

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) DIABLO CANYON, UNIT 1										DOCKET NUMBER (2) 0 5 0 0 0 1 2 7 5 1				PAGE (3) OF 012		
TITLE (4) INADVERTENT SAFETY INJECTION ACTUATION																
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 NUMBER(S)			
03	15	84	84	008	000	04	16	84					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)													
POWER LEVEL (10)			20.402(b)				20.405(c)				X 50.73(a)(2)(iv)				73.71(b)	
0 0 0			20.405(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(e)	
			20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vi)				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)(ix)					
LICENSEE CONTACT FOR THIS LER (12)																
NAME W. W. KESSINGER, REGULATORY COMPLIANCE ENGINEER										TELEPHONE NUMBER						
										AREA CODE 81015 519151-17131511						
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC						
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 15, 1984 at 0828 PST, while in Mode 5 (Cold Shutdown), the plant experienced an inadvertent safety injection actuation. The event was initiated when an Instrumentation and Controls technician failed to follow the procedure while performing a surveillance test on Train A of the Solid State Protection System. The signal caused a diesel generator and a Residual Heat Removal Pump to start; however, due to plant conditions, no water was injected into the Reactor Coolant System. Corrective action included counseling of the responsible I&C technician and the briefing of other I&C personnel on the need to follow procedures and to immediately inform supervision of any problems encountered during maintenance.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1)  DIABLO CANYON, UN1, 1	DOCKET NUMBER (2)  0 5 0 0 0 2 7 5	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	— 0 0 8	— 0 0	0 2	OF	0 2

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

On March 15, 1984, at 0828 PST, while in Mode 5 (Cold Shutdown), the plant experienced an inadvertent injection actuation. This event occurred during the performance of surveillance test STP I-16B, "Testing of Safety Injection Reset Timer and Slave Relay K602," on Train A of the Solid State Protection System (JE). During performance of STP I-16B, an Instrument and Control technician measured the voltage across terminals 3 and 4 of terminal board TB602 rather than across terminals 3 and 4 of relay K602 (RLY) as required by the procedure. The technician observed a reading of 120 VAC rather than the expected 0 VAC; he then reversed the steps in the procedure to return the SSPS to the pre-test condition. Contrary to the procedure, the technician did not immediately inform his supervisor of the problem and discontinue the test. Since the pressurizer low pressure permissive block had not been reinstated, as required further on in the procedure, the safety injection signal occurred as the technician placed the Logic Test Panel INPUT-ERROR-INHIBIT switch to "NORMAL". The safety injection signal caused Diesel Generator 1-3 (DG) and Residual Heat Removal Pump 1-2 (P) to start; however, due to plant conditions, no water was injected into the Reactor Coolant System (AB).

STP I-16B was later successfully completed. The technician involved was counselled about his failure to follow procedures. Additionally, the I&C Supervisor briefed I&C personnel on the need to follow procedures and to ensure that their supervisor is informed immediately of any problems encountered during the performance of a surveillance procedure.

Under the conditions existing at the time, this event had no safety consequences or implications and in no way affected the public's health and safety. An assessment of a similar event under the alternate condition of being at power is included as an analyzed (Condition II) event in the Final Safety Analysis Report, Section 15.2.14, "Spurious Operation of the Safety Injection System at Power".

# PACIFIC GAS AND ELECTRIC COMPANY

PG&E

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JAMES D. SHIFFER  
MANAGER

DEPARTMENT OF NUCLEAR PLANT OPERATIONS  
NUCLEAR POWER GENERATION

April 16, 1984

PGandE Letter No.: DCL-84-145

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

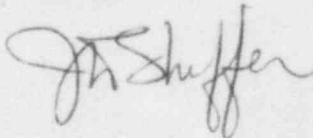
Re: Docket No. 50-275, OL-DPR-76  
Diablo Canyon Unit 1  
Licensee Event Report 84-008-00  
Inadvertent Safety Injection Actuation

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(iv), PGandE is submitting the enclosed Licensee Event Report concerning an inadvertent safety injection actuation on March 15, 1984.

This event has in no way affected the public's health and safety

Sincerely,



Enclosure

cc: J. B. Martin  
Service List

IE22  
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