

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **DIABLO CANYON UNIT 1** DOCKET NUMBER (2) **0 5 0 0 0 2 7 5** PAGE (3) **1 OF 0 1 2**

TITLE (4) **INOPERABILITY OF BOTH RHR TRAINS**

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)
01	20	85	85	005	000	02	18	85		0 5 0 0 0
										0 5 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

OPERATING MODE (9) <b>5</b>	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.408(c)	<input type="checkbox"/> 80.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
POWER LEVEL (10) <b>0 0 1 0</b>	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 80.38(a)(1)	<input type="checkbox"/> 80.73(a)(2)(v)	<input type="checkbox"/> 73.71(a)
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 80.38(a)(2)	<input checked="" type="checkbox"/> 80.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 80.73(a)(2)(i)	<input type="checkbox"/> 80.73(a)(2)(viii)(A)	
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 80.73(a)(2)(ii)	<input type="checkbox"/> 80.73(a)(2)(viii)(B)	
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 80.73(a)(2)(iii)	<input type="checkbox"/> 80.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **DAVID P. SISK, REGULATORY COMPLIANCE ENGINEER** TELEPHONE NUMBER **8 0 5 5 9 5 - 7 3 5 1**

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)  NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 2303 PST, January 20, 1985, with Unit 1 in Mode 5 (Cold Shutdown) both Residual Heat Removal (RHR) Trains became inoperable for approximately 6 minutes.

This event was caused by a plant technician checking the wrong breaker and verifying it as being open. When Overpressure Protection Channel PT-403 was removed from service, an interlock between the protection channel and RHR pump inlet valve, MOV 8702, resulted in valve closure and both RHR pumps losing suction. The pumps were manually tripped in response to the RHR low flow alarm.

At 2309, MOV 8702 was reopened. At 2312 RHR pump 1-1 was restarted and RHR flow established. All Technical Specification Action Statements were met.

An Incident Review Board met and made recommendations to revise Surveillance Test Procedures (STPs) I-68A and I-69A. The procedures will inform the technician that the breaker may be found open or closed and, if found closed, Operations Department should be notified to open it. Also, the event was reviewed with all affected personnel stressing the importance of verifying the correct breaker.

IE22  
4/1

8502250761 850215  
PDR ADOCK 05000275  
S PDR

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  DIABLO CANYON UNIT 1	DOCKET NUMBER (2)  0 5   0   0   0   2   7   5   8   5	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
			- 0   0   5	- 0   0	0   2	OF

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

At 2303 PST, January 20, 1985, with Unit 1 in Mode 5 (Cold Shutdown) both Residual Heat Removal (RHR) Trains (BP) became inoperable for approximately 6 minutes.

STP I-68A, "Functional Test of PORV Overpressure Protection Channels 403 and 433B," requires that plant technicians verify the breaker (BP) (BKR) for RHR pump inlet valve, MOV 8702, as being open. However, a plant technician checked the wrong breaker and verified it as being open. When Protection Channel PT-403 (JG) (PT) was removed from service, an interlock between the protection channel and MOV 8702 caused the valve to close and both RHR pumps (PB) (P) to lose suction. The pumps were manually tripped in response to the RHR low flow alarm.

At 2309, MOV 8702 was reopened. At 2312, RHR pump 1-1 was restarted and RHR flow established. All Technical Specification Action Statements were met.

An Incident Review Board met and made recommendations to revise STPs I-68A and I-69A. The procedures will inform the technician that the breaker may be found open or closed and, if found closed, Operations Department should be notified to open it. This event was also reviewed with all affected personnel stressing the importance of verifying the correct breaker.

This event had no safety consequences and in no way affected the health and safety of the public.

PGandE is, and has been, actively pursuing administrative and/or hardware remedies to preclude the inadvertent closure of these valves. These remedies are presently being formulated and will be discussed with the NRC on a generic basis by the utility and NSSS vendor.

A similar event was reported in LER 84-04-00.

# PACIFIC GAS AND ELECTRIC COMPANY

PG&E + 77 BEALE STREET • SAN FRANCISCO, CALIFORNIA 94106 • (415) 781-4211 • TWX 910-372-6587

JAMES D. SHIFFER  
VICE PRESIDENT  
NUCLEAR POWER GENERATION

February 15, 1985

PGandE Letter No.: DCL-85-067

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

Re: Docket No. 50-275, OL-DPR-80  
Diablo Canyon Unit 1  
Licensee Event Report 85-005-00  
Inoperability of Both RHR Trains

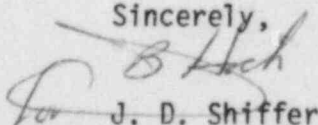
Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(vii), PGandE is submitting the enclosed Licensee Event Report concerning the inoperability of both Residual Heat Removal (RHR) Trains.

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

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

  
For J. D. Shiffer

Enclosure

cc: J. B. Martin  
Service List

IEZZ  
1/1