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ACCESSION NBR: 9105240253 DOC. DATE: 91/05/15 NOTARIZED: NO DOCKET #
 FACIL: 50-305 Kewaunee Nuclear Power Plant, Wisconsin Public Service 05000305
 AUTH. NAME AUTHOR AFFILIATION
 WEBB, T.J. Wisconsin Public Service Corp.
 EVERS, K.H. Wisconsin Public Service Corp.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-004-00: on 910415, inadvertent closure of two containment isolation valves & actuation of several dampers in auxiliary bldg ventilation occurred. Caused by error in communication. Individuals counseled. W/910515 ltr.

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 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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	AEOD/DOA		1	1	AEOD/DSP/TPAB		1	1
	AEOD/ROAB/DSP		2	2	NRR/DET/ECMB 9H		1	1
	NRR/DET/EMEB 7E		1	1	NRR/DLPQ/LHFB11		1	1
	NRR/DLPQ/LPEB10		1	1	NRR/DOEA/OEAB		1	1
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	NRR/DST/SRXB 8E		1	1	REG FILE 02		1	1
	RES/DSIR/EIB		1	1	RGN3 FILE 01		1	1
EXTERNAL:	EG&G BRYCE, J.H		3	3	L ST LOBBY WARD		1	1
	NRC PDR		1	1	NSIC MURPHY, G.A		1	1
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May 15, 1991

10 CFR 50.73

U. S. Nuclear Regulatory Commission
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Washington, D.C. 20555

Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Reportable Occurrence 91-004-00

The attached Licensee Event Report for reportable occurrence 91-004-00 is being submitted in accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System."

Sincerely,

K. H. Evers
Manager-Nuclear Power

DLR/jms

Attach.

cc - INPO Records Center
Mr. Patrick Castleman, US NRC
US NRC, Region III

21-47

9105240253 910515
PDR AIDOCK 05000305
S PDR

JE22

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Kewaunee Nuclear Power Plant	DOCKET NUMBER (2) 0 5 0 0 0 3 0 5	PAGE (3) 1 OF 0 5
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TITLE (4)
 Communication Error Results in Actuation of Engineered Safety Features

EVENT DATE (5)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (6)										
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES			DOCKET NUMBER(S)							
0	4	15	9	1	1	0	0	4	0	0	0	N/A			0 5 0 0 0				
0	4	15	9	1	1	0	0	4	0	5	1	5	9	1	0	5	0	0	0

OPERATING MODE (8) N

POWER LEVEL (10) 0 1 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input checked="" type="checkbox"/> 80.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 80.38(c)(1)	<input type="checkbox"/> 80.73(a)(3)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 80.38(c)(2)	<input type="checkbox"/> 80.73(a)(3)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 80.73(a)(2)(i)	<input type="checkbox"/> 80.73(a)(2)(vii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 80.73(a)(2)(ii)	<input type="checkbox"/> 80.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 80.73(a)(2)(iii)	<input type="checkbox"/> 80.73(a)(2)(i)	

LICENSEE CONTACT FOR THIS LER (13)

NAME Thomas J. Webb - Plant Nuclear Engineer	TELEPHONE NUMBER AREA CODE 4 1 4 3 8 8 1 - 2 5 6 1 0
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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) N/A

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

This report describes the inadvertent closure of two containment isolation valves and actuation of several dampers in the auxiliary building special ventilation system. The valves and dampers are considered engineered safety features. The event occurred at 2123 on April 15, 1991, with the plant in refueling shutdown, during performance of design change request (DCR) procedure 2417-02. DCR 2417 was implemented to relocate non-safety related 120 VAC loads from the existing safety related distribution panels to new non-safety related panels. The event occurred when an Auxiliary Operator isolated a temporary power supply to a safety related distribution panel prior to connecting it to its normal power supply. This de-energized the panel and resulted in the actuations.

This event occurred as a result of a communication error. The on duty Control Room Supervisor (CRS) had directed the Nuclear Auxiliary Operator (NAO) to perform the applicable steps in DCR procedure 2417-02. A misunderstanding between the CRS and the NAO resulted in the Auxiliary Operator performing the step that isolated the temporary power supply to the distribution panel out of sequence.

Discussions emphasizing the importance of clear communication were held with the individuals involved. Furthermore, this report will be included as part of the required reading material for all operators.

Since the event did not place the plant in an unanalyzed condition, this event had no affect on the health and safety of the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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							9 1	— 0 1 0 4	— 0 1 0	0 2	OF	0 5

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

Description of Event

This report describes the inadvertent closure of two containment isolation [ISV] valves and the actuation of several dampers [DMP] in the auxiliary building special ventilation system. The valves are classified as Engineering Safety Features. The event occurred at 2123 on April 15, 1991, with the plant in refueling shutdown, during performance of design change request (DCR) procedure 2417-02.

DCR 2417 was implemented to move non-safety related loads from the existing safety related 120 volt alternating current (VAC) distribution panels [BU], BRA-105 and BRB-105, to new non-safety related distribution panels, BRA-127 and BRB-127, refer to figure 1. Prior to DCR 2417, each non-safety related load had to be individually isolated from its safety related power supply. DCR 2417 provides one isolation point per train between the non-safety related 120 VAC distribution panels and their respective safeguards power supplies.

Prior to the actuation at approximately 2105 on April 15, the supervisor for the contract electricians informed the Shift Supervisor that step 4.17.1 of DCR procedure 2417-02 had been completed and that the electricians were ready to proceed with steps 4.17.2, 4.18, and 4.19. Steps 4.17, 4.18, and 4.19 state:

- 4.17 At 120/208Vac Distribution Cabinet BRB-127 perform the following, per drawing E3654:
 - 4.17.1 Install and terminate cable 1NPO671 in the correct phase sequence determined by Step 4.15, to the main panelboard 225-A Circuit Breaker.
 - 4.17.2 At Main 225A Circuit Breaker install DANGER TAG in the OFF position. DANGER TAG to state that breaker can be operated during the performance of this procedure.
- 4.18 At MCC 1-62C Breaker B4 place the breaker in the ON position, Reference Drawing E612.
- 4.19 At 120/208Vac Distribution Cabinet BRB-105 perform the following, Reference Drawing E843:

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

- 4.19.1 At main panelboard 250-A circuit breaker remove HOLD TAG and place breaker in the ON position.
- 4.19.2 At circuit breaker position 3 remove DANGER TAG and place breaker in the OFF position and HOLD TAG.

Please note that steps 4.17 and 4.18 were on the bottom of page 11 of procedure DCR 2417-02 while step 4.19 was at the top of page 12. For your convenience, the procedure step number and a description of the required action is shown in brackets next to its associated breaker in Figure 1.

After reviewing the steps, the Shift Supervisor gave the supervisor for the contract electricians permission to proceed. The Shift Supervisor then informed the Control Room Supervisor (a licensed operator) that the electricians were ready to proceed with their procedure. The electrical supervisor reviewed the procedure with the Control Room Supervisor and arranged for the necessary danger tags and hold cards. Danger tags and hold cards are used to control equipment status to prevent equipment damage and personnel injury. The Control Room Supervisor gave the danger card for step 4.17.2 and the hold card for step 4.19.2 to the Nuclear Auxiliary Operator (NAO) (a non-licensed operator) and requested that he place the tags in accordance with the procedure. The NAO and a contract electrician, who had a copy of the procedure with him, left the control room for the B battery room where all the breakers [BRK] described in steps 4.17, 4.18, and 4.19 are located.

At this time, the NAO was under the impression that he was only required to do steps 4.17.2, 4.19.1, and 4.19.2, i.e, those steps which required placement or removal of a danger tag or hold card. At approximately 2123, the NAO entered the B battery room and proceeded with steps 4.17.2 and 4.19.2. When he performed step 4.19.2 prior to performing step 4.18, he isolated all power to BRB-105. The electricians who were already in the room and were watching the NAO knew he had isolated all power to the bus. However they were unable to act quick enough to warn him. Annunciators in the control room immediately alerted the operators to the abnormal condition.

When BRB-105 was de-energized, the following equipment actuated as designed:

- containment isolation valves AS-2 and AS-32 closed,
- several dampers in the auxiliary building special ventilation system repositioned,
- the auxiliary building ventilation fans [FAN] (used for ventilation during normal plant operation) stopped.

Following the actuation, the bus was re-energized and the equipment was returned to the desired alignment. The procedure was then completed without further incident.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

Cause of Event

The event occurred as a result of a communication error between the Control Room Supervisor and the NAO. The Control Room Supervisor was of the impression that the Auxiliary Operator was aware of what procedure steps had been completed and what steps needed to be performed. The NAO was of the impression that he was only required to place the danger tag and hold card that were given to him and to remove a danger card.

Analysis of Event

This event was determined to be reportable in accordance with 10CFR50.73(a)(2)(iv) as an event that resulted in the inadvertent actuation of an engineered safety feature. Containment isolation valves AS-2 and AS-32 and components in the auxiliary building special ventilation system are considered engineered safety features. This event was also reported at 2342 on April 15, 1991 in accordance with 10CFR50.72(b)(2)(ii).

Since the actuations did not place the plant in an unanalyzed condition, this event did not have an adverse affect on plant safety.

Corrective Actions

Discussions were held with the individuals involved concerning the importance of clear communication. Furthermore, this report will be included as part of the required reading material for all operators.

Additional Information

Equipment Failures: None
Similar Events: None

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		YEAR 9 1	SEQUENTIAL NUMBER - 0 0 4	REVISION NUMBER - 0 0	0 5	OF 0 5

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

ATTACHMENT 1

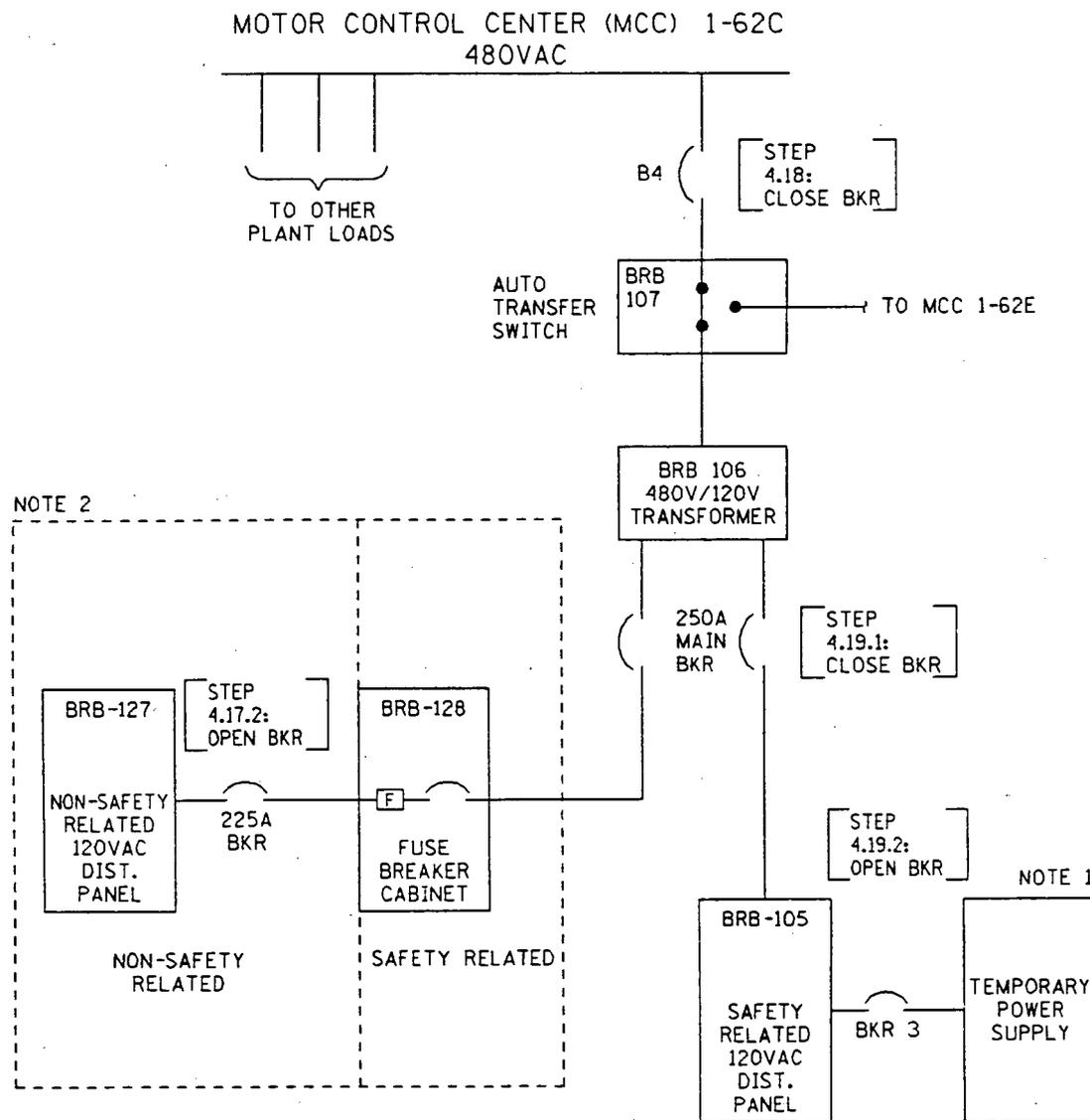


FIGURE 1

NOTES:

1. THIS POWER SUPPLY WAS INSTALLED FOR DCR 2417. IT WAS REMOVED AFTER THE DCR WAS COMPLETED.
2. COMPONENTS WITHIN THE DASHED LINE WERE INSTALLED AS PART OF DCR 2417.
3. THIS DWG. IS FOR INFORMATION ONLY.
4. REF. DWG. E-233