

PRIORITY 1

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ACCESSION NBR:9508010010 DOC.DATE: 95/07/28 NOTARIZED: NO DOCKET #
FACIL:50-305 Kewaunee Nuclear Power Plant, Wisconsin Public Service 05000305 P
AUTH.NAME AUTHOR AFFILIATION
CHARAPATA,D.W. Wisconsin Public Service Corp. R
MARCHI,M.L. Wisconsin Public Service Corp. I
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 95-004-00:on 950628,key switch failed on radiation
monitor R-19 resulted in partial SG blowdown isolation. O
Radiation monitor was tested & returned to svc on 950628.
W/950728 ltr. R

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

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600 North Adams • P.O. Box 19002 • Green Bay, WI 54307-9002

July 28, 1995

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 95-004-00

In accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System," the attached Licensee Event Report (LER) for reportable occurrence 95-004-00 is being submitted.

Sincerely,

M. L. Marchi
Manager - Nuclear Business Group

DWC/jmf

Attach.

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

010029

9508010010 950728
PDR ADDCK 05000305
S PDR

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.

FACILITY NAME (1)

Kewaunee Nuclear Power Plant

DOCKET NUMBER (2)

05000305

PAGE (3)

1 OF 5

TITLE (4) Key Switch Failure on Radiation Monitor R-19
Results in Partial Steam Generator Blowdown Isolation

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	28	95	95	004	00	07	28	95	N/A	05000
									N/A	05000

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)																					
N	96	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)	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	TELEPHONE NUMBER (Include Area Code)
Dale W. Charapata - Engineering Technician	(414) 388-2560 x2366

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
BX	IL	HS	N330	Yes					

SUPPLEMENTAL REPORT EXPECTED (14)

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

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

The following event is reportable as an unplanned actuation of steam generator blowdown isolation valves which are engineered safety features (ESF). On June 28, 1995 at 1215 hours, an Instrument and Control Technician was performing surveillance procedure SP 45-49.19 (Radiation Monitor System Channel R-19 Steam Generator Blowdown Sample Radiation Monitor Monthly Functional Test). The technician was performing step 6.10.1 of SP 45-49.19 which directs the technician to place the keyswitch on radiation monitor R-19 to the KEYPAD position. During performance of this step, an inadvertent partial blowdown isolation occurred. At the time of the actuation, the plant was at 96% power.

During testing, a momentary loss of power to the high alarm relay for R-19 caused the ESF actuation. The temporary power loss was caused by the failure of the keyswitch contacts to make up as designed. The switch was replaced during the repair process.

The radiation monitor was tested and returned to service on June 28, 1995 at 1355 hours.

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

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Kewaunee Nuclear Power Plant	05000305	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 5
		95	400	00	

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

DESCRIPTION OF EVENT

This report describes an inadvertent actuation of the steam generator blowdown isolation valves [ISV] which are ESF components. The event occurred at 1215 hours on June 28, 1995, with the plant at 96% power, while performing surveillance procedure SP 45-49.19, (Radiation Monitor System Channel R-19 Steam Generator Blowdown Sample Radiation Monitor Monthly Functional Test). The event occurred when power was lost to R-19 for approximately one second resulting in a partial steam generator blowdown isolation. The momentary power loss occurred when an Instrument and Control Technician was performing step 6.10.1 of surveillance procedure SP 45-49.19. This step places the keyswitch on the radiation monitor [MON] channel R-19 from the ON position to the KEYPAD position. The momentary power loss resulted in a partial steam generator blowdown isolation. Blowdown isolation valves BT-2A, BT-3A, BT-2B, and BT-3B closed as designed. Blowdown sample line isolation valves BT-31A and BT-31B also closed as designed. Blowdown sample line isolation valves BT-32A and BT-32B and the turbine building air ejector discharge vent valve [VTV] AR-6 did not change position as designed on a loss of power.

In response to the situation, the operators implemented operating procedure A-RM-45, "Abnormal Radiation Monitoring System". In accordance with the procedure, operations verified that automatic actuation occurred as designed with the exception of valves BT-32A, BT-32B, and AR-6. The R-19 radiation monitor was then turned "OFF" to remove power and all automatic actuations occurred as

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designed. This verified all automatic actions would have occurred if a high radiation signal was received by the R-19 radiation monitor.

Surveillance procedure exception report (SPER) 45-049.19, dated 6-28-95 and incident report 95-159 were initiated to investigate the event.

CAUSE OF EVENT

The partial ESF actuation of the steam generator blowdown isolation valves was caused by the momentary loss of power to the normally energized high alarm relay. The temporary loss of power (approximately 1 second) was caused by a failure of the R-19 radiation monitor keyswitch contacts. The failure was found to be a loose compression contact in the keyswitch mechanism that allowed the R-19 drawer to momentarily lose power. Due to the very brief loss of power to the normally energized high alarm relay, only a portion of the steam generator blowdown isolation relays changed state. This resulted in valves BT-32A, BT-32B, and AR-6 not changing position.

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

ANALYSIS OF THE EVENT

This report is being submitted in accordance with 10 CFR 50.73(a)(2)(iv) as an actuation of steam generator blowdown isolation valves which are ESF components. Blowdown isolation is considered an ESF because the isolation valves receive a signal to close when an auxiliary feedwater pump receives a signal to start. The valves are required to close to ensure maintenance of steam generator inventory under post accident conditions. The circuitry which initiates closure of the blowdown isolation valves on a high radiation signal is not an engineered safety feature. This event was also reported in accordance with 10 CFR 50.72(b)(2)(ii) on June 28, 1995 at 1428 hours.

Failure of the keyswitch did not result in any adverse plant conditions. There were no elevated radiation levels present at the time of the event and therefore, there were no safety implications associated with this event.

CORRECTIVE ACTIONS

The failed keyswitch was replaced and the monitor was retested and returned to service at 1355 hours on June 28, 1995.

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

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

ADDITIONAL INFORMATION

None.

SIMILAR EVENTS

This is the first failure of the keyswitch for the R-19 drawer. Three other keyswitch failures have occurred on other radiation monitoring drawers which did not require report submittals. Two failures occurred prior to this event, the third occurred after this event. ESR 95-040 was initiated to investigate the problem with the keyswitches.

EQUIPMENT FAILURES

Keyswitch: Manufactured by C&K Components, Inc.

Radiation Monitor: Manufactured by Nuclear Research Corporation