NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

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)

Personnel Error Occurred During Performance of Surveillance Test

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 1 2 0 8 6			8 6	—	0 1 0	— 0 0	0 2	2 0	8 6		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)			
1		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 1 0		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)	X 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)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

At approximately 0600 on January 21, 1986, Palo Verde Unit 1 was in Mode 1, (POWER OPERATION), at 10 percent reactor power, when it was discovered that a surveillance test procedure was completed within the required time interval but the results were not within the acceptance criteria.

The licensed operator who performed the surveillance test did not realize that the results were not within the acceptance criteria. This constituted a deviation from the plant's Technical Specifications.

To prevent recurrence, the Unit 1 shift supervision has been directed to take more responsibility to assure that the operators perform surveillance tests correctly. The individuals involved were counseled about their involvement in the surveillance test performance and review. In addition, the non-licensed Shift Technical Advisors are now reviewing completed operations surveillance tests to assure that the tests are performed properly.

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

At approximately 0600, on January 21, 1986, Palo Verde Unit 1 was in Mode 1, (POWER OPERATION), at 10 percent reactor power, when it was discovered that a step in a surveillance test procedure which was required by Technical Specification (T.S.) 4.5.1, had not been performed properly. The surveillance test was completed within the required surveillance interval, but the results were not within the acceptance criteria. The fact that the test results were not within the acceptance criteria was not immediately recognized.

A licensed operator had performed surveillance testing of the Safety Injection Tank (SIT)(BP) levels at approximately 2359 on January 19, 1986, when he recorded a level indication, from the control board, that was outside of the acceptance criteria. He then notified the senior reactor operator licensed assistant shift supervisor of the problem. The assistant shift supervisor checked the SIT level on the plant monitoring system and it read within the acceptance criteria. However, no action was initiated to correct the difference in level indications.

The next performance of the surveillance test on the SIT level was performed at approximately 1240 on January 20, 1986. The same SIT had an indicated level, as read from the control board, that was out of tolerance. The licensed operator, who recorded the level, did not recognize that it was out of tolerance.

At 2226 on January 20, 1986, the surveillance test was again performed and the SIT was then realized to be out of tolerance. The licensed operator declared the SIT inoperable and started draining it in order to restore tank level to an acceptable value. At 2255 on January 20, 1986, the level was back within the acceptance criteria. A review of the previous surveillance tests was then conducted to determine how long the SIT was outside of the acceptance criteria. The surveillance test errors were discovered during the review.

On January 22, 1986, an Instrumentation and Controls Technician discovered that the reference leg water level for the level transmitters was low. When the reference leg was refilled, the tank level indication dropped about 2 percent. As a result, the level indications which had been recorded by the operators were approximately 2 percent higher than the actual water level in the SIT. The out of tolerance readings recorded by the operators were not more than 2 percent over the limit. Therefore, the level in the SIT had been within the required range during the performance of the surveillance tests.

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

Since the SIT level was not actually out of the T.S. required range, this event had no impact on the health and safety of the public.

An evaluation is being conducted on how to make all SIT level indications more reliable and accurate. If necessary, a Plant Change Package will be issued to install plant changes on the SIT level instrumentation.

To prevent recurrence, a letter has been distributed to the Unit 1 shift supervision directing them to take more responsibility in assuring that the operators perform surveillance tests correctly and on time. The individuals involved were also counseled about their involvement in the improper surveillance test performance and review. In addition, the Shift Technical Advisors (non-licensed) are now reviewing completed operations surveillance tests at the end of every shift to assure that every step is performed properly.

A previous similar event occurred in Unit 1 and was reported in LER 85-087-00.

Arizona Nuclear Power Project
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February 20, 1986
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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-41
Licensee Event Report - 86-010-00
File: 86-020-404

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 86-010-00 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 questions, please contact me.

Very truly yours,

E. E. Van Brunt

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

EEVB/JKO/rw
Attachment

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

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