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 AUTH. NAME AUTHOR AFFILIATION
 SCHOMMER, K. Wisconsin Public Service Corp.
 SCHROCK, C.A. Wisconsin Public Service Corp.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-013-00: on 911206, unplanned automatic actuation of steam generator blowdown valves & sample valves occurred. Caused by procedural inadequacy. Procedures re high alarm setpoint revised. W/920106.

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

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January 6, 1992

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 91-013-00

The attached Licensee Event Report for reportable occurrence 91-013-00 is being submitted in accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System."

Sincerely,

C. A. Schrock
Manager-Nuclear Engineering

KJS\jac

Attach.

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

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 3
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TITLE (4) Procedural Deficiency Results in Closure of Steam Generator Blowdown Isolation Valves

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)
1	2	0	9	1	0	0	1	0	N/A		0 5 0 0 0
1	2	0	9	1	0	0	1	0	N/A		0 5 0 0 0

OPERATING MODE (8) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
POWER LEVEL (10) 1 0 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.408(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.408(a)(1)(i)	<input type="checkbox"/> 50.38(e)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.408(a)(1)(ii)	<input type="checkbox"/> 50.38(e)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.408(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.408(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
	<input type="checkbox"/> 20.408(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)							

LICENSEE CONTACT FOR THIS LER (12)

NAME Keith Schommer - Plant Nuclear Engineer	TELEPHONE NUMBER
	AREA CODE 4 1 4 3 8 1 - 2 5 6 0

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)	EXPECTED SUBMISSION DATE (15)	MONTH DAY YEAR
<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input type="checkbox"/> NO	N/A	

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

This report describes an unplanned automatic actuation of the steam generator blowdown valves and steam generator blowdown sample valves, engineered safety features (ESF). At 0924 on December 6, 1991 with the plant at 100% power, the valves closed and isolated steam generator blowdown and blowdown sampling. The valves closed as designed on a high radiation signal from the steam generator blowdown monitor (R-19). The high radiation signal was generated during the monthly source check of R-19 when a nuclear control operator in training, directly supervised by a licensed operator, positioned the "Operation Selector Switch" from "Operate" to "Check Source". As expected, an upscale meter response was observed. However, the operator in training did not return the "Operation Selector Switch" to the "Operate" position prior to reaching the R-19 nominal high alarm setpoint (450 cpm) thus causing the unplanned ESF actuation. Past practice was to hold the "Operation Selector Switch" in the "Check Source" position only long enough to observe a response to the source and then return to the "Operate" position.

To prevent recurrence of this type event, operations will review and revise their procedures as necessary to ensure the procedures accurately instruct operators on the potential of reaching a high alarm setpoint when performing source checks.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0 1 3 -	0 1 0	0 1 0	0 1 2	OF	0 1 3

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

Description of Event

This report describes the unplanned automatic actuation of the steam generator [SG] blowdown and blowdown sampling isolation valves [ISV], an engineered safety feature (ESF). The steam generator blowdown isolation valves (BT-2A, BT-2B, BT-3A, and BT-3B) and steam generator blowdown sample isolation valves (BT-31A, BT-31B, BT-32A, and BT-32B) closed when the steam generator blowdown radiation monitor [MON] (R-19) alarmed high. The high alarm was generated by the check source associated with this monitor.

At 0924 on December 06, 1991 with the plant at 100% power, a nuclear control operator in training, directly supervised by a licensed operator, was performing surveillance procedure SP45-230, "Radiation Monitors Monthly Source Check." Upon positioning the R-19 "Operation Selector Switch" from "Operate" to "Check Source", the operator in training observed the expected upscale meter response. Before the "Operation Selector Switch" was returned to the "Operate" position, the check source caused the meter to reach its high alarm setpoint (450 cpm), thus generating an R-19 high radiation signal. As designed, the high radiation signal caused valves BT-2A, BT-2B, BT-3A, BT-3B, BT-31A, BT-31B, BT-32A, and BT-32B to close.

After verifying that R-19 levels were normal at 0925, the operators reset the "HI" radiation alarm on R-19 and re-established steam generator blowdown and blowdown sampling.

At 1020 SP45-230, "Radiation Monitors Monthly Source Check," was completed with no other problems encountered. At 1115 on December 6, 1991, a four hour NRC notification was made in accordance with 10CFR50.72(b)(2)(ii).

Cause of Event

The valves automatically closed when the detector for R-19 was exposed to high radiation during a monthly source check. Past operating practices allowed R-19 to be exposed to the check source only long enough for the operator to see an upscale meter response; however, the operator in training was inexperienced with this procedure and thus allowed R-19 to remain exposed to the check source for approximately 1 second. This was sufficient time for the R-19 reading to increase from the normal background reading of approximately 100 cpm to the nominal high alarm setpoint of 450 cpm.

The procedure does not alert the operators of the possibility that continued check source exposure could cause a high radiation signal. Past R-19 source check performances were done by operators, who from experience, would return the "Operation Selector Switch" to the "Operate" position before the high alarm setpoint was reached. Therefore, due to the procedural inadequacy of failing to warn the operator of the potential of reaching the high alarm setpoint, the R-19 high radiation signal was generated and the unplanned ESF actuation occurred.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Kewaunee Nuclear Power Plant	DOCKET NUMBER (2) 0 5 0 0 0 3 0 5	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 1	- 0 1 3	- 0 0	0 3	OF	0 3

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

Analysis of Event

This event is being reported in accordance with 10 CFR 50.73(a)(2)(iv) as an event that resulted in automatic actuation of an ESF. The steam generator isolation valves and sampling isolation valves are required to close on the start of an auxiliary feedwater pump to ensure an adequate secondary heat sink.

Since the valves functioned as designed and all secondary radiation levels were normal, this event had no impact on the health and safety of the public.

Corrective Actions

Operations will review and revise their procedures as necessary to ensure the procedures accurately instruct operators of the potential for reaching the high alarm setpoint while performing source checks.

Additional Information

Equipment failure: None

Similar Events: None