

LICENSEE EVENT REPORT

CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | 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 9 14 15 25 26 57 CAT 58
 LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CONT
 01 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 3 | 4 | 7 | 1 | 1 | 1 | 3 | 8 | 0 | 8 | 1 | 1 | 2 | 5 | 8 | 0 | 9
7 8 60 61 68 69 74 75 80
 DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | An operator tried to do an (OST) Operation Surveillance Test on an Intermediate
 03 | Range nuclear instrument. The operator then realized he couldn't do the test
 04 | because the reactor was critical and power level was too high. The test at this
 05 | time was in progress with the channel in bypass which is the way it was left until
 06 | approximately nine hours later. The power range low setpoint trips were available
 07 | for any trip functions that would have been needed.

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7 8 9
 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
 11 12 13 14 15 16
 I A A Z Z Z Z Z Z Z Z Z
 17 LER/RO REPORT NUMBER 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
 8 0 0 0 8 7 0 3 L 0
 EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47
 H H Z Z 0 0 0 0 Y N Z Z 9 9 9 9
 ACTION FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRO-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The cause of the incident is a combination of circumstances including operator
 11 | error and possible inadequate guidance in situational analysis. Immediate
 12 | corrective action was to institute an expanded equipment checklist, increased
 13 | training, review existing administrative procedures and conduct training classes by
 14 | the Station Superintendent.

15 | FACILITY STATUS 16 | % POWER 17 | OTHER STATUS 18 | METHOD OF DISCOVERY 19 | DISCOVERY DESCRIPTION
 C 0 0 0 0 N/A B Shift turnover
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
 16 | ACTIVITY RELEASED OF RELEASE 17 | AMOUNT OF ACTIVITY 18 | LOCATION OF RELEASE
 Z Z N/A N/A
 17 | PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
 0 0 0 Z N/A
 18 | PERSONNEL INJURIES NUMBER DESCRIPTION
 0 0 0 N/A
 19 | LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
 Z N/A
 20 | PUBLICITY ISSUED DESCRIPTION
 N N/A
 21 |
 NRC USE ONLY
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POOR ORIGINAL

NAME OF PREPARER W. S. Lacey

PHONE 412-643-8525

8012090392

Attachment To LER 80-087/03L
Beaver Valley Power Station
Duquesne Light Company
Docket No. 50-334

The apparent generic attitude and understanding problems associated with this incident appear to be the root cause of incidents of this nature. In order to adequately address and analyze this aspect, a planned course of analysis action was developed by the senior station staff, discussed with the Resident NRC Inspector (D. A. Beckman) and implemented on November 17, 1980. This plan consists of the following major phases:

- 1) Participatory involvement of all licensed operating personnel and Shift Technical Advisors in the analysis, evaluation and actions to be taken to resolve the root problem. A letter (copy attached) was issued on November 17, 1980 requesting direct and individual input to the Station Superintendent on this subject.
- 2) Review of existing Station Administrative Procedures, Operating Manual Procedures and Training Program content by Senior Station Management staff for any necessary changes or additions.
- 3) Review of the inputs from item (1) above to formulate:
 - a. Specific long term actions to preclude future occurrence
 - b. Assessment of individual attitude/understanding by critical analysis of responses
- 4) Development and implementation of necessary programs to resolve any definite or implied attitude and understanding problems which be indicated by the analysis of the responses noted in (3b) above. These may include:
 - Motivational Training
 - Increased management surveillances
 - Human factors training
 - Communication skills training
 - Constructive Quality Concept training
 - Feedback and Assessment Programs
- 5) In parallel with phases (1) through (4) above, a series of discussion sessions will be conducted by the Station Superintendent with operating personnel. There will be scheduled on a small group (3-4) basis, consistent with existing operator shift schedule requirements and regulations until all operating personnel have participated. The purpose of these discussions will be to reinforce the seriousness and ramifications of this type of incident, the reasons leading to and the ways to preclude such occurrences, and as a supplemental method to assess overall attitudes and understanding. Pending resolution of operator schedules, plant status and vacation/holiday schedules, it is anticipated that this discussion series will commence during the week of November 24, 1980 and require approximately 6 weeks for completion.

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A licensed reactor operator commenced an operational surveillance test that had to be stopped prior to completion. The reason the test had to be stopped was because the reactor was critical and above the test intermediate range power level that was supposed to be indicated. When the operator realized what the problem was he immediately stopped the test, noted the problems and informed his supervisor. The breakdown in communication happened at this point since the nuclear instrumentation channel was left in "bypass" and not immediately returned to normal service. Because the test was being run late in the shift in conjunction with low power physics testing, there were a number of evolutions taking place. The midnight (2300 - 0700 hours) shift reactor operator found the channel in bypass and returned the system to normal. Several administrative procedures were violated during this evolution. Immediate action taken to prevent reoccurrence consisted of evaluation of the incident with involved personnel by the Station Superintendent and senior station management staff. Following this, the Station Superintendent personally discussed with all available Shift Supervisors the fact that administrative controls were bypasses and the number of people involved and results of critical questioning of those involved indicated that the problem may be a generic attitude problem. Each Shift Supervisor was directed to personally discuss the incident with all operating personnel on their shift. On November 17, 1980, a letter was issued by the Station Superintendent to all Shift Supervisors reiterating the above noted directions and requiring documentation of accomplishment, including names and times, to the Station Superintendent within 24 hours of receipt of the letter. This same letter was also issued to the Station Technical Advisory Engineer directing him to take the same actions with all Shift Technical Advisors.

In parallel with the above, due to the apparent generic implications, an in-depth evaluation was instituted. This evaluation is identified as follows.

Initial reviews by senior station management, including critical questioning of involved personnel indicate that underlying reasons for this incident may include:

- 1) Existing Station Administrative Procedures cover this type of situation, however they may need further clarification to explicitly define all situations involving terminating procedures prior to the "normal" end point.
- 2) Existing station implementing procedures (Operating manual) - same as (1) above.
- 3) Present training program appears to need supplementing to include further emphasis on non-technical aspects of operations (e.g. decision-making, responsibilities, quality applications, management/supervisory processes).
- 4) A generic problem regarding attitude and total understanding of underlying reasons for formal controls may exist within the operations personnel organization.

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A supplementary report including results and actions to be taken from this overall program will be issued upon completion. It is anticipated that this report should be available by January 1, 1981.

DUQUESNE LIGHT COMPANY
Beaver Valley Power Station

November 17, 1980

BVPS:JAW:1025

Request For Input To Resolution Of
November 13, 1980 IR-NIS Incident

To all: Shift Supervisors Nuclear Control Operators
 Shift Foremen

On November 13, 1980, an incident occurred whereby one channel of the Intermediate Range Nuclear Instrumentation System (IR-NIS) was placed in BYPASS mode during the performance of an improperly scheduled OST. When it was determined that the OST was not required, the OST was terminated; however, restoration of the original initial conditions prior to the start of the OST was not accomplished, thereby leaving the IR-NIS channel in the BYPASS mode with the plant in Mode 2 and the reactor critical. This occurred during the 0800-1600 hour shift and was not discovered until the turnover between the 1600-2400 shift and the 2400-0800 shift. Hence, this condition went unnoticed for one shift turnover and approximately 1 1/3 shifts of normal duty.

A similar such incident occurred approximately one year ago resulting in several administrative procedure changes to preclude recurrence. The occurrence of this November 13, 1980 incident implies either: 1) ineffective administrative controls exist to preclude this type of incident; 2) disregarding of existing controls by the personnel involved; or 3) carelessness. With the magnitude of the responsibility we have as operators of a nuclear facility, none of these conditions are acceptable - either to us or to the public we serve.

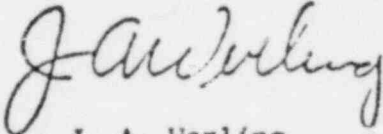
Due to the extreme seriousness of this type of incident, it is imperative that we address the solution collectively in order to obtain as much input to the solution as possible. I regard your input, as licensed operators of this station, to be of extreme importance. Therefore, I request that you provide to me your written, individual analysis and recommendations regarding this incident by return letter. In this manner, the final decisions made regarding future actions may be made taking into consideration the input from those of us who must actually live by the decisions.

POOR ORIGINAL

To All Licensed Personnel
November 17, 1980
BVPS:JAW:1025
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1. What, in your opinion, was the underlying root cause of this occurrence?
2. Should existing administrative procedures be revised, amplified, or expanded to avoid such occurrences?
3. Would additional training help? If so, what type?
4. Is disciplinary action warranted? If so, what and to whom?
If not, why?
5. Are existing Control Room formalities and shift turnover procedures commensurate with the responsibility of the task we have in operating this station?
6. Are existing attitudes, dedication and concern with safety of the operating staff (which includes you) conducive to the philosophy that in our business, "merely satisfactory performance is unacceptable"?
7. What overall actions do you recommend to resolve the root cause of this occurrence?

Your reply to this letter is to be made, in writing, before December 1, 1980.


J. A. Werling

JAW:sas

cc: C. W. Moore
J. J. Carey
H. P. Williams
L. G. Schad
J. V. Vassello
J. D. Sieber
Central File (2)

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