

# Duquesne Light Company

Beaver Valley Power Station  
P.O. Box 4  
Shippingport, PA 15077-0004

JOHN D. SIEBER  
Vice President - Nuclear Group

(412) 393-5255

March 15, 1990

U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, DC 20555

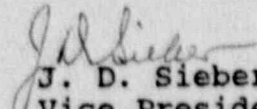
Reference: Beaver Valley Power Station, Unit No. 1 and No. 2  
BV-1 Docket No. 50-334, License No. DPR-66  
BV-2 Docket No. 50-412, License No. NPF-73  
Combined Inspection Report 50-334/89-23 and 50-412/89-22

Gentlemen:

In response to NRC correspondence dated February 15, 1990 and in accordance with 10 CFR 2.201, the attached reply addresses the Notice of Violation included with the referenced inspection report.

If there are any questions concerning this response, please contact my office.

Very truly yours,

  
J. D. Sieber  
Vice President  
Nuclear Group

## Attachment

cc: Mr. J. Beall, Sr. Resident Inspector  
Mr. W. T. Russell, NRC Region I Administrator  
Mr. Edward C. Wenzinger, Chief Reactor Projects Branch No. 4,  
Division of Reactor Projects, Region I  
Mr. P. Tam, Sr. Project Manager  
Mr. R. Saunders (VEPCO)

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DUQUESNE LIGHT COMPANY  
Nuclear Group  
Beaver Valley Power Station Units 1 and 2

Reply to Notice of Violation  
Combined NRC Inspection Report 50-334/89-23 and 50-412/89-22  
Letter dated February 15, 1990

VIOLATION (Severity Level IV, Supplement I)

Description of Violation (50-334/89-23-01)

Technical Specification 6.8 requires that written procedures be established, implemented, and maintained covering activities listed in Appendix A of Regulatory Guide 1.33, Revision 2, February, 1978.

Operating Manual Procedure OM 1.1.4W requires that when returning a train of Solid State Protection System to service, all trips be inhibited until the Low Pressurizer Pressure and Low Steam Line Pressure Safety Injection signals are blocked.

Contrary to the above, on December 13, 1989, Train A of the Solid State Protection System was returned to service without the Low Pressurizer Pressure and Low Steam Line Pressure Safety Injection signals blocked. This resulted in a Safety Injection actuation.

Corrective Action Taken

Our review of this event indicates that the cause of the unplanned Safety Injection actuation was the failure of the crew to follow the approved procedure for returning the Solid State Protection System (SSPS) to service. Deficiencies in understanding the functions of the SSPS test switches led the crew to believe that they could restore the single switch involved without reliance on the procedure that is used for full system restoration.

Operations personnel reset the safety injection signal and returned the plant to pre-safety injection conditions. Additional corrective steps included formal written counseling of the crew members involved. This counseling included crew responsibilities in regard to utilizing available procedures, and the role of shift communication/teamwork in preventing such events.

Action Taken to Prevent Recurrence

To avoid further violations, this event was covered in detail during license retraining classes which were completed on March 2, 1990. The training clarified the specific functions of the SSPS switches and included a step by step discussion of the OM 1.1.4W procedure. Each licensed individual was required to participate in the procedure review.

Date of Full Compliance

Full compliance has been achieved at this time.