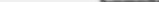


LICENSEE EVENT REPORT

CONTROL BLOCK: 

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	P	A	B	V	S	1	2	0	0	-	7	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5				
7	8	LICENSEE CODE							14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	57 CAT 58				

CONT

REPORT SOURCE: 01 L 6 0 5 0 0 0 3 3 4 7 0 8 1 9 7 9 8 0 8 3 1 7 9 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | At 1446 hours, the reactor was manually tripped following the trip of the 1B Steam
03 | Generator Feed Pump due to low NPSH. The operators performed the immediate manual
04 | actions following a reactor trip and loss of normal feedwater. An operator, thinking
05 | that the generator output breakers were taking too long to trip, manually tripped them
06 | prior to the automatic trip which normally occurs 30 seconds after the trip. Frequency
07 | dropped on the 1A and 1B 4KV Buses and all three RCPs tripped on underfrequency.

0 8 | _____ 80

0	9		H	A	11	A	12	A	13	C	K	T	B	R	K	14	A	15	Z	16				
7		8	9		10	11		12		13						18	19		20					
17		LER/RO REPORT NUMBER		EVENT YEAR				SEQUENTIAL REPORT NO.						OCCURRENCE CODE		REPORT TYPE				REVISION NO.				
			7	9	21	22	23	0	2	8	24	26	27	0	1	28	29	T	30	31	0	32		
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS				ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER						
H	18	Z	19	Z	20	Z	21	0	0	0	0	37	40	Y	23	N	24	Z	25	Z	9	9	9	26
33		34		35		36		37					40	41		42		43		44				47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The incident resulted from operator error in tripping the main generator output breaker

1 1 prior to the automatic trip. The LC RCP was started four minutes after the trip and

1 2 forced flow was returned to the RCS. The involved operator was reprimanded for his

1 3 action and all Operations personnel will review the incident circumstances.

7 8 9 80

FACILITY STATUS			% POWER			OTHER STATUS			METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	5	E	0	5	0	N/A			A	Operator observation		
7	8	9	10	11	12	13	14	15	16	17	18	

ACTIVITY CONTENT
RELEASED OF RELEASE

1 6 2 33 4 34

AMOUNT OF ACTIVITY (35)

N/A

LOCATION OF RELEASE (36)

N/A

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	37	2	38	N/A	

PERSONNEL INJURIES		80
NUMBER	DESCRIPTION	
000	(40) N/A	

1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31		32		33		34		35		36		37		38		39		40		41		42		43		44		45		46		47		48		49		50	
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7		8		9		10		80	
ISSUED		PUBLICITY		DESCRIPTION				NRC USE ONLY	
2	0	N	(44)	N/A					

NAME OF PREPARER J. A. Werling

PHONE: 412-643-1258

NRC USE ONLY

Attachment To LER 79-28/01T
Beaver Valley Power Station
Duquesne Light Company
Docket No. 50-334

At 1446 hours on August 19, 1979, the reactor was manually tripped from approximately 50% rated power following the trip of the 1B Main Feed Pump due to low net positive suction head. The 1A Condensate Pump was shutdown for cleaning of its strainer. The 1B Main Feed Pump had just been started and the 1A Pump secured to investigate a high bearing temperature on the 1A Pump.

Upon initiation of the reactor trip, the operators performed the immediate manual actions following a reactor trip and loss of normal feedwater. An operator, thinking that the generator output breakers were taking too long to trip, manually tripped them prior to the automatic trip which normally occurs 30 seconds after the reactor/turbine trip. Since the main generator was no longer tied to the system, frequency dropped on the 1A and 1B 4KV Buses and all three reactor coolant pumps tripped on underfrequency (2 of 3 buses). The 1C and 1D 4KV Buses were tied into the system and did not experience the underfrequency condition. Thirty seconds after the turbine trip, the 1A and 1B Buses transferred to system power and the underfrequency condition cleared. Four minutes after the reactor trip, the 1C Reactor Coolant Pump was started and forced flow returned to the reactor coolant system. All systems operated as designed and at no time was the health and safety of the public jeopardized. The involved operator was reprimanded for his action. All Operations personnel will review the incident.

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