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 Results in Termination of Continuous Fire Watch

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 1	2 6	8 5	8 5	–	0 9 2	–	0 1	0 6	2 0	8 6	N/A	0 5 0 0 0

OPERATING MODE (9)	3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 0 0	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)

This is a supplement to LER 85-092-00 submitted on December 27, 1985.

Continued investigation of this incident has revealed the following additional information. At 1810 MST on November 26, 1985, with Palo Verde Unit 1 in Mode 3 (HOT STANDBY) a Technical Specification required continuous fire watch for the Main Steam Support Structure (MSSS) was inadvertently terminated for a period of 64 hours, 50 minutes. This information is different than that provided in the original LER, which stated that the continuous fire watch was replaced with an hourly patrol. The original error was discovered at 1100 on November 29, 1985, and the continuous fire watch was resumed. This additional information has no effect on the reporting requirements or the corrective action taken as stated below.

The event was caused by a member of the Fire Protection Department who did not correctly transfer fire watch information to the documents which direct Fire Watch personnel in the field.

As a corrective action, the continuous fire watch was re-established as soon as this error was identified. Discussions were held with the Fire Protection Department personnel involved in this event to ensure that the proper method of transferring fire watch information to the documents which direct Fire Watch personnel in the field is understood.

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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 5	— 0 9 2	— 0 1	0 2 OF 0 3

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

This is a supplement to LER 85-092-00 submitted on December 27, 1985.

Continued investigation of this incident has revealed the following additional information. At 1810 MST on November 26, 1985, with Palo Verde Unit 1 in Mode 3 (HOT STANDBY) a Technical Specification required continuous fire watch was inadvertently terminated for a period of 64 hours and 50 minutes. This information is different than that provided in the original LER, which stated that the continuous fire watch was replaced with an hourly patrol. The hourly fire watch discussed previously was assigned as a roving watch whose duties were not specifically addressed to compensate in this area. Therefore, based on the additional investigation, it was determined that credit could not be taken for that watch. The original error was discovered during a review of Fire System Impairment Log Forms at 1100 on November 29, 1985. At that time, the continuous fire watch was resumed. The additional information has no effect on the reporting requirements or the corrective action taken as stated below.

Unit 1 fire protection preaction valve FPV-801 (KP) was closed at 1450 on November 25, 1985. Closure of the preaction valve resulted in the fire suppression system (KP) for the Main Steam Support Structure (MSSS) being declared inoperable. A continuous fire watch was posted within 1 hour of the preaction valve closure, as required by Technical Specification Action Statement 3.7.11.2.a.

The termination of the continuous fire watch was a cognitive personnel error by a non-licensed utility member of the Fire Protection Department. The person involved incorrectly recorded the return to operable status for the Unit 2 fire protection preaction valve in the Unit 1 Fire System Impairment Log. This error resulted in cancellation of the continuous fire watch in the Unit 1 Fire Watch Status Log, and the inadvertent termination of the required continuous fire watch in the Unit 1 MSSS. The Fire System Impairment Log and the Fire Watch Status Log record all inoperable fire protection equipment and direct necessary compensatory actions to field personnel, respectively. These actions were contrary to an approved procedure.

As a corrective action, the continuous fire watch was re-established as soon as the event was identified, and the Fire Protection Department personnel who were involved were counseled to ensure that the need to accurately transfer the correct fire watch requirements to the Fire System Impairment Log Sheet is understood.

If a fire threat had existed during this period, it would have been detected by the installed fire detection instrumentation, allowing actions to mitigate the fire threat to be taken in a timely manner. Therefore, there was no threat to the health and safety of the public.

This event did not result in the manual or automatic actuation of any safety systems. There were no unusual characteristics of the work location that directly contributed to the error. There were no inoperable structures, components or systems at the start of the event that contributed to the event.

A similar event involving inadequate fire watches, but due to a different cause, was reported in Unit 1 LER 85-040-00.

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

June 20, 1986
ANPP-37080-EEVB/PGN/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 - 85-092-01
File: 86-020-404

Dear Sirs:

Attached please find Supplement Number 01 to Licensee Event Report (LER) No. 85-092-00 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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