

AmerGen

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Clinton Power Station

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2C.220

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Docket No. 50-461

10CFR50.73

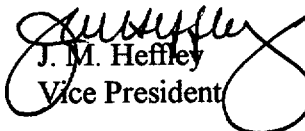
Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Subject: Clinton Power Station
Licensee Event Report No. 2000-007-00

Dear Madam or Sir:

Enclosed is Licensee Event Report (LER) No. 2000-007-00: Unknown Division 1 Logic Circuit Card Failure Goes Undetected During Division 2 Surveillance Test Due to Inadequate Procedure and Completes Actuation Logic Resulting in Main Steam Line Containment Isolation and Reactor Scram. This report is being submitted in accordance with the requirements of 10CFR50.73.

Sincerely yours,


J. M. Heffley
Vice President

RSF/krk

Enclosure

cc: NRC Clinton Licensing Project Manager
NRC Resident Office, V-690
NRC Region III, Regional Administrator
Institute of Nuclear Power Operations

IE22

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

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TITLE (4)

Unknown Division 1 Logic Circuit Card Failure Goes Undetected During Division 2 Surveillance Test Due to Inadequate Procedure and Completes Actuation Logic Resulting in Main Steam Line Containment Isolation and Reactor Scram

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 NAME	DOCKET NUMBER
12	18	2000	2000	007	00	01	17	2001	None	05000
									None	05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
		20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
POWER LEVEL (10)	100	20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	X 50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
J. C. Wemlinger, Corrective Action Coordinator Lead	(217) 937-3846

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
X	AD	RLY	F180	Y					
X	SJ	IMOD	G080	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

A Containment Main Steam Line isolation (Group 1) and subsequent reactor scram from 100 percent reactor power occurred during a Division (Div) 2 Main Steam Line tunnel ambient temperature channel functional test. The logic for the isolation was completed when a Div 2 channel functional test signal combined with a pre-existing Div 1 trip signal. The Div 1 trip signal was a result of a circuit card failure and was unknown at the time of the test. The isolation initiated a Reactor Scram. During recovery from the event, an additional scram occurred on low reactor water level. While reestablishing the main condenser as a heat sink, a deficient procedure lacked provisions for opening both the inboard and outboard main steam isolation valves and an at risk revision of the procedure was initiated. During the revision process, poor command and control allowed reactor pressure to increase and water level to decrease to the scram setpoint. The cause of the Group 1 and scram was inadequate provisions in the procedure for preventing a pre-existing fault in an alternate channel from completing the logic. The cause of the additional scram was poor command and control. Corrective action for this event includes revising procedures, counseling the main control room crew, providing remedial training, and developing a comprehensive corrective action plan to address the operator performance issues.

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

DESCRIPTION OF EVENT

On December 18, 2000, the plant was in Mode 1 (Power Operation) at 100 percent reactor power. Instrumentation and Control technicians were performing surveillance procedure CPS 9532.07, "MSL Ambient Temp. E31-N604A&E (B&F) Channel Functional," on the Division 2 Main Steam Line Tunnel Leak Detection System [SJ]. The leak detection system bypass switches [HS] for the Division 2 Reactor Core Isolation Cooling System (RCIC) [BN] and Reactor Water Cleanup System (RT) [CE] were in the bypass position as required by the procedure to support the surveillance test.

At about 1329 hours, while performing testing in accordance with CPS 9532.07, a Group 1 Containment Isolation occurred. The Group 1 Isolation caused the Main Steam [SB] Isolation Valves (MSIVs) [ISV] and main steam line drain valves to automatically close, resulting in an automatic reactor scram.

Following the reactor scram, the Main Control Room (MCR) crew entered Emergency Operating Procedure (EOP)-1, "RPV Control," and off-normal procedure CPS 4100.01, "Reactor Scram." The Control Room Supervisor (CRS) directed operators to control reactor water level between level 3 and level 8 and reactor pressure between 800 and 1065 pounds per square inch gage (psig) using safety relief valves (SRVs) [RV]. Because the MSIVs closed, the main condenser [COND] (the normal heat sink following a reactor scram) was not available for pressure control. Initially, following the scram, reactor pressure and level were maintained by automatic and manual operation of the SRVs; manual initiation of the RCIC pump [P] injecting into the vessel from the RCIC storage tank [TK] and operating RCIC in the tank-to-tank mode; Control Rod Drive System [AD] injection; and reactor feed supplied through the motor-driven reactor feed pump and condensate booster pumps.

At approximately 1542 hours, the MCR crew commenced activities to reestablish the main condenser as the heat sink in accordance with procedure CPS 3101.01, "Main Steam (MS, IS, ADS)," for reactor pressure control. During performance of CPS 3101.01 section 8.1.1.3, "MSL Warmup/Unisolation when RPV is Pressurized MODE 2/3," the operator realized that the procedure section had steps for opening the inboard MSIVs, but not for opening the outboard MSIVs. Procedure section 8.1.1.3 was written with the assumption that the outboard MSIVs were already open; an earlier section of the procedure opens these valves. Operators initiated At Risk Revision (ARR) 00-0660 to change the procedure section to allow opening of the outboard MSIVs.

While the procedure change process was being pursued, reactor pressure was slowly increasing, and reactor water level was slowly decreasing. When reactor pressure increased to the discharge pressure of the condensate booster pumps that were feeding the vessel, feed flow to the reactor vessel stopped and water level decreased more rapidly. At Risk Revision 00-0660 was approved at about 1842 hours and the outboard MSIVs were opened; however, reactor water level dropped to low level 3, initiating a reactor scram at about 1845 hours. At the time of this scram, the plant was in Mode 3 (HOT SHUTDOWN), reactor coolant temperature was approximately 500 degrees Fahrenheit, and pressure was approximately 700 psig.

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Following opening of the MSIVs, reactor pressure control was established by bleeding steam to the main condenser through the turbine bypass valves, and reactor water level control was established using the Condensate/Condensate Booster Systems [SD].

Investigation of this event identified that the Group 1 Isolation was caused by performance of the Division 2 Main Steam Line tunnel leak detection system surveillance at the same time that an unidentified failure of a Digital Signal Conditioning (DSC) card [IMOD] existed in the circuitry for the Division 1 Main Steam line tunnel ambient temperature channel. This condition satisfied the 2-out-of-4 logic for the Group 1 isolation. Maintenance work document AR F20376 was initiated to investigate and correct this issue.

During the review of the scram response and recovery efforts the following human performance deficiencies/weaknesses were identified:

- Following the scram, the "B" MCR operator placed the Division 2 Leak Detection System bypass switches back to the normal position without first notifying the Control Room Supervisor. Placing the bypass switch back in the normal position while a main steam line temperature trip was still locked-in from performance of surveillance CPS 9532.07, resulted in a Division 2, Group 4 Reactor Water Cleanup System containment isolation that tripped the running RT "A" and "C" pumps.
- The "A" MCR operator did not manually trip the turbine driven reactor feed pumps (TDRFPs) prior to receiving the automatic high reactor water level 8 trip of the TDRFPs during the initial level transient following the scram as stated in off-normal procedure CPS 4100.01.
- While using the motor-driven reactor feed pump (MDRFP), the reactor vessel was overfed when feedwater regulating valve 1FW004 failed to respond to level control signals. This resulted in the MDRFP tripping on high reactor water level 8. The failure of 1FW004 to respond was caused by the "A" MCR operator inappropriately using the startup level controller for 1FW004 in manual with the push-buttons in the "double-detent" mode.
- During the scram recovery, coordination between operators in controlling reactor water level and pressure was poor and did not minimize the number of low reactor water level 3 trips that occurred during the initial level transients following the scram.

During the event, a relay [RLY] failure in the Reactor Recirc (RR) [AD] flow control valve [FCV] circuit caused a premature runback of the FCVs when reactor water level decreased to level 4. The relay issue was known and documented prior to the trip in Maintenance work documents AR F20511 and F24375. Repair of the faulty relay condition had been included in the scope for a forced outage due to the plant conditions required for the repair. The faulty relay condition was corrected prior to plant startup following this event.

Condition Reports 2-00-12-107 and 2-00-12-109 were initiated to track a cause and corrective action determination for the Group 1 Containment isolation, reactor scrams, and the operator human performance issues associated with this event.

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No other automatic or manually initiated safety system responses were necessary to place the plant in a safe and stable condition. Other inoperable equipment or components did not directly affect this event.

CAUSE OF EVENT

The cause of the Group 1 containment isolation and subsequent reactor scram is attributed to an inadequate procedure. Surveillance procedure CPS 9532.07 had inadequate provisions for preventing a pre-existing fault in an alternate channel from completing the Group 1 actuation logic. There is no annunciation available for the operator to detect the fault.

The primary cause for the reactor scram on low water level while attempting to establish reactor pressure control by bleeding steam to the main condenser was poor command and control of this evolution by the Control Room Supervisor. This deficiency resulted in a loss of reactor water level and pressure control while a procedure revision was being pursued to allow opening the MSIVs to establish the main condenser as a heat sink. The loss of level and pressure control resulted in a reactor scram on low water level 3.

An additional cause for the reactor scram while attempting to establish reactor pressure control via the main condenser was an inadequate procedure. System operating procedure CPS 3101.01 sections for main steam line startup were formatted for specific sections to be performed independently for the plant condition. The section initially used by the operator during this event to open the MSIVs, Section 8.1.1.3, "MSL Warmup/Unisolation when RPV is Pressurized MODE 2/3," had provisions for opening only the inboard valves and assumed that the outboard MSIVs were already opened by a previous procedure section. This procedural inadequacy substantially delayed efforts in restoring the main condenser as a heat sink to control reactor pressure, resulting in reactor water level decreasing to the low water level 3 scram setpoint.

Contributing causes for the reactor scram on low water level include an inadequate pre-job briefing and a failure to adequately review the procedure prior to use. An inadequate pre-job briefing and the failure to adequately review the procedure prior to initiating actions to establish the main condenser as a heat sink resulted in the failure to identify the procedure deficiency prior to starting the evolution.

CORRECTIVE ACTIONS

The DSC card that failed was replaced in accordance with maintenance work document AR F20376.

I&C Maintenance reviewed Reactor Protection System and Nuclear Steam Supply Shutoff System logic circuits to determine the plant's exposure to similar pre-existing circuit faults that can result in a reactor scram or Group 1 Containment isolation during surveillance testing. The review identified nine surveillance procedures having the potential to be affected by similar faults that can cause a reactor scram or Group 1 Containment isolation. Four of the procedures have been revised to include appropriate precautions to prevent similar events. The remaining surveillance procedures will be revised prior to use.

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System operating procedure CPS 3101.01 will be revised to improve human factors and to provide clear instructions for opening both the inboard and outboard MSIVs.

An Operations Night Order will be issued to emphasize preplanning of evolutions.

During the events described in this LER and follow-up critique, several operator and control room supervisor human performance issues were identified in areas such as command and control, control of resources, communications, equipment operation, and pre-evolution planning. In response to these issues, the affected members of the Main Control Room crew during these events were provided remedial training in the simulator with acceptable results. In addition, the Main Control Room crew was counseled on these issues.

The Director of Operations met with several Operations shift managers and control room supervisors at an offsite location to review Operations performance as documented by the NRC, Exelon Regional Operating Group, and site organizations. During this meeting, a comprehensive corrective action plan was developed to address the operator performance issues.

All Operations shift crews will be trained on this event during the first requalification cycle of 2001. The training will include a discussion of the events of the scram, the inappropriate actions, the positive behaviors, equipment deficiencies noted, the skill and rule based errors, the causal factors, and recommended corrective actions. The shift manager of the crew involved in the scram is planning to provide a portion of the training.

ANALYSIS OF EVENT

This event is reportable under the provisions of 10CFR50.73(a)(2)(iv) due to the actuations of the Reactor Protection System [JC] and engineered safety features.

This event was compared with Updated Safety Analysis Report (USAR) Section 15.2.4, "MSLIV Closures," and the Transient Safety Analysis Design Report, and was found to be less severe than the analyses.

ADDITIONAL INFORMATION

The Digital Signal Conditioner circuit card discussed during this event is model 147D8461G010, manufactured by General Electric Company.

A relay failure in relay logic card 1B33K649A4 caused the premature runback of the reactor recirculation flow control valves. The relay card is model 2AO+L2C-R, manufactured by the Foxboro Company.

Clinton Power Station has not had any reportable events involving a Containment isolation or reactor scram due to a similar cause in the past 5 years.

For further information regarding this event, contact J. C. Wemlinger, Corrective Action Coordinator Lead, at (217) 937-3846.