

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8803080340 DOC. DATE: 88/03/07 NOTARIZED: NO DOCKET #
 FACIL: STN-50-530 Palo Verde Nuclear Station, Unit 3, Arizona Publi 05000530
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 SHRIVER, T. D. Arizona Nuclear Power Project (formerly Arizona Public Serv
 HAYNES, J. G. Arizona Nuclear Power Project (formerly Arizona Public Serv
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-003-00: on 880204, failure to perform 96 h ASME
 Section XI technical review identified. Caused by cognitive
 personnel error. Shift technical advisor "in" basket
 separated from all other baskets. W/880307 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4
 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: Standardized plant.

05000530

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	PD5 LA	1 1	PD5 PD	1 1
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INTERNAL:	ACRS MICHELSON	1 1	ACRS MOELLER	2 2
	AEOD/DOA	1 1	AEOD/DSP/NAS	1 1
	AEOD/DSP/ROAB	2 2	AEOD/DSP/TPAB	1 1
	ARM/DCTS/DAB	1 1	DEDRO	1 1
	NRR/DEST/ADS7E4	1 0	NRR/DEST/CEB8H7	1 1
	NRR/DEST/ESB 8D	1 1	NRR/DEST/ICSB7A	1 1
	NRR/DEST/MEB9H3	1 1	NRR/DEST/MTB 9H	1 1
	NRR/DEST/PSB8D1	1 1	NRR/DEST/RSB 8E	1 1
	NRR/DEST/SGB 8D	1 1	NRR/DLPQ/HFB10D	1 1
	NRR/DLPQ/QAB10A	1 1	NRR/DOEA/EAB11E	1 1
	NRR/DREP/RAB10A	1 1	NRR/DREP/RPB10A	2 2
	NRR/DRIS/SIB9A1	1 1	NRR/PMAS/ILRB12	1 1
	REG FILE 02	1 1	RES TELFORD, J	1 1
	RES/DE/ETB	1 1	RES/DRPS DIR	1 1
	RGN5 FILE 01	1 1		
EXTERNAL:	EG&G GROH, M	5 5	FORD BLDG HOY, A	1 1
	H ST LOBBY WARD	1 1	LPDR	1 1
	NRC PDR	1 1	NSIC HARRIS, J	1 1
	NSIC MAYS, G	1 1		

NOTES: 1 1

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Arizona Nuclear Power Project

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

192-00349-JGH/TDS/JEM

March 7, 1988

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

Dear Sirs:

Subject: Palo Verde Nuclear Generating Station (PVNGS)
Unit 3
Docket No. STN 50-530 (License No. NPF-74)
Licensee Event Report 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
R. C. Sorenson
E. A. Licitra
A. C. Gehr
INPO Records Center

IE22
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 3										DOCKET NUMBER (2) 0 5 0 0 0 5 3 0										PAGE (3) 1 OF 0 3	
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TITLE (4)
ASME Section XI 96 Hour Test Review Not Performed 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 N/A					DOCKET NUMBER(S) 0 5 0 0 0														
0	2	0	4	8	8	8	8	0	0	3	0	0	0	3	0	7	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)				20.406(e)				50.73(a)(2)(iv)				73.71(b)					
		20.406(a)(1)(i)				50.38(c)(1)				50.73(a)(2)(v)				73.71(c)					
		20.406(a)(1)(ii)				50.38(c)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 365A)					
		20.406(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(vii)(A)									
		20.406(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)									
		20.406(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)									

LICENSEE CONTACT FOR THIS LER (12)																	
NAME Timothy D. Shriver, Compliance Manager												TELEPHONE NUMBER 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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

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 approximately 1340 on February 4, 1988, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION) at 100 percent power when it was identified that a 96 hour ASME Section XI technical review was not performed in accordance with Technical Specification 4.0.5 on surveillance test 43ST-3SI10 (High Pressure Safety Injection (HPSI) Pump Operability Test 4.5.2.f.1)(BQ)(P). The test was performed on November 11, 1987.

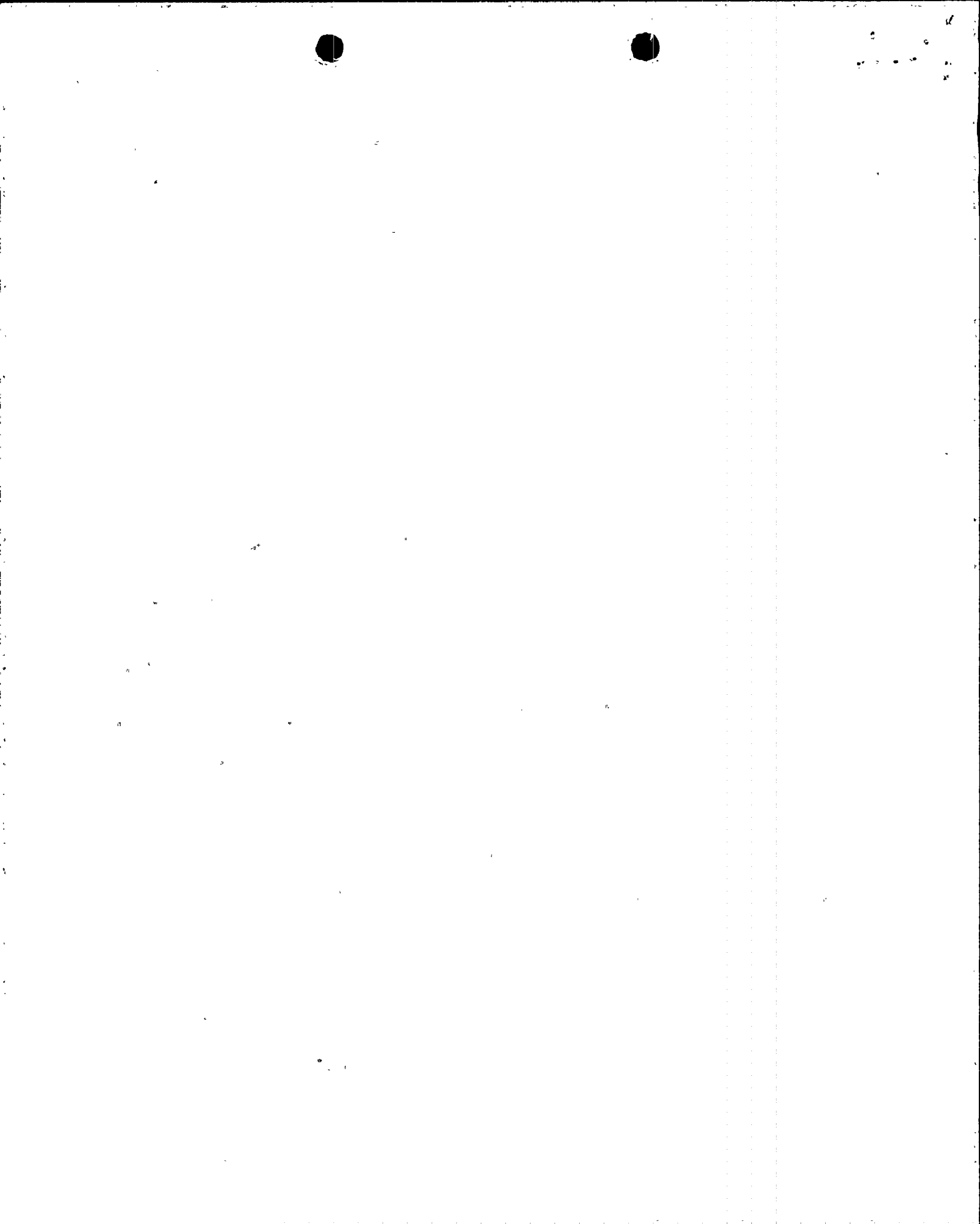
The event was discovered on February 4, 1988 during a review of the February 1988 surveillance test. The ASME Section XI engineer noted that there was no entry for the November, 1987 performance in his trend log book. He then retrieved the November, 1987 test from records and performed the technical review. All data was found to be acceptable and no abnormalities were identified.

The root cause of the event was determined to be a cognitive personnel error by a performance group immediate supervisor (utility, licensed) and the Shift Technical Advisor Supervisor (utility, licensed) in that they did not take adequate measures to ensure that the proper reviews were conducted.

To prevent recurrence of the event, the STA's "in" basket was separated from all other baskets and this event will be discussed with responsible individuals.

Previous similar occurrences were reported in LER's 85-035-00 and 85-045-00

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

EXPIRES: 8/31/88

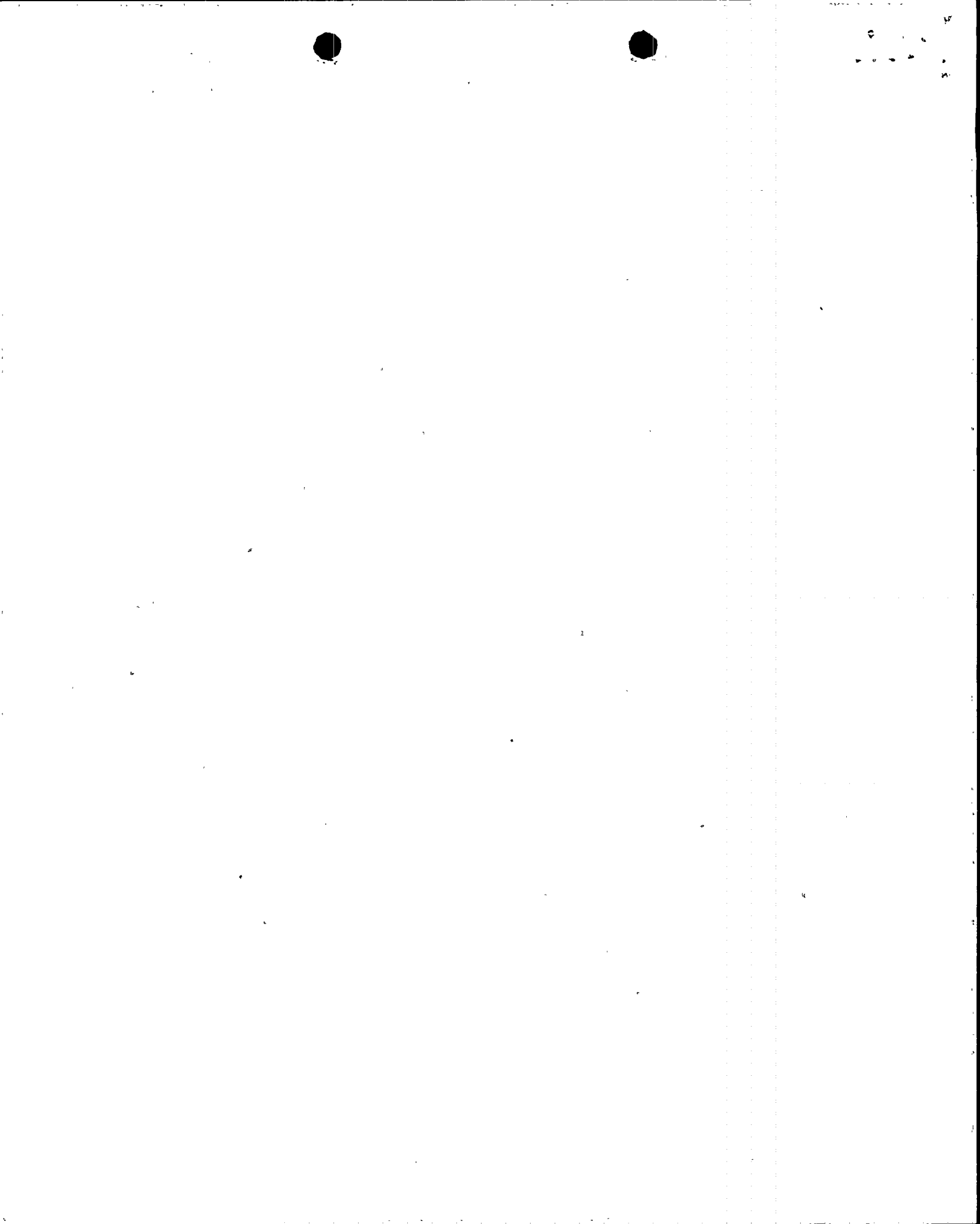
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Palo Verde Unit 3	0 5 0 0 0 5 3 0	8 8	— 0 0 3	— 0 0	0 2	OF	0 3

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

At approximately 1340 on February 4, 1988, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION) at 100 percent power when it was identified that a 96 hour ASME Section XI technical review was not performed as required by Technical Specification 4.0.5. The review had not been performed on surveillance test 43ST-3SI10 (High Pressure Safety Injection (HPSI) Pump Operability Test 4.5.2.f.1)(BQ)(P). The test was performed on November 11, 1987.

The event was discovered by an ASME Section XI pump (P) and valve (V) engineer (utility, non-licensed) during his review of the February, 1988 quarterly surveillance test. The engineer was reviewing the February test to enter data into his trending data base and compare it with previous data. During this review he noticed that there was no data for the November, 1987 surveillance test. The engineer retrieved the surveillance test from Document Control and discovered that the technical review had not been performed. The engineer performed the technical review and all data was found to be acceptable. The engineer updated his trending log and completed his evaluation noting no other abnormalities.

Current procedural controls require that upon completion of a surveillance test, a test results acceptance review be performed by the performance group immediate supervisor. In this instance with 43ST-3SI10, the test results acceptance review was satisfactorily performed by an Assistant Shift Supervisor (utility, licensed). The surveillance test package was then to have been taken by an Operations Technician (utility, non-licensed) to the Shift Technical Advisor (STA)(utility, licensed and non-licensed) for the conduct of the ASME technical review. After the acceptance review, the surveillance package did not get appropriately delivered to the STA as the package was delivered to the Surveillance Program Control Group (SPCG)(utility, non-licensed) for verification of proper review signatures and for rescheduling without the documented ASME technical review. The SPCG then transmitted the package to Drawing and Document Control (DDC) for retention. The implementation of these controls require that the performance group immediate supervisor ensure that ASME Section XI surveillance test packages for safety-related pumps be delivered to the Shift Technical Advisor (STA) within 96 hours for the technical review. In this event, the performance group immediate supervisor (utility, licensed) did not ensure that the test package was delivered as required. Additionally, the STA Supervisor (or his designee) is responsible to ensure that the on duty STA reviews the completed test packages. The STA Supervisor (utility, licensed) did not take adequate measures to ensure that the review was completed. Interviews conducted with the responsible individuals indicated that they believed the completed package was forwarded to the STA for review. However, no one could remember where this particular package was placed. That is, if it was placed in the proper "in" box for review or if the STA inadvertently placed the package in the "out" box without documenting the review. The evaluation that was conducted could not determine the exact sequence of events; however, it was apparent



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

EXPIRES: 8/31/88

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

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

that the root causes were cognitive personnel errors in that the performance group immediate supervisor and the STA Supervisor did not take adequate measures to ensure that the proper reviews were conducted on the completed test package. As discussed above, this was contrary to approved procedural controls. The procedure has been evaluated and although it does not contain specific guidance on administrative routing techniques, it is considered adequate.

As corrective action this event has been reviewed by the responsible supervisors and will be reviewed by the STA's and shift personnel. In order to minimize the potential for personnel errors in the routing of the test packages, the STA's "in" box will be separated from other routing boxes.

It should be noted that during the initial evaluation conducted in November by SPCG personnel (utility, non-licensed), it was discovered that the test package had not been properly reviewed. However, the package was inadvertently forwarded to DDC for retention prior to obtaining the review. This error has been discussed with the Manager and Supervisor responsible for the activities of SPCG. They feel that the event was an isolated case and no corrective actions are required.

There were no structures, components or systems inoperable at the start of the event that contributed to the event. This event was contrary to an approved procedure. The procedural controls have been evaluated and are considered adequate. There were no operator actions that affected the event. There were no unusual characteristics of the work location that directly contributed to the event. There were no manually or automatically initiated safety system responses.

The missed technical review on the test results rendered the Safety Injection Train "A" administratively inoperable. The subsequent review found no discrepancies; therefore, the system was technically operable throughout the event. Additionally if required, the "B" Train was available; therefore, this event had no effect on the health and safety of the public. The total time of the event was approximately 85 days and 7 hours.

Previous similar events were reported in LER's 85-035-00 and 85-045-00. Actions taken as a result of these events were to place the STA in line to conduct the required reviews instead of forwarding the packages to the engineering group. Therefore, although the events were similar in nature (i.e. not obtaining the required reviews within 96 hours), the root causes are different and the actions taken previously would not have been expected to prevent this event.

