

LICENSEE EVENT REPORT

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	P	A	B	V	S	1	2	0	0	-	0	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			59

CON'T

REPORT SOURCE L 6 0 5 0 0 0 3 3 4 7 0 9 2 2 8 3 8 1 0 2 1 8 3 9

60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On 9/22/83, following the completion of surveillance test on the 1A River Water pump, two of the three river water pumps were left in the "Pull-to-Lock" positions. Station Management was informed of this system lineup and immediate actions were taken to correct this lineup (within time limits of T.S. LCO of 72 hours.). There were no safety implications because the Auxiliary River Water System was available and operable.

SYSTEM CODE W E 11		CAUSE CODE A 12		CAUSE SUBCODE A 13		COMPONENT CODE P U M P X X 14		COMP. SUBCODE B 15		VALVE SUBCODE Z 16							
EVENT YEAR 8 3 21 22		SEQUENTIAL REPORT NO. 0 3 3 24 26		OCCURRENCE CODE 0 3 28 29		REPORT TYPE L 30		REVISION NO. 0 32									
ACTION TAKEN X 33		FUTURE ACTION X 34		EFFECT ON PLANT Z 35		SHUTDOWN METHOD Z 36		HOURS 0 0 0 0 37 40		ATTACHMENT SUBMITTED Y 41		NPRD-4 FORM SUB. N 42		PRIME COMP. SUPPLIER A 43		COMPONENT MANUFACTURER B 5 8 0 44 47	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause for this incident was the failure of the operator to return
1 1 the river water system (the 1A and 1C pumps) to their pre-test
1 2 conditions after completion of the surveillance test. A complete report
1 3 of corrective actions and measures taken is included in the attachment
1 4 to this report.

FACILITY STATUS										% POWER										OTHER STATUS										METHOD OF DISCOVERY										DISCOVERY DESCRIPTION									
1	5	C	28	0	0	0	29	N/A										31	NRC Resident Inspector																														
ACTIVITY CONTENT										AMOUNT OF ACTIVITY										LOCATION OF RELEASE																													
1	6	Z	33	Z	34	N/A										N/A																																	

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	(37) Z (38) N/A				

PERSONNEL INJURIES
NUMBER DESCRIPTION
1 0 0 0 40 N/A
LOSS OF OR DAMAGE TO FACILITY 41

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		51		52		53		54		55		56		57		58		59		60		61		62		63		64		65		66		67		68		69		70		71		72		73		74		75		76		77		78		79		80		81		82		83		84		85		86		87		88		89		90		91		92		93		94		95		96		97		98		99		100	
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ISSUED DESCRIPTION
2 14 N/A
PDR ADOCK 05000334
S PDR
68 69 80
NAME OF PREPARED Robert J. Druga, Chief Engineer
PHONE 412/643-1264

8311210250 831021
PDR ADOCK 05000334
S PDR

NRC USE ONLY

Robert J. Druga, Chief Engineer

412/643-1264

Attachment to LER 83-033/03L
Beaver Valley Power Station
Duquesne Light Company
Docket No. 50-334

On 9/22/83, at approximately 1015 hours, preparations were being made to perform a surveillance test on the 1A river water pump (OST 1.30.2 "River Water Pump 1A Test"). The Nuclear Shift Operating Foreman (NSOF) and a plant operator discussed the OST prior to its performance. Prior to the start of the surveillance test, the 1B pump was operating and the 1C river water pump was in AUTO (for use as a standby pump) and racked on the 1AE 4160 Volt emergency bus. At this time, the 1A river water pump was caution tagged, saying that "it required a time response check" and that it "can be used but not considered operable for Modes 1-4". To perform the OST, the 1C pump had to be racked off the 1AE bus and the 1A pump racked on the 1AE bus. Electrical interlocks would not permit two pumps to be racked in on the same emergency bus. The Nuclear Control Operator in the control room then placed the 1A and 1C river water pumps in the "PULL-TO-LOCK" positions so that the breakers could be aligned to perform the surveillance test. The breakers were aligned to perform the surveillance test. The plant operator then proceeded to the Intake Structure (location of the 1A river water pump) and the 1A pump was started for the surveillance test.

During the performance of the test, the plant operator returned to the control room with data that he had taken for this test. The plant operator then calculated the differential pressure on the 1A pump and found that it was high and unacceptable. This was verified by a second control room operator. The plant operator then discussed the system line-up needed upon completion of the surveillance test, with the NSOF. The NSOF told the plant operator to return the system to pre-test conditions (1A pump racked off the 1AE bus and the 1C pump racked on the bus). The plant operator then returned to the Intake Structure to take some additional data on the 1A river water pump. At approximately 1115 hours, after completion of the surveillance test, the 1A pump was shutdown and placed in the "PULL-TO-LOCK" position to enable breaker alignment to return the system to its pre-test condition. The plant operator then returned to the control room and was assigned another surveillance test (OST 1.6.2) by the NSOF. The plant operator failed to inform the NSOF that the system was not placed back in its pre-test condition (1A pump racked off and the 1C pump racked on). This left one river water pump operating and two pumps in "PULL-TO-LOCK".

During the shift turnover, at 1500-1530 hours, the control room operator, the NSOF and the Shift Supervisor all discussed the operation of the 1A river water pump and its failure to pass its surveillance test. It was not verified at this time that the system had not been returned to its original pre-test condition.

After the shift turnover, at approximately 1800 hours, the NRC Resident Inspector toured the control room and questioned the Station Superintendent as to why only one river water pump was in operation. The 1A river water pump was immediately placed in "AUTO" position. The Shift Supervisor then had the 1A river water pump racked off the 1AE bus and the 1C river water pump racked on the 1AE bus and set up for "AUTO" operation. A review of the control board walkdown surveillance (OST 1.48.3) performed by the Shift Technical Advisor, after the shift turnover, reflected that caution tags were placed on the 1A and 1C river water pumps, but did not reflect that the pumps were both in the

"PULL-TO-LOCK" positions. This notation was reviewed by the Shift Supervisor as noted by his initials, but no action was taken at that time. The Station Superintendent then directed the Shift Technical Advisor to perform the control board walkdown (OST 1.48.3) again. This second walkdown was again reviewed by the Shift Supervisor.

The primary cause for this incident was the failure of the operator to return the pumps to the pre-test condition after completion of the surveillance test. A number of other problem areas were identified which also contributed to this incident.

- (1) Failure to maintain river water pumps operable.
- (2) Failure to observe river water pump status during shift.
- (3) Failure to note river water pump status during turnover.
- (4) Procedural inadequacy.
- (5) Failure to meet all administrative requirements when removing the river water pump from service.

The following corrective actions are completed or in progress as a result of this incident:

- (1) Procedures will be reviewed and revised to include the necessary operations needed to transfer swing pumps on the 4KV emergency bus.
- (2) Procedure changes to identify control room operator/field operator interface responsibility during testing.
- (3) Plant Operator/Reactor Operator list of responsibilities from the Administrative Manual and job specifications will be issued.
- (4) Supervisory job responsibilities to be reviewed during pre-job discussions.
- (5) Turnover checklist for Plant Operator/Reactor Operator will be revised to sequence activities and priorities in order of importance.
- (6) Control board walkdowns will be performed by the (Nuclear Control Operator - Plant Operator), (the Shift Technical Advisor), and the (Shift Technical Advisor and the Nuclear Shift Supervisor) each shift.
- (7) The Plant operator is being re-evaluated by the Nuclear Shift Supervisor/Nuclear Shift Operating Foreman. Until this evaluation is complete, this individual is prohibited from performing safety related activities without supervision.
- (8) This incident has been reviewed with all shifts and is being discussed at license retraining modules with all Operations personnel.
- (9) Disciplinary action is pending with individuals involved.

These corrective actions should preclude this type of problem in the future. The interim corrective actions in effect at the present time will remain in effect until such time as the effectiveness of permanent corrective action can be sufficiently evaluated.



Duquesne Light

Nuclear Division
P.O. Box 4
Shippingport, PA 15077-0004

Telephone (412) 393-6000

October 21, 1983
ND1SS1:0983

Beaver Valley Power Station, Unit No. 1
Docket No. 50-334, License No. DPR-66
LER 83-033/03L

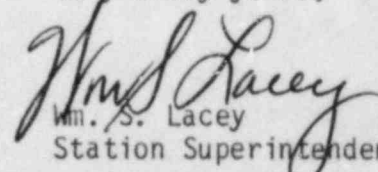
Dr. Thomas E. Murley
Regional Administrator
United States Nuclear Regulatory Commission
Region 1
631 Park Avenue
King of Prussia, PA 19406

Dear Dr. Murley:

In accordance with Appendix A, Beaver Valley Technical Specifications,
the following Licensee Event Report is being submitted:

LER 83-033/03L, Technical Specification 3.7.4.1, Reactor Plant River
Water System (RPRWS).

Very truly yours,


Wm. S. Lacey
Station Superintendent

Attachment

IE22
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Dr. T. E. Murley
October 21, 1983
ND1551:0983
Page two

cc: Director of Management & Program Analysis
United States Nuclear Regulatory Commission
Washington, D.C. 20555

C. A. Roteck, Ohio Edison

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