

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8708060080 DOC. DATE: 87/07/30 NOTARIZED: NO DOCKET #
 FACIL: 50-410 Nine Mile Point Nuclear Station, Unit 2, Niagara Moha 05000410
 AUTH. NAME AUTHOR AFFILIATION
 RANDALL, R. G. Niagara Mohawk Power Corp.
 LEMPGES, T. E. Niagara Mohawk Power Corp.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-039-00: on 870623, limiting condition for operation exceeded when one of two diesel generator room exhaust ventilation sys fans inoperable for 16 h. Caused by personnel error. Personnel counseled. W/870730 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

| | RECIPIENT ID CODE/NAME | COPIES LTTR ENCL | RECIPIENT ID CODE/NAME | COPIES LTTR ENCL |
|-----------|---------------------------|---------------------|---------------------------|---------------------|
| | PD1-1 LA | 1 1 | PD1-1 PD | 1 1 |
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| INTERNAL: | ACRS MICHELSON | 1 1 | ACRS MOELLER | 2 2 |
| | AEOD/DOA | 1 1 | AEOD/DSP/NAS | 1 1 |
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| | NRR/PMAS/ILRB | 1 1 | NRR/PMAS/PTSB | 1 1 |
| | REG FILE 02 | 1 1 | RES DEPY GI | 1 1 |
| | RES TELFORD, J | 1 1 | RES/DE/EIB | 1 1 |
| | RGN1 FILE 01 | 1 1 | | |
| EXTERNAL: | EG&G GROH, M | 5 5 | H ST LOBBY WARD | 1 1 |
| | LPDR | 1 1 | NRC PDR | 1 1 |
| | NSIC HARRIS, J | 1 1 | NSIC MAYS, G | 1 1 |

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LICENSEE EVENT REPORT (LER)

| | | |
|--|---|----------------------------|
| FACILITY NAME (1) Nine Mile Point Unit 2 | DOCKET NUMBER (2) 0 5 0 0 0 410 | PAGE (3) 1 OF 04 |
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TITLE (4) **Violation of Technical Specifications as a Result of Removing DG Fan from Service due to Personnel Error**

| 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) | | |
| 06 | 23 | 87 | 87 | 039 | 00 | 07 | 30 | 87 | N/A | | 0 5 0 0 0 | | |
| | | | | | | | | | N/A | | 0 5 0 0 0 | | |

OPERATING MODE (9) **2**

POWER LEVEL (10) **002**

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

| | | | |
|-------------------|-------------------|----------------------|--|
| 20.402(b) | 20.406(c) | 50.73(e)(2)(iv) | 73.71(b) |
| 20.406(a)(1)(i) | 50.36(c)(1) | 50.73(a)(2)(v) | 73.71(c) |
| 20.406(a)(1)(ii) | 50.36(c)(2) | 50.73(a)(2)(vii) | OTHER (Specify in Abstract below and in Text, NRC Form 366A) |
| 20.406(a)(1)(iii) | X 50.73(a)(2)(ii) | 50.73(a)(2)(viii)(A) | |
| 20.406(a)(1)(iv) | 50.73(a)(2)(iii) | 50.73(a)(2)(viii)(B) | |
| 20.406(a)(1)(v) | 50.73(a)(2)(iii) | 50.73(a)(2)(ix) | |

LICENSEE CONTACT FOR THIS LER (12)

| | | |
|--|-------------------------|-------------------------------------|
| NAME Robert G. Randall, Supervisor Technical Support | AREA CODE 315 | TELEPHONE NUMBER 349-2445 |
|--|-------------------------|-------------------------------------|

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

| CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NRPDS | CAUSE | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NRPDS |
|-------|--------|-----------|--------------|---------------------|-------|--------|-----------|--------------|---------------------|
| | | | | | | | | | |
| | | | | | | | | | |

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

| | | | |
|------------------------------|-------|-----|------|
| EXPECTED SUBMISSION DATE 15. | MONTH | DAY | YEAR |
| | | | |

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

On June 30, 1987 it was discovered that a surveillance required by a Limiting Condition for Operation (LCO) as defined by Technical Specification (TS) 3.8.1.1 had not been performed at Nine Mile Point Unit 2 (NMP2). The event occurred on June 23, 1987 with the unit in its initial startup phase and the mode switch in the "Startup/Hot Standby" position. Reactor power during the event was approximately 2.4 percent.

The LCO was exceeded when one of the two 50% capacity Diesel Generator Room Exhaust Ventilation System (HVP) fans and associated dampers were marked up (tagged out) of service (inoperable) for approximately 16 hours without complying with the proper TS Action Item.

The root cause of this event was a cognitive personnel error. The Station Shift Supervisor (SSS) failed to realize that he was removing one 50% capacity fan from service when he approved the markup. The SSS reviewed the systems prints and assumed the two 50% capacity fans were in fact 100% capacity and redundant to each other.

Corrective actions include notifying personnel involved in this event to make them aware of the errors that led to this event. A Training Modification Recommendation has been submitted to Operators Training to discuss this incident with all Niagara Mohawk Operators.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | | | |
| | | 87 | 039 | 00 | 02 | OF | 04 |

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

I. DESCRIPTION OF EVENT

On June 30, 1987 it was discovered that a surveillance required by a Limiting Condition for Operation (LCO) as defined by plant Technical Specifications (TS) had not been performed at Nine Mile Point Unit 2 (NMP2). The LCO which was exceeded (TS 3.8.1.1) is concerned with the operability of AC electrical power sources and details actions which must be taken when such power sources are inoperable. At the time of the event NMP2 was in its startup phase with the mode switch in the "Startup/Hot Standby" position (Mode 2). Reactor power at the time of the event was approximately 2.4 percent.

The LCO was exceeded as the result of removing from service (tagging out) one of the two 50% capacity fans of the Division 2 Diesel Generator Room Exhaust Ventilation System (HVP) for approximately 16 hours without observing the proper Action Item as defined in TS 3.8.1.1. Per TS, in some cases, removing all or part of an auxiliary system from service renders that particular system inoperable. Under certain conditions removing one of the two 50% capacity HVP fans from service renders the Division 2 Diesel Generator (EDG*3) inoperable and requires the following TS Action Items to be performed:

LCO:

- 3.8.1.1.b) With Diesel Generator EDG*3 inoperable, demonstrate the Operability of the required AC offsite power sources by performing Surveillance Requirement 4.8.1.1.1 (see Surveillance) within one hour and at least once every eight hours thereafter.
- 3.8.1.1.e) In addition to taking Action 3.8.1.1.b, verify within two hours that all required systems, subsystems, trains, components, and devices that depend on the remaining Operable Diesel Generator as a source of emergency power are Operable; otherwise, be in at least Hot Shutdown within the next 12 hours and Cold Shutdown within the following 24 hours.

Surveillance:

- 4.8.1.1.1) Each of the above required independent circuits between the offsite transmission network and the onsite Class 1E distribution system shall be determined OPERABLE at least once every seven days by verifying correct breaker alignments and indicated power availability.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

The sequence of events that lead up to exceeding the LCO were:

1. On June 23, 1987 at 1005 hours a Blue Markup was placed by the Operations Department on one of the two HVP system fans (2HVP*FN1D) and associated dampers (2HVP*MOD1D and 2HVP*MOD6D). This allowed maintenance to be performed on the system per procedure N2-EMP-GEN-778.
2. June 24, 1987 at 0130 hours the Blue Markup was removed and the HVP system was returned to service. Following return to service, it was brought to the attention of the Superintendent of Operations that the LCO Action Items referenced above had not been performed during the time period when the one HVP fan was marked up and EDG*3 possibly should have been considered administratively inoperable. However, since the fan and dampers have no explicit requirements in TS for automatic start, and since the fan could have been quickly placed in service, initial review determined that the diesel was still considered operable and TS's had not been violated. At that time Licensing was contacted to review the event and system design to make an interpretation of TS requirements and whether TS were violated during the period that the fan was marked up.
3. On June 30, 1987 Licensing made a determination that the event was reportable. The basis for this determination was the definition of operability and as Licensing determined through communications with the design organization that both fans were required based on the ambient temperature during the summer months. The Operations staff was then contacted to write an Occurrence Report and to initiate an LER.

II. CAUSE OF EVENT

A root cause analysis for this event has been completed per Site Supervisory Procedure S-SUP-1, "Root Cause Analysis Program". The root cause has been determined to be cognitive personnel error. The Station Shift Supervisor (SSS) failed to realize that he was removing one 50% capacity fan from service when he authorized the markup. The SSS reviewed the systems prints and assumed the two 50% capacity fans were in fact 100% capacity and redundant to each other.

III. ANALYSIS OF EVENT

Although this event was a TS violation, no adverse safety consequences resulted. The placing of the Blue Markup only rendered the automatic operation of this fan inoperable. The Diesel would have started and run for a considerable amount of time with only one cooling fan operating. Had an automatic Diesel start occurred while the maintenance was being performed, the fan could easily have been made Operable. The event did not in any way adversely affect any other safety systems nor the Operators' ability to achieve safe shutdown.

In a review of the event an Assistant Station Shift Supervisor (SRO) retraced the steps that led to the event and noted that the normal offsite electrical power lineup was maintained throughout the event. The total time of the event was less than 16 hours.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

IV. CORRECTIVE ACTIONS

1. The immediate Operator action was to verify correct breaker alignment for the fan and offsite power sources. In addition, the Operators reviewed the equipment status log to ensure all required systems and devices that depend on the remaining Operable Diesel, as a source of emergency power, were operable.
2. The personnel who were involved in this event have been made aware of the errors that led to the event.
3. A Training Modification Recommendation has been submitted to Operator's training to discuss this incident with all Niagara Mohawk Operators, reminding them to always properly assess the consequences of removing an auxiliary system from service.
4. This event will be added to Operations "Lessons Learned" book which will provide NMP2 Operators with a detailed description of the event. This book is required reading for all Operators on shift.
5. Guidance on circumstances when blue markups do and do not cause component inoperability will be included in Administrative procedures.

Corrective actions 2 and 3 above have been performed and actions 1, 4, and 5 will be completed by September 1, 1987.

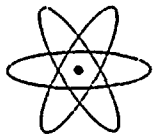
V. ADDITIONAL INFORMATION

Identification of Components Referred to in this LER

| Component | IEEE 803 EIIS Funct | IEEE 805 System ID |
|---|------------------------|-----------------------|
| Diesel Generator Exhaust Ventilation System | N/A | VJ |
| Damper | DMP | VJ |
| Fan | FAN | VJ |

There has been one previous similar event (LER 87-08) as a result of Operators placing a markup which resulted in exceeding an LCO.





NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

301 PLAINFIELD ROAD
SYRACUSE, NY 13212

THOMAS E. LEMPGES
VICE PRESIDENT—NUCLEAR GENERATION

July 30, 1987

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

RE: Docket No. 50-410
LER 87-39

Gentlemen:

In accordance with 10 CFR 50.73, we hereby submit the following Licensee Event Report:

LER 87-39 Which is being submitted in accordance with 10 CFR 50.73 (a) (2) (i) (B), "Any operation or condition prohibited by the plant's Technical Specifications;"

This report was completed in the format designated in NUREG-1022, Supplement No. 2, dated September 1985.

Very truly yours,

Thomas E. Lempges
Vice President
Nuclear Generation

TEL/SCN/mjd

Attachments

cc: Regional Administrator, Region 1
Sr. Resident Inspector, W. A. Cook

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