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SUBJECT: LER 88-003-00:on 880120,Tech Specs action requirement performed late due to personnel error.
W/8 ltr.

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192-00346-JGH/TDS/JEM
February 16, 1988

NRC Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 2
Docket No. STN 50-529 (License No. NPF-51)
Licensee Event Report 2-88-003-00
File: 88-020-404

Attached please find Licensee Event Report (LER) No. 88-003-00 prepared and submitted pursuant to 10CFR 50.73. In accordance with 10CFR 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. D. Shriver, Compliance Manager at (602) 393-2521.

Very truly yours,

J. G. Haynes
Vice President
Nuclear Production

JGH/TDS/JEM/kj

Attachment

cc: O. M. DeMichele (all w/a)
E. E. Van Brunt, Jr.
J. B. Martin
T. J. Polich
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INPO Records Center

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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 2	0 5 0 0 0 5 2 9	1 OF 0 2

TITLE (4)

Technical Specification Action Requirement Performed Late 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 1	2 0	8 8	8 8	— 0 0 3	— 0 0	0 2	1 6	8 8	N/A	0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 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
Timothy D. Shriver, Compliance Manager	6 0 2 3 9 3 - 2 5 2 1

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 0958 MST on January 20, 1988, Palo Verde Unit 2 was in Mode 1 (POWER OPERATION) at 100 percent power when Emergency Diesel Generator "A" (DG) was declared inoperable for preplanned preventive maintenance. The diesel generator was returned to OPERABLE status at 1107 MST on January 20, 1988.

At approximately 1200 MST on January 20, 1988 it was identified that Technical Specification 3.8.1.1 ACTION b was not complied with. The OPERABILITY of the A.C. offsite sources was not verified within 1 hour after declaring the diesel generator inoperable. The surveillance was satisfactorily completed at 1223 MST on January 20, 1988.

The root cause of the event was cognitive personnel error on the part of the control room personnel (utility, licensed) in that they did not perform the specified ACTION requirement within 1 hour.

As corrective action appropriate disciplinary action was administered.

Previous similar events were reported in Palo Verde Unit 1 LER's: 85-054-00, 85-072-00 and 86-001-00.

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

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

At 0958 MST on January 20, 1988, Palo Verde Unit 2 was in Mode 1 (POWER OPERATION) at 100 percent power when Emergency Diesel Generator "A" (DG) was declared inoperable for preplanned preventive maintenance. The diesel generator was returned to OPERABLE status at 1107 MST on January 20, 1988.

At approximately 1200 MST on January 20, 1988 it was identified, through a routine review of shift activities conducted by the Operations Manager (utility, licensed), that Technical Specification 3.8.1.1 ACTION b had not been performed. ACTION b requires that with one emergency diesel generator inoperable, the OPERABILITY of the A.C. offsite sources must be demonstrated operable by performing Surveillance Requirement 4.8.1.1.1.a within 1 hour and at least once per 8 hours thereafter. Contrary to Technical Specification 3.8.1.1 ACTION b the offsite power sources were not determined to be operable within 1 hour of declaring the diesel generator inoperable. The Surveillance Requirement was satisfactorily completed at 1223 MST on January 20, 1988.

The root cause of the event was cognitive personnel error on the part of the control room personnel (utility, licensed) in that they did not perform the specified ACTION requirement within 1 hour. This was contrary to Technical Specification 3.8.1.1 ACTION b. Although there are no specific procedural controls provided that require the performance of the action statement, ANPP believes the generic administrative controls used in conjunction with the specific guidance provided in the PVNGS Technical Specifications are adequate. There were no unusual characteristics of the work location that directly contributed to the event. There were no automatically or manually initiated safety system responses. There were no structures, components or systems inoperable at the start of the event that contributed to the event other than that mentioned above. No safety limits were approached, no fission product barriers were challenged and the A.C. offsite sources were OPERABLE at all times. Therefore, there was no threat to the health and safety of the public.

As corrective action to prevent recurrence appropriate disciplinary action was administered.

Previous similar events were reported in Palo Verde Unit 1 LER's: 85-054-00, 85-072-00 and 86-001-00. Cognitive errors are primarily the result of mental lapses and are not normally correctable with revised procedures or additional training. Therefore, ANPP believes that the corrective action taken in response to the previous events would not have prevented this event.