unit CHANNEL FUNCTIONAL TEST For the Fuel Pool Area Radiation Monitor (RU-31) when they inadvertently started testing on the Remote Indicating Controller (RIC) for the Containment Power Access Purge Exhaust Radiation Monitor (RU-37). As the trip setpoint for RU-37 was reached, a Train "A" CPIAS was received. The Train "A" CPIAS cross channel tripped the Train "A" CREFAS along with a cross train trip to Train "B" CPIAS and CREFAS. These trips are in accordance with plant design and all associated equipment operated satisfactorily.

The root cause of the incident was personnel error attributable to the failure of the I&C Technicians to verify the identification numbers on the RIC being tested. To prevent recurrence, I&C Technicians will attend a training briefing session on the importance of verifying complete instrument numbers prior to commencing work.

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NRC Form 366A
(9-83)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
Palo Verde Unit 2	0 5 0 0 0 5 2 9	8 6	— 0 0 4 —	0 0	0 2 OF 0 2

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

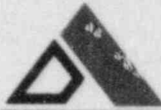
On January 24, 1986, at 1849, Palo Verde Unit 2 was in Mode 5 (COLD SHUTDOWN) when a Containment Purge Isolation Actuation Signal (CPIAS) (JE) and Control Room Essential Filtration Actuation Signal (CREFAS) (JE) were received on both channels.

Two utility Instrument and Control (I&C) Technicians were performing the radiation monitor unit (IL) CHANNEL FUNCTIONAL TEST for the Fuel Pool Area Radiation Monitor (RU-31) when they inadvertently started testing on the Remote Indicating Controller (RIC) for the Containment Power Access Purge Exhaust Radiation Monitor (RU-37). As the trip setpoint for RU-37 was reached, a Train "A" CPIAS was received. The Train "A" CPIAS cross channel tripped the Train "A" CREFAS along with a cross train trip to Train "B" CPIAS and CREFAS. These trips are in accordance with plant design and all associated equipment operated satisfactorily.

The root cause of the incident was personnel error attributable to the failure of the I&C Technicians to verify the identification numbers on the RIC being tested. To prevent recurrence, I&C Technicians will attend a training briefing session on the importance of verifying complete instrument numbers prior to commencing work.

No safety limits were approached, no fission product barriers were challenged, and all equipment functioned as designed. Therefore, there was never any threat to the health and safety of the public.

A similar event occurred in Unit 2 and was reported in LER 85-006-00.



Arizona Nuclear Power Project

P.O. BOX 52034 • PHOENIX, ARIZONA 85072-2034

February 20, 1986
ANPP-35240-EEVB/BJA/98.05

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

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 2
Docket No. STN 50-529 (License NPF-46)
Licensee Event Report - 86-004-00
File: 86-020-404

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 86-004-00 prepared and submitted pursuant to 10 CFR 50.73. In accordance with 10 CFR 50.73(d), we are herewith forwarding a copy of the LER to the Regional Administrator of the Region V Office.

If you have any question, please contact me.

Very truly yours,

E. E. Van Brunt

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

EEVB/BJA/rw
Attachment

cc: J. B. Martin (all w/a)
R. P. Zimmerman
A. L. Hon
E. A. Licitra
A. C. Gehr
INPO Records Center

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