

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 3		

TITLE (4)

Safety Injection Tanks Inoperable 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)								
									N/A						0	5	0	0	0			
0	7	1	7	8	6	8	6		0	4	8		0	0	0	8	1	5	8	6		
									N/A						0	5	0	0	0			

OPERATING MODE (8)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)				
4		20.402(b)		20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0 0 0	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	
Thomas R. Bradish, Compliance Supervisor (Ext. 6936)	AREA CODE	
	6 0 2	9 3 2 - 5 3 0 0

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) _____		<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH 	DAY 	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)

At 2105 MST on July 17, 1986, Palo Verde Unit 2 was in Mode 4 (HOT STANDBY) when Technical Specification Limiting Condition for Operation 3.0.3 was entered due to four (4) Safety Injection Tanks being declared inoperable. The tanks were declared inoperable because the high level limit was exceeded based on the wide range level indication. This was discovered by a control room operator during the performance of surveillance procedure 42ST-2ZZ18 (Mode 1-4 Log Readings).

The root cause of the event was cognitive personnel error by the control room operator (utility-licensed) in that SIT level monitoring was not performed sufficiently during plant heatup per the caution statement in procedure 420P-2ZZ01 (Mode 5 to Mode 3 operations).

To prevent recurrence, the Unit 2 Day Shift Supervisor (utility-licensed) has issued a department night order stating the importance of SIT level monitoring during plant heatup.

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PDR ADUCK 05000529
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/88

FACILITY NAME (1) Palo Verde Unit 2	DOCKET NUMBER (2) 0500052986	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		86	048	00	02	OF	03

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

At 2105 MST on July 17, 1986, Palo Verde Unit 2 was in Mode 4 (HOT STANDBY) when Technical Specification Limiting Condition for Operation (LCO) 3.0.3 was entered as a result of four (4) Safety Injection Tanks (SIT)(BP) being declared inoperable. The tanks were declared inoperable because the high level limit was exceeded based on the wide range level indication. This was discovered by a control room operator (utility-licensed) during the performance of surveillance procedure 42ST-2ZZ18 (Mode 1-4 Log Readings). This procedure satisfies Surveillance Requirements 4.5.1 a.1.

There were no level alarms (LA) present because the circuitry for the wide range is not alarmed in accordance with design. The level alarms are only associated with the narrow range level indication (LI) which showed the levels to be within specification. At the time of the event, operating procedure 42OP-2ZZ01 (Mode 5 to Mode 3 Operation) was in progress. This involved the pressurizing of the Reactor Coolant System (RCS)(AB) to 1200 psia. It was during the process of increasing RCS pressure that the levels increased above the high limit on the wide range level instrumentation. During the process of increasing RCS pressure, 42OP-2ZZ01 cautions the operator to monitor the SIT level.

The narrow range and the wide range instruments were within calibration tolerances with the wide range reading higher than the narrow range. Action was taken in accordance with LCO 3.0.3 and the control room operator (utility-licensed) restored the levels to within specifications at 2308, at which time LCO 3.0.3 was exited. The event lasted 2 hours and 3 minutes.

Discrepancies presently exist in correlating the wide and narrow range levels. Prior to the event, an Engineering Evaluation Request (EER)(86-SI-093) had been generated requesting correlation between wide and narrow range SIT level indications. This correlation discrepancy was a contributing factor in the event. The operators assumed that if the narrow range was below the high limit the wide range would also be below the high limit.

The root cause of the event was cognitive personnel error by the control room operator (utility-licensed) in that the SIT level monitoring was not performed sufficiently during plant heatup as indicated in the caution statement provided in procedure 42OP-2ZZ01. As previously discussed, a contributing factor was the correlation between the wide and narrow ranges.

To prevent recurrence, the Unit 2 Day Shift Supervisor (utility-licensed) has issued a department night order stating the importance of SIT level monitoring during plant heatup. Procedural guidance provided in this area is considered adequate and there were no procedural deficiencies which contributed to the event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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EXPIRES: 8/31/88

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					0 3	OF	0 3

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

No structures, systems or components were inoperable prior to the event that contributed to the event. There were no automatic or manual safety system responses. No safety limits were approached, no fission product barriers were challenged and all equipment would have functioned if required. Therefore, there was no threat to the health and safety of the public. Both high and low pressure Safety Injection (SI)(BQ)(BP) trains were operable and capable of injecting borated water in the event of a loss of coolant. Therefore, there were no safety consequences or implications of the event.

There have not been any similar events reported.



Arizona Nuclear Power Project

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

August 15, 1986
ANPP-00052-JGH/TDS/JEM/96.03

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
Licensee Event Report-86-048-00
File: 86-020-404

Dear Sirs:

Attached please find Licensee Event Report (LER) No.86-048-00 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 T. R. Bradish, Compliance Supervisor at (602)932-5300 Ext.6936.

Very truly yours,

J. G. Haynes
Vice President
Nuclear Production

JGH/JEM/dh

Attachment

cc: O. M. DeMichele (all w/a)
E. E. Van Brunt, Jr.
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