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 2

TITLE (4)
Maximum Surveillance Interval Exceeded 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 5 0 0 0
0 3	0 4	8 6	8 6	–	0 1 2	– 0 0	0 4	0 3	8 6		0 5 0 0 0

OPERATING MODE (9): 1

POWER LEVEL (10): 1 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)	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)	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)

On March 6, 1986, the following event which occurred on March 4, 1986 was identified. On March 4, 1986, Palo Verde Unit 1 was in Mode 1 (POWER OPERATION), at approximately 100 percent reactor power when Surveillance Test 41ST-1ZZ16, Routine Surveillance Daily Midnight Logs, was performed beyond the maximum allowable time for three consecutive surveillance tests.

The root cause of the incident was a cognitive personnel error in that the operating crews failed to follow an approved procedure revision which changed the performance times to coincide with revised shift schedules. The personnel performing the surveillance test were licensed operators. There were no unusual chracteristics of the work location that directly contributed to the event. There were no component, system, or safety train failures that contributed to the event.

A night order has been written informing the operating crews of the time changes in 41ST-1ZZ16. To prevent recurrence, a department guideline has been developed to notify all operating personnel of any procedure changes.

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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 6	— 0 1 2	— 0 0	0 2 OF 0 2

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

On March 6, 1986, the following event, which occurred on March 4, 1986, was identified. On March 4, 1986, Palo Verde Unit 1 was in Mode 1 (POWER OPERATION), at approximately 100 percent reactor power when Surveillance Test 41ST-1ZZ16, Routine Sureillance Daily Midnight Logs, was to be performed by 0100 and was not performed until 0327. This exceeded the 3.25 times the maximum allowable interval for any three consecutive surveillances as stated in Technical Specification 4.0.2. This occurred between March 1, 1986, and March 4, 1986. This procedure satisfies the daily surveillance requirements of Technical Specifications; 4.1.3.6, 4.1.1.1.1.e, 4.1.1.2.b, 4.1.2.5.b, 4.1.2.5.c, 4.1.2.6.b, 4.1.2.6.c, 4.3.3.8.a, 4.4.3.2.1, 4.4.5.2.1.d, 4.5.4.b, 4.6.1.5, 4.7.1.6.a, 4.7.5, 4.3.3.4, and 4.3.1.1 table 4.3-1 items I.A.8 2,4), I.B.1 (2,4), I.A.9 (2,4), I.C.2 (2,4).

A new revision of the surveillance test became effective on February 24, 1986, whicn changed the time the daily surveillance is to be performed. The times were changed to coincide with the operators' revised shift schedule.

The root cause of the incident was a cognitive personnel error in that the operating crews failed to follow an approved procedure revision. The personnel performing the surveillance test were licensed operators. There were no unusual characteristics of the work location that directly contributed to the event. There were no component, system or safety train failures that contributed to the event. No safety limits were approached, no fission product barriers were challenged and, therefore, there was no threat to the health and safety of the pubic.

A night order has been written informing the operating crews of the time changes in 41ST-1ZZ16.

To prevent recurrence, a department guideline has been developed to notify operating personnel of any procedure changes.

A similar event occurred in Unit 1 as reported in LER 85-015-00.

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

April 3, 1986
ANPP-35942-EEVB/DAL/98.05

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 NPF-41)
Licensee Event Report - 86-012-00
File: 86-020-404

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 86-012-00 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,
EE VanBrunt Jr/KJ
E. E. Van Brunt, Jr.
Executive Vice President
Project Director

EEVB/DAL/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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