

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 5 1 2 9										PAGE (3) 1 OF 0 1 3				
TITLE (4) Control Room Ventilation Recirculation Discontinued Due to Operator 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									
1	2	1	8	8	5	8	5	0	0	5	0	1	0	6	0	5	8	6	N/A					
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																						
6		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 10 10		20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 356A)										
		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)(ix)														
LICENSEE CONTACT FOR THIS LER (12)																								
NAME										TELEPHONE NUMBER														
William F. Quinn, Manager - Nuclear Licensing (Extension 4087)										6 1 0 2 9 4 1 3 - 7 1 2 0 1 0														
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																								
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS														
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)

This LER supplements the information submitted in LER 85-005-00.

At 0746 MST on December 19, 1985, Palo Verde Unit 2 was in Mode 6 (REFUELING) when it was realized that the Control Room Essential Ventilation System had been removed from operation in the recirculation mode. Operation in the recirculation mode was required by Technical Specifications (T.S.) because of the inoperable status of both safety trains of control room ventilation intake noble gas radiation monitors.

The root cause of this event was a cognitive personnel error which was complicated by a failure to follow the approved procedure which controls the determination of equipment operability. This event was not directly contributed to by any system or component failures.

As a corrective action, the ventilation system was restored to the recirculation mode after the termination was discovered. A meeting was held with the operations personnel who were on the crew that had terminated operation of the ventilation system. Items discussed in this meeting included the need to ensure that the conditions that require T.S. action have cleared prior to termination of the action. In order to ensure proper future interpretation of T.S. 3.3.3.1, Action Statement 26, it was also discussed that the recirculation fan must be running in order to qualify the recirculation mode as being in "operation".

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMS NO. 3150-0104

EXPIRES: 8/31/88

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

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

At 0746 on December 19, 1985, Palo Verde Unit 2 was in Mode 6 (REFUELING) when it was discovered that the Technical Specification required operation of the Control Room Essential Ventilation System (VI) in the recirculation mode had been discontinued. The unit was in Mode 6 for the duration of this event.

Prior to this event, the Train "B" control room ventilation intake noble gas radiation monitor (IL), RU-30, had been declared INOPERABLE and removed from service. The corresponding radiation monitor for Train "A", RU-29, was rendered technically INOPERABLE when the Train "A" engineered safety feature (ESF) load sequencer (JE) was removed from service. As a result of both trains of control room ventilation intake noble gas radiation monitors being INOPERABLE, the Control Room Essential Ventilation System was aligned and operated in the recirculation mode, as required by Action Statement 26 of Technical Specification 3.3.3.1.

A spare ESF load sequencer was located and installed to replace the load sequencer which had been previously removed. Upon installation of the spare ESF load sequencer, an operator (licensed-utility) assumed that the Technical Specification condition which had required operation of the Control Room Essential Ventilation System in the recirculation mode had cleared. At some time between 2100 on December 18, and 0552 on December 19, the operator secured the recirculation fan, removing the system from operation in the recirculation mode.

Although the replacement ESF load sequencer was in service, it was not OPERABLE, since response time testing of the sequencer had not yet been performed. As a result, the operator was incorrect in assuming that the Train "A" radiation monitor, RU-29, was OPERABLE following the installation of the replacement load sequencer. The operator terminated operation of the Control Room Essential Ventilation System in the recirculation mode based upon this assumption.

The shift crew which followed the crew that had terminated operation of the Control Room Essential Ventilation System recognized the error and reinitiated operation of the ventilation system in the recirculation mode at 0746 on December 19.

The root cause of this event was a cognitive personnel error, which was demonstrated by the licensed operator not recognizing the continued applicability of the Technical Specification condition which required operation of the Control Room Essential Ventilation System in the recirculation mode. The event was complicated by a failure to follow the approved procedure which controls determination of the operability of components and systems. This event was not directly contributed to by any failed or inoperable components, structures, or systems, nor was it contributed to by any unusual characteristics of the work location.

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		8 5 -	0 0 5 -	0 1	0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 365A's) (17)

As a corrective action, the Control Room Essential Ventilation System was restored to the recirculation mode. A meeting was held with the operations personnel who were on the crew that had terminated operation of the ventilation system in the recirculation mode. Items discussed during this meeting included the need to verify that the conditions that require Technical Specification action have cleared prior to termination of the required action. In order to ensure proper future interpretation of Technical Specification 3.3.3.1, Action Statement 26, it was also discussed that the recirculation fan must be running in order to qualify the recirculation mode as being in "operation" as required by the Technical Specification Action Statement.

Although operation of the Control Room Essential Ventilation System in the recirculation mode was terminated when the recirculation fan was secured, the system remained aligned for operation in the recirculation mode, with the outside air dampers closed. Therefore, had an event involving a release outside of the control room (NA) occurred, the safe operation of the plant would not have been affected by this event.

No previous events of this type have been reported for Unit 2.



Arizona Nuclear Power Project

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

June 5, 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 2
Docket No. STN 50-529 (License NPF-51)
Licensee Event Report - 85-005-01
File: 86-020-404

Dear Sirs:

Attached please find Supplement Number 01 to Licensee Event Report (LER) No. 85-005-00 prepared and submitted pursuant to 10 CFR 50.73. In accordance with 10 CFR 50.73(d), we are herewith forwarding a copy of this report to the Regional Administrator of the Region V Office.

If you have any questions, please contact me.

Very truly yours,

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

EEVB/PGN/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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