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OVERBECK,G.R. Arizona Public Service Co. (formerly Arizona Nuclear Power
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 93-005-00:on 930309,missed TS ACTION statement occurred due to personnel.Independent investigation of event was conducted.W/980305 ltr.

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Commitment. Innovation. Energy.

Palo Verde Nuclear Generating Station

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192-01013 – GRO/DGM/KR
March 5, 1998

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
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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 93-005-00

Attached please find Licensee Event Report (LER) 93-005-00 prepared and submitted pursuant to 10CFR50.73. This LER reports a Technical Specification (TS) violation due to a missed TS Limiting Condition for Operation ACTION statement due to personnel error.

In accordance with 10CFR50.73(d), a copy of this LER is being forwarded to the Regional Administrator, NRC Region IV. If you have any questions, please contact Daniel G. Marks, Section Leader, Nuclear Regulatory Affairs, at (602) 393-6492.

Sincerely,

Gregg R. Overbeck

GRO/DGM/KR/mah

Attachment

cc: E. W. Merschoff (all with attachment)
K. E. Perkins
J. H. Moorman
INPO Records Center

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Palo Verde Unit 3	0 5 0 0 0 5 3 0	1 OF 0 3

TITLE (4)

Missed Technical Specification ACTION Statement 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 NUMBERS
									N/A	0 5 0 0 0
0 3	0 9	9 3	9 3	- 0 0 5	- 0 0	0 3	0 5	9 8	N/A	0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
	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)
	20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract
	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	below and in Text, NRC Form
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	366A)
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Daniel G. Marks, Section Leader, Nuclear Regulatory Affairs	AREA CODE 6 0 2 3 9 3 - 6 4 9 2

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)		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)

On March 9, 1993, at approximately 2010 MST, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION), operating at approximately 100 percent power when the requirement of Technical Specification Limiting Condition for Operation (TS LCO) 3.8.1.1 ACTION b for one emergency diesel generator inoperable was not met within the one hour allowed by TS. Between 0200 MST and 0400 MST on March 10, 1993, Control Room personnel discovered the missed TS LCO ACTION and subsequently performed the surveillance satisfactorily.

The cause of the event was attributed to personnel error. The root cause of the personnel error was indeterminate due to limited information available after five years had lapsed since the event occurred. The NRC initially identified the event in late 1997. The APS investigation surrounding the event was completed by APS on February 10, 1998. The APS investigation determined that an LER was required to be submitted to report the event. As corrective action, appropriate disciplinary action was issued to applicable Control Room personnel.

No previous similar events have been reported pursuant to 10CFR50.73.

1. REPORTING REQUIREMENT:

This LER 530/93-005-00 is being written to report an event that resulted in an operation or condition prohibited by the plant's Technical Specifications (TS) as specified in 10 CFR 50.73(a)(2)(i)(B).

TS Limiting Condition for Operation (LCO) 3.8.1.1 (A.C. Sources - Operating) ACTION b states that with one emergency diesel generator (EDG) (EK) inoperable, demonstrate the OPERABILITY of the OPERABLE offsite circuits by performing SR 4.8.1.1.1.a (verifying correct breaker alignment and indicated power availability for required offsite circuits) within 1 hour and once per 8 hour thereafter.

2. EVENT DESCRIPTION:

At approximately 2110 MST on March 9, 1993, Palo Verde Unit 3 was in Mode 1 (POWER OPERATION) operating at approximately 100 percent power.

At approximately 2010 MST on March 9, 1993, Control Room personnel removed the Train B emergency diesel generator (EDG-B) from service for planned maintenance. At approximately 2358 MST, Control Room personnel restored EDG-B to OPERABLE. Contrary to the requirement for TS LCO 3.8.1.1, by approximately 2110 MST on March 9, 1993, Control Room personnel had not performed the appropriate ACTION statement within the one hour allowed by TS. Between 0200 MST and 0400 MST on March 10, 1993, Control Room personnel discovered the missed TS LCO ACTION and subsequently performed the surveillance satisfactorily.

There were no safety system actuations and none were required.

3. ASSESSMENT OF THE SAFETY CONSEQUENCES AND IMPLICATIONS OF THIS EVENT:

Control Room personnel would have become immediately aware of any changes to correct breaker alignment and indicated power availability for the offsite circuits because of control room annunciation (IB). The event did not result in any challenges to the fission product barriers or result in any release of radioactive materials. Therefore, there were no adverse safety consequences or implications as a result of this event. This event did not adversely affect the safe operation of the plant or health and safety of the public.

4. CAUSE OF THE EVENT:

An independent investigation of this event was conducted. The investigation determined that Control Room personnel (utility-licensed

TEXT

operator) failed to promptly conduct the required TS LCO ACTION statement for one EDG inoperable (SALP Cause Codes: A: Personnel Error). The root cause of the personnel error was indeterminate due to limited information available after five years had lapsed since the event occurred. The NRC initially identified the event in late 1997. The investigation surrounding the event was completed by APS on February 10, 1998. The investigation determined that an LER was required to be submitted to report the event.

No unusual characteristics of the work location (e.g., noise, heat, poor lighting) directly contributed to this event. No procedural errors contributed to this event.

5. STRUCTURES, SYSTEMS, OR COMPONENTS INFORMATION:

There are no indications that any structures, systems, or components were inoperable at the start of the event which contributed to this event. No component or system failures were involved. No failures of components with multiple functions were involved. No failures that rendered a train of a safety system inoperable were involved.

6. CORRECTIVE ACTIONS TO PREVENT RECURRENCE:

An independent investigation of this event was conducted. Actions to prevent recurrence were developed based upon the results of the investigation. Appropriate disciplinary action was issued to applicable Control Room personnel in accordance with the APS Positive Discipline Program.

7. PREVIOUS SIMILAR EVENTS:

Although previous events have been reported pursuant to 10 CFR 50.73 in the past three years for missing TS surveillance requirements, the causes discussed in the previous events have not been similar to this event. Specific to this event, the root cause of the personnel error was indeterminate due to limited information available after five years had lapsed since the event occurred.