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FACIL: 50-365 Kewaunee Nuclear Power Plant, Wisconsin Public Service 05000305
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SCHROCK, C.A. Wisconsin Public Service Corp.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 93-013-00: on 930604, both motor driven AF pumps actuated due to feedwater regulating valve failing to completely close & subsequent operator actions. FW-7A adjusted & monitored. W/930702 ltr.

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

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July 2, 1993

10 CFR 50.73

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

Ladies/Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Reportable Occurrence 93-013-00

In accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System," the attached Licensee Event Report for reportable occurrence 93-013-00 is being submitted.

Sincerely,

C.A. Schrock
Manager-Nuclear Engineering

KJS/cjt

Attach.

cc - INPO Records Center
US NRC Senior Resident Inspector
US NRC, Region III

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9307090037 930702
PDR ADDCK 05000305
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LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), 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.

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TITLE (4) Actuation of Both Motor Driven Auxiliary Feedwater Pumps Due to Feedwater Regulating Valve Failing to Completely Close and Subsequent Operator Actions

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
06	04	93	93	013	00	07	02	93	N/A	05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)																						
POWER LEVEL (10) 000	20.402(b)	20.405(a)(1)(i)	20.405(a)(1)(ii)	20.405(a)(1)(iii)	20.405(a)(1)(iv)	20.405(a)(1)(v)	20.405(c)	50.36(c)(1)	50.36(c)(2)	50.73(a)(2)(i)	50.73(a)(2)(ii)	50.73(a)(2)(iii)	X	50.73(a)(2)(iv)	50.73(a)(2)(v)	50.73(a)(2)(vii)	50.73(a)(2)(viii)(A)	50.73(a)(2)(viii)(B)	50.73(a)(2)(x)	73.71(b)	73.71(c)	OTHER	
	(Specify in Abstract below and in Text, NRC Form 366A)																						

LICENSEE CONTACT FOR THIS LER (12)										
NAME Keith J. Schommer	TELEPHONE NUMBER (Include Area Code) 414 388-2560									

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	
X	SJ	FCV	C635	Y						

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

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

This report describes an unplanned actuation of the auxiliary feedwater system, which is an engineered safety feature. On June 4, 1993, with the plant in hot shutdown, an automatic actuation of both motor driven auxiliary feedwater pumps occurred. This event occurred while the plant was being shut down for a scheduled outage. Prior to the event, the B main feedwater pump had been secured while the A main feedwater pump remained running. As the demand for feedwater to the steam generators diminished, the main feedwater regulating valves automatically throttled closed. However, the A steam generator level continued to increase with the main feedwater regulating valves indicating fully closed. In order to stop the A steam generator level increase and prevent an automatic trip of the main feedwater pump at 67% steam generator narrow range level, the operator shut off the A feedwater pump. This action caused an automatic start of both motor driven auxiliary feedwater pumps as designed. The circuitry that initiates this automatic auxiliary feedwater pump start is not an engineered safety feature.

The contributing causes of this event were determined to be the failure of the A main feedwater regulating valve to completely isolate feedwater flow and the operator actions taken to isolate the feedwater flow. The main feedwater regulating valve was subsequently repaired and is being monitored. Additionally, the analyses of this event will be required reading for the operations group.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

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

Description of Event

This report describes an unplanned actuation of the auxiliary feedwater system, which is an engineered safety feature. At 2342 hours on June 4, 1993 with the plant in hot shutdown, an automatic actuation of both motor driven auxiliary feedwater pumps [P] occurred. This actuation occurred while the plant was shutting down for a scheduled maintenance outage. Operations personnel were performing operating procedure N-0-04, "15% Power to Hot Shutdown Condition," and were in the process of shutting down the main feedwater system in accordance with operating procedure N-FW-05A, "Feedwater System Normal Operation."

Prior to the event, B main feedwater (FW) pump had been secured in accordance with operating procedure N-FW-05A while A main FW pump remained running. Steam generator (SG) [SG] level was being controlled with the main feedwater regulating valves [LCV], FW-7A and FW-7B. FW-7A and FW-7B were in automatic control [LC] and the bypass feedwater valves, FW-10A and FW-10B, were in manual control and closed (reference Figure 1). The feedwater regulating valves (FW-7s) maintain programmed SG water level using inputs from steam flow, feedwater flow, and SG water level.

As the demand for feedwater to the SGs diminished, valves FW-7A and FW-7B automatically throttled closed as designed. An additional operator, who was monitoring SG levels, noted that the FW-7s indicated fully closed. The operator also noted that A SG level was still increasing while B SG level had stabilized. The balance of the plant (BOP) operator recalled that FW-7A or FW-10A had leaked by its seat in the past. In order to stop the A SG level increase and avoid an automatic trip of the A main FW pump at 67% SG narrow range level, the BOP operator decided to shut off the A main FW pump. Prior to shutting off the A main FW pump the BOP operator announced the action being taken, but shut off the A main FW pump before the additional operator could respond. Shutting down the A main FW pump initiated an automatic start signal for the motor driven auxiliary feedwater (AFW) pumps. When the A main FW pump was shut off the A SG

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water level was approximately 56% and increasing while the B SG water level was approximately 43% and stable.

After verifying proper operation of the AFW pumps, the operator continued at the appropriate step in operating procedure N-FW-05A and continued the plant shutdown. The plant reached cold shutdown at 1726 hours on June 5, 1993.

Cause of the Event

The additional operator was preparing to transfer SG level control from the main feedwater regulating valves to the bypass valves in accordance with operating procedure N-FW-05A when the event occurred. The SG automatic level controller had closed both feedwater regulating valves, however, the A SG level continued to increase. The BOP operator, cognizant of the automatic trip of the main feedwater pumps and the automatic closure of feedwater isolation valve [ISV], FW-12A, at 67% SG level, decided to manually stop the main FW pump prior to the trip actuation. This decision was based on the following:

1. The water level in the SGs was capable of providing an adequate heat sink.
2. The AFW pumps were capable of supplying adequate flow to the SGs to remove decay heat at this point in the shutdown; therefore, there was no need to keep the main FW pump in operation.
3. Operating procedure N-FW-05A subsequently directs the operator to stop the remaining feedwater pump.

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- Operations personnel have a heightened awareness concerning pre-exercising equipment prior to scheduled testing. During the beginning of shift turnover, the scheduled "stroke time" test of the FW-12's was discussed. Therefore, concerns associated with pre-exercising equipment may have subtly influenced the operator not to consider FW-12A to isolate the FW flow.

Although the operator immediately recognized why the motor driven AFW pumps started, he failed to anticipate this start when he secured the remaining main FW pump. When the operator announced that he was securing the remaining main FW pump, sufficient time was not provided for the other operators' input. Therefore, the contributing causes of this event were determined to be the failure of FW-7A to completely isolate feedwater flow and the operator actions to isolate the feedwater.

Analysis of the Event

The motor driven AFW pumps are required to start on various signals, one of which is the opening of both A and B main FW pumps' breakers. This motor driven AFW pump automatic start signal ensures that an adequate heat sink is available. The circuitry that initiates this signal is not considered an engineered safety feature. Since the AFW pumps functioned as designed and the SGs provided an adequate heat sink, there were no safety implications associated with this event.

Additionally, Kewaunee management agrees that the operator's actions were in accordance with our plant operating philosophy. Kewaunee's philosophy, in part, provides the operator with the authority and the responsibility to perform whatever actions are necessary to shutdown the plant. However, management, as well as the operator, recognize that even though the operator's actions were not inappropriate, better alternatives were available. These alternatives were discussed with the operator and are referenced in the corrective actions listed below.

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This event is being conservatively reported in accordance with 10 CFR 50.73(a)(2)(iv) as an event that resulted in an unplanned automatic actuation of an engineered safety feature. This event was also reported in accordance with 10 CFR 50.72 (b)(2)(ii) at 0247 hours on June 5, 1993.

Corrective Actions

The following corrective actions have been or will be taken:

1. FW-7A was adjusted and is being monitored.
2. Although the operator actions taken did not compromise safety, other actions that could have prevented the automatic start of the motor driven AFW pumps were discussed with the personnel involved. The actions discussed include:
 - A. Isolate the FW flow to the SG using main feedwater isolation valve FW-12A (reference Figure 1.)
 - B. Manually start the motor driven AFW pumps prior to stopping the main feedwater pump.
3. This report will be required reading for the operations group.

Additional Information

Similar Events: None

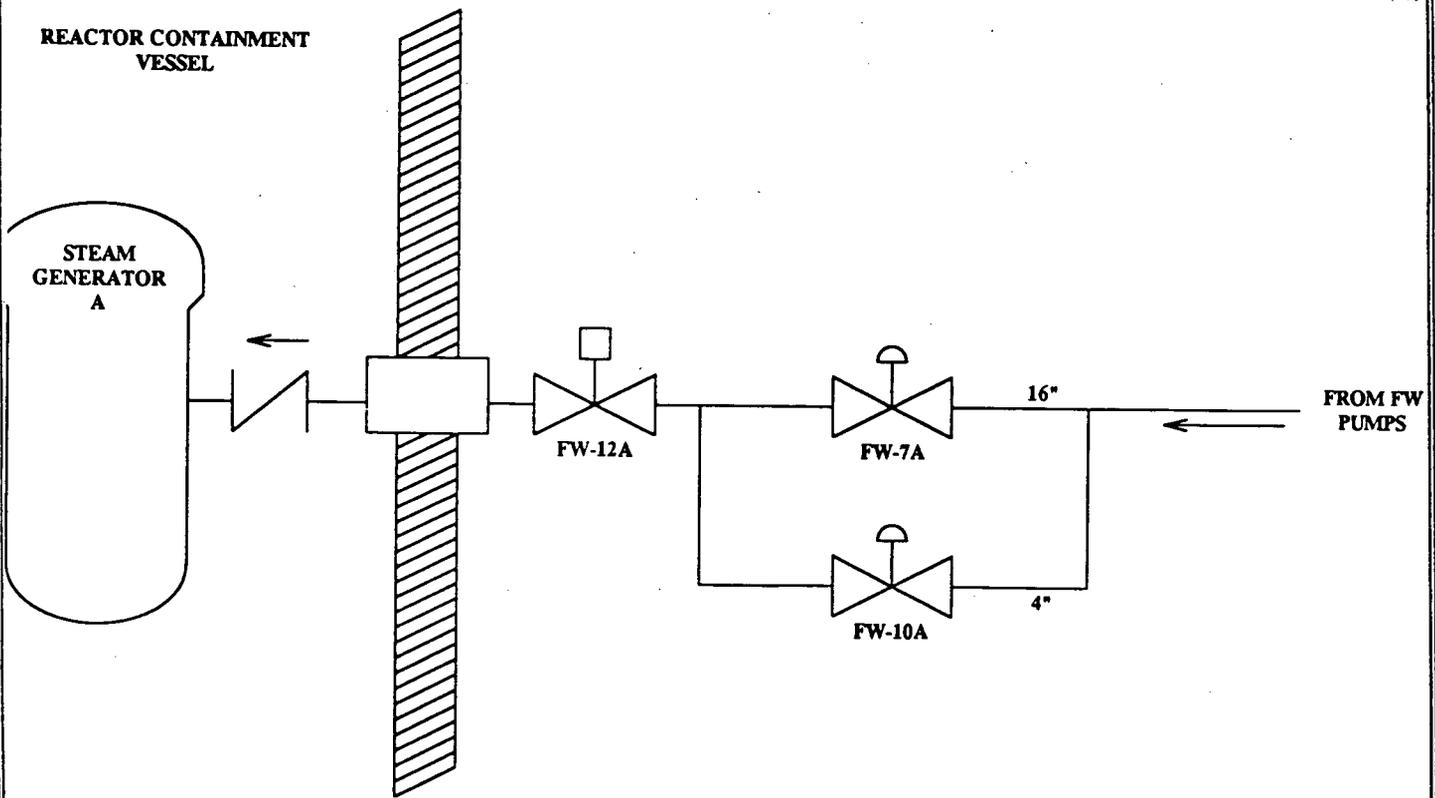
Equipment Failures: FW-7A is a 16 inch Copes-Vulcan, Inc valve model D-100

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FEEEDWATER LINE

FIGURE 1

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Description of Event

This report describes an unplanned automatic actuation of the steam generator [SG] blowdown isolation valves [ISV] and steam generator blowdown sample isolation valves, which are engineered safety features.

At 1437 hours on September 10, 1993, with the plant at 100% power, the steam generator blowdown isolation valves (BT-2A, BT-2B, BT-3A, and BT-3B) and blowdown sampling isolation valves (BT-31A, BT-31B, BT-32A, and BT-32B) automatically closed. The valves closed, as designed, on a high radiation signal from the steam generator blowdown radiation monitor [MON] (R-19). A R-19 output signal exceeded the monitor's high alarm setpoint of 450 CPM.

Approximately one hour prior to this event, temporary change request (TCR) 93-09 was removed. This TCR was implemented to document an increase in R-19's high alarm setpoint from 450 CPM to 3000 CPM. The setpoint had been increased to prevent unnecessary actuation of R-19 during the time period in which Kewaunee had an approximate 100 gallon per day primary-to-secondary leak in one of the steam generators. The leak was corrected during a scheduled maintenance outage in June 1993. The TCR remained in effect after the leak was repaired to allow time for the residual contamination in the plant's secondary systems to dissipate. After reviewing data from R-19 for the previous week, it was concluded that TCR 93-09 could be removed. Background radiation at R-19 was down to 200 CPM with spikes below 400 CPM. Therefore, the alarm setpoint was reduced to the normal value of 450 CPM.

Subsequent to the actuation, the following actions were taken:

1. The Shift Supervisor requested a SG blowdown sample be taken and analyzed to determine whether there was primary-to-secondary leakage.

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2. R-15, condenser air ejector gas monitor, was monitored to determine if a primary-to-secondary leak existed.
3. R-19 was declared out of service.
4. A work request was initiated to investigate the performance of R-19.

After determining that a primary-to-secondary leak did not exist and after R-19 was declared out of service, R-19 blowdown isolation signals were bypassed and blowdown was reestablished, as allowed by Kewaunee's technical specifications.

Cause of Event

The most probable cause of the high radiation output signal was a piece of slightly radioactive sludge passing near the detector causing a momentary spike. Over the operating cycle, sludge accumulates in the detector's housing. The sludge was slightly radioactive as a result of the steam generator leak mentioned earlier. The buildup of sludge caused the background radiation to remain higher than normal (normal being 60 to 70 CPM). It was speculated that a piece of the radioactive sludge broke free and was detected by R-19. With the activity in the vicinity of the detector higher than normal and the setpoint recalibrated, a piece of sludge most likely caused the monitor to spike above the setpoint.

It should also be noted that the 450 CPM setpoint of R-19 is very conservative even when background radiation is low. The default high alarm setpoint for R-19, as defined in the Offsite Dose Calculation Manual (ODCM), is 2500 CPM plus background. Since background radiation levels were close (200 CPM) to the high alarm setpoint of 450 CPMs, it is possible that the spike was caused by small fluctuations in background levels. It is also possible that this event could have been caused by a spurious electronic signal.

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Analysis of Event

This event is being reported in accordance with 10 CFR 50.73(a)(2)(iv) as an event that resulted in the automatic actuation of engineered safety features. This event was also reported in accordance with 10 CFR 50.72(b)(2)(ii) at 1724 hours on September 10, 1993.

The steam generator blowdown isolation valves and blowdown sampling isolation valves are required to close on the start of an auxiliary feedwater pump [P] to ensure an adequate secondary heat sink. The valves are also designed to close on a high radiation signal from R-19 or R-15 to isolate the steam generator in the event of a primary-to-secondary leak. Since the valves functioned as designed and there was no primary-to-secondary leakage, this event had no impact on the health and safety of the public.

Corrective Actions

Subsequent to the R-19 actuation, the following actions were taken:

1. A steam generator blowdown sample was taken and analyzed. The condenser air ejector gas monitor (R-15) was also monitored. Activity levels of both did not indicate the existence of a primary-to-secondary leak.
2. The housing of the monitor was wiped free of sludge and then visually inspected as documented on the previously mentioned work request. As a result, background radiation was reduced to approximately 60 CPM which is normal for this monitor.
3. Radiation monitor R-19 was returned to service at 1249 hours on September 16, 1993.

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Additional Information

Similar Events:

LER 87-004 "Steam Generator Blowdown and Blowdown Sampling Isolation Due to Residual Radiation in the 1A Steam Generator"

LER 92-008 describes a spurious actuation of radiation monitor R-21 that initiated a containment ventilation isolation signal.