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 FACIL: 50-275 Diablo Canyon Nuclear Power Plant, Unit 1, Pacific Ga      05000275  
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SUBJECT: PNO-V-89-059: on 891006, reactor trip & safety injection from 100% power due to instrumentation problems.

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This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information presented is as initially received without verification or evaluation and is basically all that is known by Region V staff on this date.

FACILITY: PACIFIC GAS & ELECTRIC COMPANY  
DIABLO CANYON UNIT 1  
DOCKET NO. 50-275  
SAN LUIS OBISPO COUNTY, CA

Emergency Classification  
XX Notification of Unusual Event  
     Alert  
     Site Area Emergency  
     General Emergency  
     Not Applicable

SUBJECT: REACTOR TRIP AND SAFETY INJECTION FROM 100% POWER DUE TO INSTRUMENTATION PROBLEMS

On October 6, 1989 at 1:02 pm (PDT), Diablo Canyon Unit 1 experienced a reactor trip and steam line differential pressure safety injection. The unit had been at continuous power for a Westinghouse, U.S.A. record setting 399 days prior to the event and was conducting multiple pre-outage work tasks, while at power, in preparation for a scheduled shutdown for refueling on October 14, 1989. The pre-outage work being conducted contributed at least in part to the event and to some subsequent complications in recovery.

Prior to the event, initial plant conditions included steam flow and steam pressure bistables in a tripped condition (for one of four protection set logics). The bistables were tripped to allow performance of a calibration of the channels to gather data for a feedwater control design modification (the channel calibration was not due). Additionally, two of the four atmospheric steam dump valves were isolated in preparation for routine testing of their control circuits to ensure correct operation for the upcoming shutdown scheduled in about one week.

The event occurred at a time when I&C technicians were physically closing the isolation valve for one of the pressure transmitter which provides the control signal for one of the atmospheric steam dump valves which were to receive this routine testing for the pending plant shutdown. This transmitter does not provide the safeguards signal, but shares a common pressure tap on the main steamline and is physically adjacent to a safeguards steam pressure transmitter (an adjacent panel). It is speculated that the repositioning of this valve initiated a false pressure spike on the steamline pressure instrumentation which when combined with other channels in trip gave the necessary coincidence for safety injection/reactor trip. The event sequence showed a reactor trip and safety injection at 1:02 pm. The licensee has tried to recreate the condition, but has not been able to reproduce the trip signal.

All safety systems actuated normally. Operators responded promptly in accordance with plant procedures. The resident inspectors were in the control room immediately after the trip and monitored plant status and operator actions. Several complications were appropriately responded to by operators:

The unit lost both circulating water pumps (the seawater for condenser cooling). Only one circulating water pump should be lost per design. Hence, the steam dumps valves to the condenser were prevented from opening. The licensee's investigation subsequently revealed a timer relay failure caused the trip of the circulating water pump.

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During the recovery process, at 1:08 pm a rapid increase of RCS pressure was experienced. At 1:10 pm a pressurizer power operated relief valve lifted due to rapidly increasing pressurizer pressure. Initial indication are that it lifted at a lower pressure than it should have, by about 85 psi. The control circuit for this valve is capable of a floating setpoint which may have caused the lift at the lower pressure.

At about 1:30 pm operators attempted to open the two in-service atmospheric steam dumps. Neither valve responded to initial manual demands (cause still unknown). At 1:35 pm a second attempt to open the atmospheric steam dumps was made and one valve opened. At 1:48 pm the two out-of-service atmospheric dumps were returned to service and appropriately opened. The licensee verified the correct operation of all, similar Unit 2 atmospheric steam dump valves.

At 1:22 pm a circulating water pump was manually restarted to reestablish condenser vacuum. At 2:11 pm cooldown was transferred to the condenser steam dumps, and at 2:30 pm the plant was stable in Mode 3 and the Unusual Event was terminated.

The licensee has decided to begin the scheduled refueling outage early and not attempt restart. The licensee formed a comprehensive event response plan to determine the cause of the event and corrective actions for the event and the complicating factors. The residents will continue to monitor licensee investigations and corrective actions.

There has been some media interest.

This information is current as of 10:00 am on October 10, 1989.

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