

LICENSEE EVENT REPORT (LER)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/86

NAME (1) DIABLO CANYON UNIT 2 DOCKET NUMBER (2) 0 5 0 0 0 3 2 3 1 OF 0 4 PAGE (3)

INCOPERABILITY OF BOTH RHR TRAINS DUE TO OPERATOR ERROR

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	17	86	86	002	00	02	18	86			0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
5		20.402(b)		20.406(c)		50.73(a)(2)(iv)		73.71(b)			
POWER LEVEL (10)		20.405(a)(1)(i)		50.38(c)(1)		50.73(a)(2)(v)		73.71(c)			
0 0 0		20.405(a)(1)(ii)		50.38(c)(2)		50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 365A)			
		20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(vii)(A)					
		20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)					
		20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)					

LICENSEE CONTACT FOR THIS LER (12)									
NAME								TELEPHONE NUMBER	
DAVID P. SISK, REGULATORY COMPLIANCE ENGINEER								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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)		X NO				

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

At 0455 PST on January 17, 1986, while attempting to transfer instrument AC panel PY 2-1A from normal to backup power supply, an unlicensed operator went to the wrong panel and inadvertently transferred instrument AC panel PY 2-1 to its backup power source. This momentary loss of power caused relay actuation which resulted in the closure of residual heat removal (RHR) valve 8702. In response to the ensuing loss of flow alarm, RHR pump 2-1 was secured by a licensed operator. RHR valve 8702 was reopened from the control room. RHR pump 2-1 was restarted, observed for seal damage, and declared operable at 0508 PST, January 17, 1986. No operations were in progress that involved a reduction in reactor coolant system boron concentration. Thus, the requirements of Technical Specification (T.S.) 3.4.1.4.1 Action b were met.

To prevent recurrence, the operator involved has been counseled, operating procedures on transferring instrument AC panel power supplies will be revised, and panel identification labels in the instrument AC panels will be upgraded.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

ANYON UNIT 2

DOCKET NUMBER (2)										LER NUMBER (6)						PAGE (3)					
										YEAR	SEQUENTIAL NUMBER		REVISION NUMBER								
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is required, use additional NRC Form 366A's (17)

I. Initial Conditions

The unit was in Mode 5 (Cold Shutdown) with a reactor coolant system (AB) temperature of 120 degrees fahrenheit and pressure of 18 psig.

II. Description of Event

A. Event:

At 0455 PST on January 17, 1986, while attempting to transfer instrument AC panel (EJ) PY 2-1A from normal to backup power supply, an unlicensed operator went to the wrong panel and inadvertently transferred instrument AC panel PY 2-1 to its backup power source. This momentary loss of power caused relay actuation which resulted in the closure of residual heat removal (RHR) valve (BP)(V) 8702. In response to the ensuing loss of flow alarm, RHR pump 2-1 was secured by a licensed operator. RHR valve 8702 was reopened from the control room. RHR pump 2-1 was restarted, observed for seal damage, and declared operable at 0508 PST, January 17, 1986. No operations were in progress that involved a reduction in reactor coolant system boron concentration. Thus, the requirements of Technical Specification (T.S.) 3.4.1.4.1 Action b were met.

B. Inoperable structures, components, or systems that contributed to the event:

None

C. Dates and approximate times for major occurrences:

1. January 17, 1986, at 0455 PST: Event and discovery date
2. January 17, 1986, at 0508 PST: RHR system returned to operation

D. Other systems of secondary functions affected:

None

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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EXPIRES: 8/31/85

ON UNIT 2

DOCKET NUMBER (2)

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NUMBER

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Use additional NRC Form 365A's (17)

E. Method of discovery:

Event was immediately apparent due to the RHR low flow alarm in the control room.

F. Operator actions:

RHR pump 2-1 was immediately secured and the RHR system was declared inoperable in accordance with Technical Specification 3.4.1.4.1. RHR valve 8702 was reopened from the control room. RHR pump 2-1 was restarted. The pump was observed for abnormal leakage and normal operation. No abnormal leakage was observed and the pump operated satisfactorily. The RHR system was returned to operable status.

G. Safety systems responses:

None

III. Cause of Event

A. Immediate cause:

While attempting to transfer instrument AC panel PY 2-1A from normal to backup power supply, an unlicensed operator went to the wrong panel and inadvertently transferred instrument AC panel PY 2-1 from normal to backup power source.

B. Root cause:

The root cause was personnel error (cognitive). The operator failed to look at the panel nameplate to ensure he was at the correct inverter panel.

IV. Analysis of Event

The unit was in Mode 5 (Cold Shutdown) with a reactor coolant system temperature of 120° fahrenheit. The RHR low flow alarm provided immediate warning in the control room. Due to prompt response, RHR flow loss was for only 13 minutes. Therefore, this event had no affect on the safety of the plant or the health and safety of the general public.

Had the loss of suction flow not been noticed and a prompt response not made, the pump seals of RHR pump 2-1 may have been damaged. This would have required the start and operation of the redundant RHR pump 2-2 after reopening of valve 8702, but the health and safety of the public would not have been affected.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

V. Corrective Actions

- A. The operator involved has been counseled as to the importance of verifying that the proper equipment is located prior to initiating action.
- B. Operating procedures on transferring instrument AC panel power supplies will be revised to require independent verification of proper devices prior to any equipment operation.
- C. Labels in the instrument AC panels will be upgraded such that the panel identification number is clearly visible with the panel door open.

VI. Additional Information

A. Failed components:

None

B. Previous LERs on similar events:

1. LER 1-85-020, "Start of Wrong Diesel Generator," submitted on July 25, 1985.

This event was caused by an unlicensed operator misunderstanding verbal instructions. Corrective actions included a requirement to repeat verbal commands. Since the event of LER 2-86-002 was not caused by missed communications, the corrective actions of LER 1-85-020 were not applicable in preventing the present event.

2. LER 1-85-005, "Inoperability of Both RHR Trains," submitted on February 15, 1985.

This event was caused by a plant technician checking the position of the wrong breaker. Corrective actions included the review of the event with all affected I&C personnel, stressing the importance of verifying the identification of a breaker prior to operation. This corrective action was not applicable to operations personnel. Since the event of LER 2-86-002 was not caused by I&C personnel, the corrective actions of LER 1-85-005 were not applicable in preventing the present event.

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PACIFIC GAS AND ELECTRIC COMPANY

PG&E

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JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

February 18, 1986

PGandE Letter No.: DCL-86-039

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

Re: Docket No. 50-323, OL-DPR-82
Diablo Canyon Unit 2
Licensee Event Report 2-86-002-00
Inoperability of Both RHR Trains Due to Operator Error

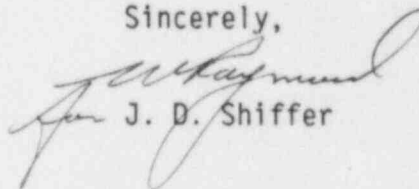
Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(v)(B), PGandE is submitting a Licensee Event Report concerning an event that alone could have prevented the fulfillment of the safety function of the residual heat removal system.

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,


J. D. Shiffer

Enclosure

cc: L. J. Chandler
R. T. Dodds
J. B. Martin
B. Norton
H. E. Schierling
CPUC
Diablo Distribution
INPO

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