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CONTROL NO: 7416

FILE: INCIDENT REPORT FILE

FROM: Rochester Gas & Elec. Corp Rochester, N.Y. 14649 L.D. White, Jr.		DATE OF DOC 6-25-75	DATE REC'D 7-11-75	LTR XX	TWX	RPT	OTHER
TO: Mr. J. P. O'Reilly		ORIG 1 signed	CC	OTHER	SENT AEC PDR SENT LOCAL PDR		XX XX
CLASS	UNCLASS XXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-244		

DESCRIPTION: Ltr trans the following:

PLANT NAME: R.E. Ginna

ENCLOSURES: Licensee Event Report A0-50-244/75-10 on 6-11-75 re failure of the "C" SI pump discharge MOV's 871A & 871B were found closed...
(1 cy encl rec'd)

**Do Not Remove
ACKNOWLEDGED**

FOR ACTION/INFORMATION DHL 7-12-75

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GT |
| 1 - ACRS SENT TO LIC ASST Sheppard 7-12-75 | | |
| ** SEND ONLY TEN DAY REPORTS | | |



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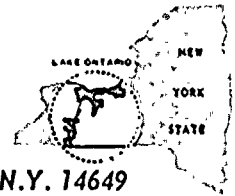
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Regulatory Docket File



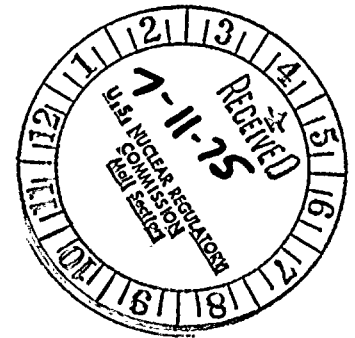
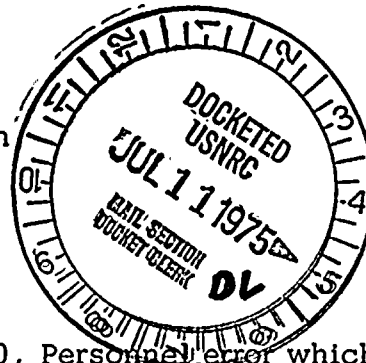
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LEON D. WHITE, JR.
VICE PRESIDENT

TELEPHONE
AREA CODE 716 546-2700

June 25, 1975

Mr. James P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region I
631 Park Avenue
King of Prussia, Pennsylvania 19406



Subject: Abnormal Occurrence 75-10, Personnel error which could prevent the fulfillment of the functional requirements of systems required to cope with accidents analyzed in the SAR.
R. E. Ginna Nuclear Power Plant, Unit No. 1
Docket No. 50-244

Dear Mr. O'Reilly:

In accordance with Technical Specifications, Article 6.6.2a, the attached report of Abnormal Occurrence 75-10 is hereby submitted. Two additional copies of this letter and the attachment are enclosed.

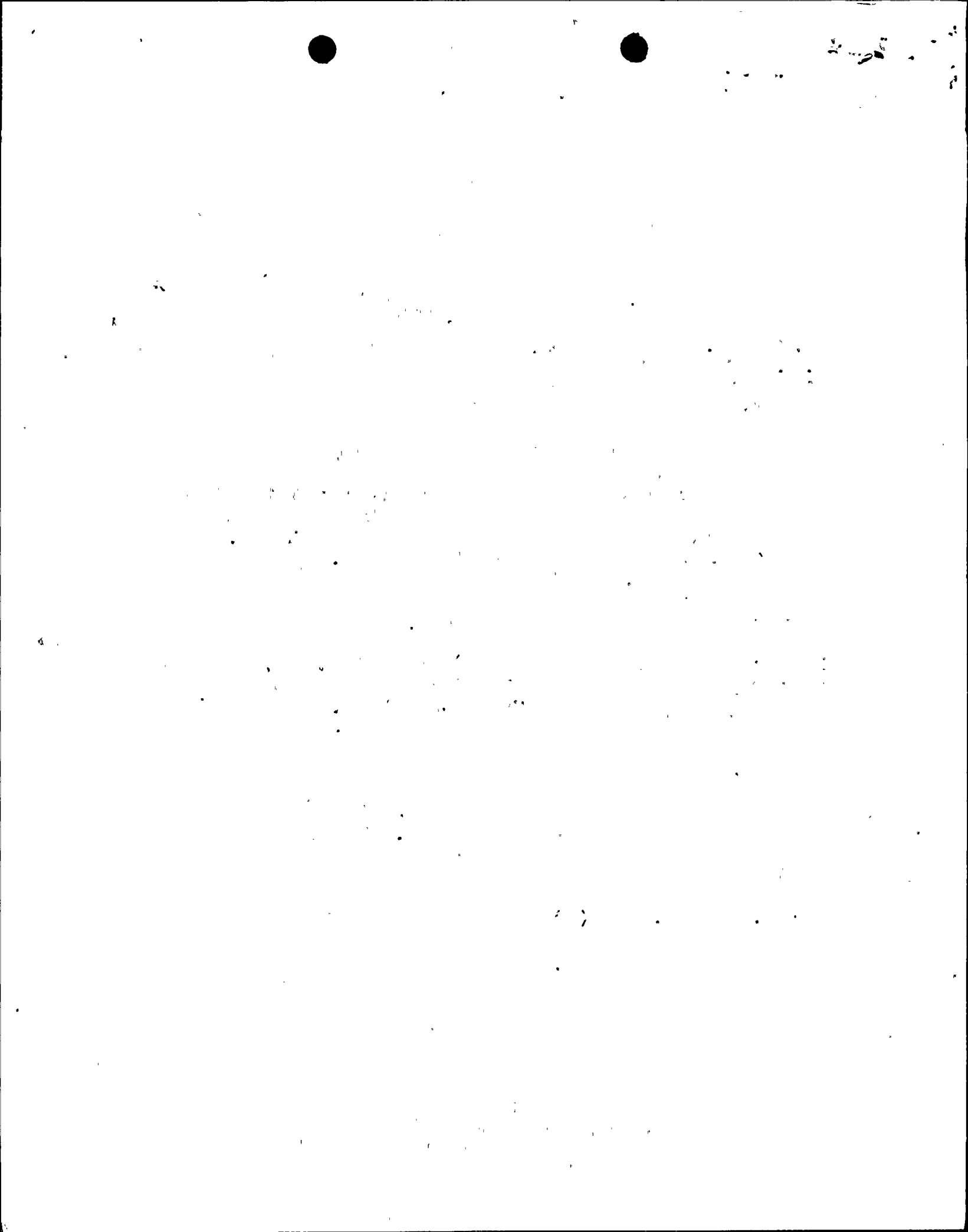
Very truly yours,

L. D. White, Jr.
L. D. White, Jr.

Attachment

cc: Mr. Donald F. Knuth (40)

7416



LICENSEE EVENT REPORT

Regulatory Docket File

CONTROL BLOCK:

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(PLEASE PRINT ALL REQUIRED INFORMATION)

Issued by/Ltr Dated **6-25-75**

LICENSEE NAME 01 N Y R E G 1										LICENSE NUMBER 00 - 0 0 0 0 0 - 0 0										LICENSE TYPE 4 1 1 1				EVENT TYPE 0 1	
7	8	9	14	15	25	26	30	31	32	57	58	59	60	61	68	69	74	75	80						
CATEGORY 01 CONT		REPORT TYPE D I		REPORT SOURCE T L		DOCKET NUMBER 0 5 0 - 0 2 4 4				EVENT DATE 0 6 1 1 7 5				REPORT DATE 0 6 2 5 7 5											
7	8	7	8	7	8	61	68	69	74	75	80	7	8	7	8	7	8	7	8	9					

EVENT DESCRIPTION

02 During safeguard valve surveillance testing the "C" SI pump discharge MOV's 871A and																				
03 871B were found closed. The two other SI pumps on separate buses were capable of																				
04 performing their intended function. Valves were placed to correct open position. Sub-																				
05 sequently a check was made to verify that all SIS valves were in the proper position.																				
06 (Abnormal Occurrence 50-244/75-10)																				
7	8	9	7	8	9	7	8	9	7	8	9	7	8	9	7	8	9	7	8	9

SYSTEM CODE 07 S F			CAUSE CODE A		COMPONENT CODE Z Z Z Z Z Z					PRIME COMPONENT SUPPLIER Z		COMPONENT MANUFACTURER Z 9 9 9			VIOLATION Y	
7	8	9	10	11	12	17	43	44	47	48						

CAUSE DESCRIPTION

08 Incorrect position of the valves was due to operator error during safety injection pump																				
09 monthly surveillance testing. Measures to prevent recurrence are on attached page.																				
10																				
7	8	9	7	8	9	7	8	9	7	8	9	7	8	9	7	8	9	7	8	9

FACILITY STATUS 11 E		% POWER 0 9 0		OTHER STATUS NA				METHOD OF DISCOVERY b		DISCOVERY DESCRIPTION NA					
7	8	9	10	12	13	44	45	46	80						
FORM OF ACTIVITY RELEASED 12 Z		CONTENT OF RELEASE Z		AMOUNT OF ACTIVITY NA				LOCATION OF RELEASE NA							
7	8	9	10	11	44	45	80								

PERSONNEL EXPOSURES

NUMBER 13 0 0 0		TYPE Z		DESCRIPTION NA													
7	8	9	11	12	13	80											

PERSONNEL INJURIES

NUMBER 14 0 0 0		DESCRIPTION NA																	
7	8	9	11	12	80														

OFFSITE CONSEQUENCES

15 NA																			
7	8	9	80																

LOSS OR DAMAGE TO FACILITY

TYPE 16 Z		DESCRIPTION NA																	
7	8	9	10	80															

PUBLICITY

17 NA																			
7	8	9	80																

ADDITIONAL FACTORS

18 In the event of safeguards actuation, all 3 50% capacity SI pumps are automatically																				
19 started in a timed sequence, and, in case one of the other (cont'd. on attached page)																				
7	8	9	7	8	9	7	8	9	7	8	9	7	8	9	7	8	9	7	8	9

NAME: Bruce A. Snow

PHONE: 716-546-2700, ext. 291-214



[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is scattered across the page and cannot be transcribed accurately.]

Measures to Prevent Recurrence:

The operator involved was reprimanded for his error. The procedure used during error committal was reviewed and no inadequacies were noted in the procedure. However, a procedure change was reviewed by the Plant Operations Review Committee and was recommended for approval on June 23, 1975 to eliminate procedural options relative to the operation of MOV-871A and MOV-871B.

In addition, the Operations Engineer has issued a memorandum to all operators to once again impress upon them the importance of adhering to procedures, and stressed the importance of verification of status lights on safeguards equipment when assuming control board duties.

Additional Factors (cont'd.)

2 SI pumps fails to start, one of the "C" SI pump discharge MOV's will automatically close to direct flow to the affected loop. Emergency Procedure E-1.1, Safety Injection Actuation, directs operators to observe measured variables and status indicators to verify proper automatic actions, and to perform any necessary actions manually. In doing so, if either "A" or "B" SI pump were to fail to start, the required manual action would be performed to provide flow to the affected loop from the "C" pump, namely to open the appropriate MOV.

