

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Palo Verde Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 5 2 8										PAGE (3) 1 OF 0 2																																		
TITLE (4) Inadvertent Actuation of Emergency Safety Feature System																																																						
EVENT DATE (5) MONTH DAY YEAR 0 4 0 6 8 5										LER NUMBER (6) YEAR SEQUENTIAL NUMBER REVISION NUMBER 8 5 0 2 3 0 0 0 5 0 6 8 5										REPORT DATE (7) MONTH DAY YEAR 0 5 0 6 8 5										OTHER FACILITIES INVOLVED (8) FACILITY NAMES DOCKET NUMBER(S) 0 5 0 0 0 0																								
OPERATING MODE (9) 5										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)										X 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)										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 William F. Quinn (extension 4087)																				TELEPHONE NUMBER AREA CODE 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 NPROS					CAUSE					SYSTEM					COMPONENT					MANUFACTURER					REPORTABLE TO NPROS									
SUPPLEMENTAL REPORT EXPECTED (14)																																																						
YES (If yes, complete EXPECTED SUBMISSION DATE)																				X NO										EXPECTED SUBMISSION DATE (15)										MONTH DAY YEAR														

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

While performing an Electrical Surveillance Test on April 6, 1985, an Electrical Test Technician opened a breaker not specified in the test procedure resulting in automatic actuation of the Control Room Essential Filtration Actuation Signal, Safety Injection Actuation Signal, Containment Spray Actuation Signal, Main Steam Isolation Actuation Signal, and Recirculation Actuation Signal. In addition, Reactor Trip Breakers "A" and "C" opened, Condensate Transfer Pumps "A" and "B" started, and the Control Room Normal Fan stopped.

To prevent recurrence of this event, members of the Breaker Test Organization have been re-instructed in the need for procedural compliance and the importance of resolving all questions regarding test procedures prior to performance of tests.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

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

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

On April 6, 1985 at 1527, while Palo Verde Unit 1 was in Mode 5, an Electrical Test Technician (contractor) was performing Electrical Surveillance Test 32ST-9ZZ07, "Sixty Month Molded Case Circuit Breaker Inspection and Preventive Maintenance Surveillance Test". During the performance of this ongoing test, the Channel "A" Class 1E 120 volt Vital Instrumentation and Control Distribution Panel Main Feeder Breaker, which was not specified in the test procedure, was opened. This resulted in automatic actuation of the Train "A" and "B" Control Room Essential Filtration Actuation Signal and a one-half, Leg 1 and 3, Safety Injection Actuation Signal, Containment Isolation Actuation Signal, Main Steam Isolation Actuation Signal, and Recirculation Actuation Signal. In addition, Reactor Trip Breakers "A" and "C" opened, Condensate Transfer Pumps "A" and "B" started, and the Control Room Normal Fan stopped.

There were no structures, systems, or components inoperable at the start of the event that contributed to the event; all attendant equipment operated satisfactorily; and there were no safety consequences or implications to plant personnel, equipment, or to the public as a result of this event.

The equipment identification number of the opened breaker, which was shown on the work order (No. 00078745), was 1EPNAD25; whereas the equipment identification number of the breaker authorized by the Assistant Shift Supervisor was 1ENHND25. Upon leaving the Control Room and proceeding to breaker 1ENHND25, the Test Technician discovered that this breaker was not on the work order to be tested. The Test Technician concluded that the Shift Test Director and the Assistant Shift Supervisor had approved 1EPNAD25. He changed the test data sheet from 1ENHND25 to 1EPNAD25 to agree with the work order equipment list and opened the breaker without further concurrence from the Shift Supervisor.

When the breaker was opened, ventilation dampers closed alerting the Test Technician to a problem. He immediately reclosed the breaker, proceeded to the Control Room, and informed the Shift Supervisor.

Immediate corrective action included resetting all actuated engineered safety features systems, reclosing the Reactor Trip Breakers, and stopping the Condensate Transfer Pumps. Final corrective action to prevent recurrence of this event involves re-instructing members of the breaker test organization of the need for procedural compliance and the importance of resolving all questions regarding test procedures prior to performance of tests. In addition, a Breaker Service List currently being computer generated will assist plant personnel in identifying systems affected by each breaker.

No other similar events have been reported.



## Arizona Nuclear Power Project

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

ANPP-32561-EEVB/GEC  
May 6, 1985

Subject: Palo Verde Nuclear Generating Station (PVNGS)  
Unit 1  
Docket No. STN 50-528, License No. NPF-34  
Licensee Event Report-Inadvertent  
Engineered Safety Feature Actuation  
File: 85-056-026; G.1.01.10

Dear Sirs:

Attached please find Licensee Event Report (LER) No. 85-023-00 prepared and submitted pursuant to 10 CFR 50.73. This LER addresses an inadvertent Engineered Safety Feature System actuation. By copy of this letter we are also forwarding a copy of the LER to the Regional Administrator of the Region V Office.

If you have any questions or concerns, please contact me.

Very truly yours,

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

EEVB/GEC/das  
Attachment

cc: J.B. Martin  
R.P. Zimmerman  
A.L. Hon  
E.A. Licitra  
A.C. Gehr  
INPO Records Center

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