NRC FORM 366 (12-81) 10 CFR 50

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

APPROVED BY OMB 3150-0011

CONTROL BLOCK: [| | | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | LICENSEE CODE: P A S E S 1 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT: (5)

CON'T

01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 3 8 7 (7) | EVENT DATE: 0 3 0 1 8 3 (8) | REPORT DATE: 0 3 1 5 8 3 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While operating at 100% power, an Operator tagged out the "A" Standby Gas Treat-
03 ment System to allow removal of a test canister from the charcoal bed. However,
04 due to the extent of the blocking used, the Operator unknowingly caused both
05 trains of SGTS to be inoperable. There were no consequential effects to the
06 public health and safety. The Reactor Building HVAC was operable and maintained
07 a ¼" negative pressure during the event. No other events occurred which re-
08 quired SGTS to operate.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
09	S C (11)	A (12)	A (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 2 6	/	0 1	T	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER (26)
X (18)	H (19)	Z (20)	Z (21)	0 0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 This event was caused by an Operator using a common point for tagging out a
11 piece of equipment and not knowing the consequential effects of his actions.
12 Re-instruction and training is being formulated for operations personnel, as
13 well as work group personnel, to emphasize the importance of work planning,
14 review and responsibilities.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
15	B (28)	1 0 0 (29)	n/a	A (31)	operator observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
16	Z (33)	Z (34)	n/a	n/a

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
17	0 0 0 (37)	Z (38)	n/a

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
18	0 0 0 (40)	n/a

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
19	Z (42)	n/a

8303250123 830315
PDR ADOCK 05000387
S PDR

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
20	N (44)	n/a	

NAME OF PREPARER Jon T. Todd PHONE (717) 542-2181 X3524

Attachment

Licensee Event Report 83-026/01T-0

While in Operating Condition 1 at 100% power, Operations tagged out the "A" train of the Standby Gas Treatment System for personnel protection while removing test canisters from the charcoal bed. A part of this tagging included two 120V AC panel breakers which were known to de-energize the controls for the cross-tie dampers from train "A" to "B". What was not known was that these breakers also supplied power to other dampers and instrumentation. Each of these breakers controlled one cross-tie damper and additional circuitry that would cause the associated train of SGTS to be inoperable; when the Operator opened both breakers, he made both trains inoperable. The Alarm Response procedures for the loss of power annunciators that came in when the breakers were opened did not clearly indicate to the Operator that the SGTS subsystems were inoperable.

Both trains of SGTS were inoperable for a period of approximately 25 hours. It was not until the "A" train was being restored in preparation for the "B" train to come out of service, that the problem was clearly identified. The Operator left the two 120V AC panel breakers open, as they were also to be included in the tagging for the "B" train. When the "A" train would not start for an operability checkout, the Operator recognized the full impact of the loss of power annunciators that were still in.

The Reactor Building Ventilation System was in operation and maintaining a ¼" negative pressure in the building during the entire event. There were no other events that required an initiation of Standby Gas Treatment System while the system was inoperable.

To prevent recurrence of this event, the following action items have been identified; some were of an immediate nature and others are long term:

A. Immediate Actions:

1. A detailed review was conducted and a letter was issued to all licensed personnel discussing the event.

2. The Nuclear Safety Assessment Group was assigned to make an independent review.

3. A letter has been sent to each Shift Supervisor updating him in the changes that are to take effect immediately concerned with tagging out equipment via panel breakers.

4. The Operations Supervisor has conducted formal training with all licensed operators in 4 of the 5 shifts. (The fifth shift to be trained 3/16/83).

5. The Assistant Superintendent of Plant and the Operations Supervisor now make a daily review of Operations' logs and turnover sheets in the Control Room with the Shift Supervisor to clearly identify minimum standards for these items.

B. Long Term Actions:

1. Change procedures/policies as required to:

   a. Clearly place plant status responsibility with the Plant Control Operator.

   b. Clearly identify responsibility of individuals to identify operational effects of all requested work.

   c. Review current work planning and unit coordination process to effectively identify and coordinate all work effecting Unit operation.

   d. Establish plant policy that out-of-service Safeguards Equipment must be worked continuously to completion.

2. Conduct training on above changes to policies and procedures.

3. Remove nuisance alarms from the Control Room.

4. Complete development of and conduct training on the effects and recognition of loss of control power to Safeguards equipment.

5. Conduct formal training on reporting requirements.

6. Develop required drawings and improve existing drawings on electrical distribution so Operators and Maintenance personnel can efficiently identify and perform electrical tag-outs.

7. Review the Alarm Response procedure to incorporate any required changes.

JTT/cg