

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8709300174 DOC. DATE: 87/09/25 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

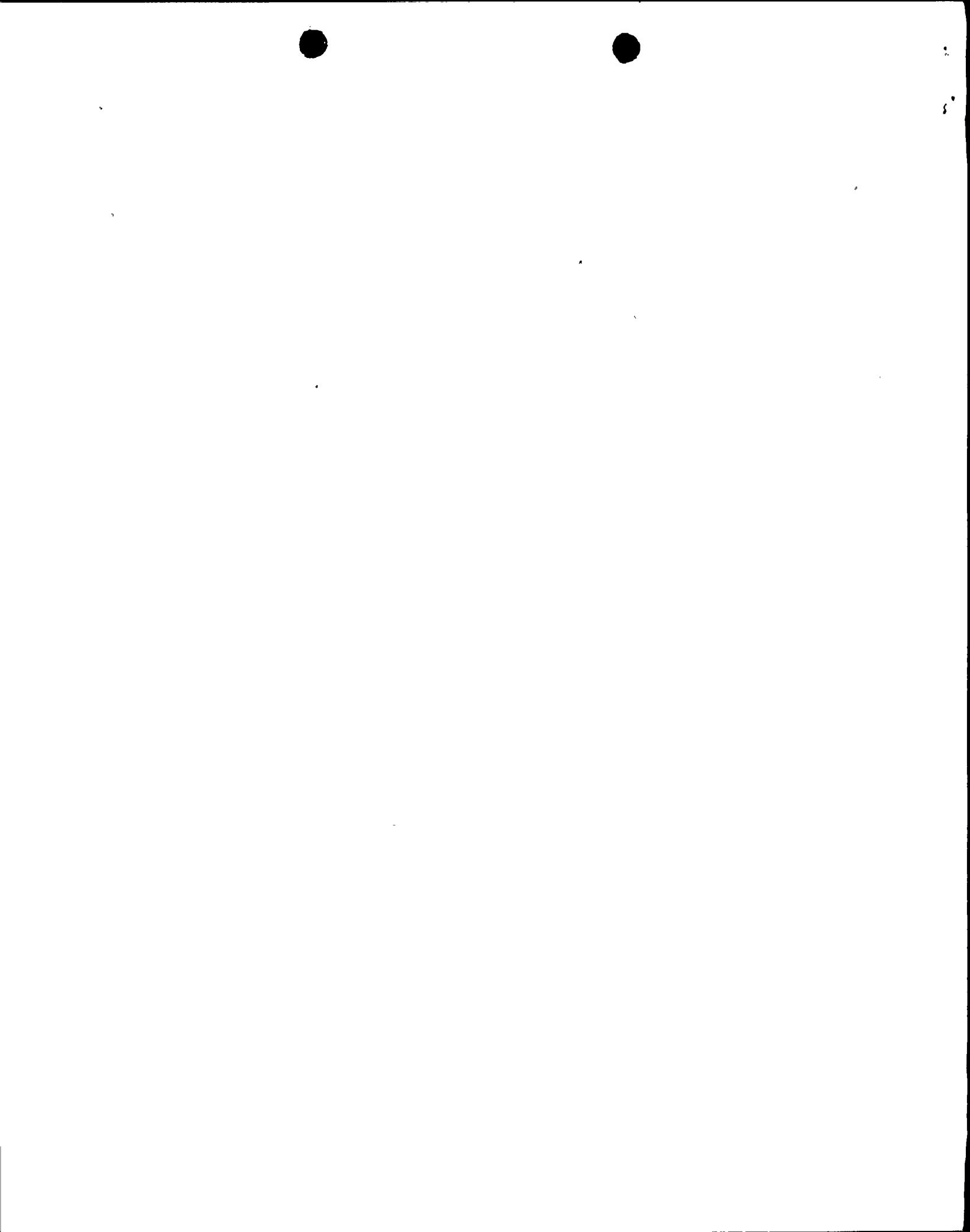
SUBJECT: LER 87-050-00: on 870829, while performing surveillance test, unit experienced automatic initiation of standby gas treatment sys. Caused by personnel error due to improper communication. Training mod recommendation made. W/870925 ltr.

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

NOTES: 21

05000410

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	HAUGHEY, M	1 1	BENEDICT, B	1 1
INTERNAL:	ACRS MICHELSON	1 1	ACRS MOELLER	2 2
	AEOD/DOA	1 1	AEOD/DSP/NAS	1 1
	AEOD/DSP/ROAB	2 2	AEOD/DSP/TPAB	1 1
	DEDRO	1 1	NRR/DEST/ADS	1 0
	NRR/DEST/CEB	1 1	NRR/DEST/ELB	1 1
	NRR/DEST/ICSB	1 1	NRR/DEST/MEB	1 1
	NRR/DEST/MTB	1 1	NRR/DEST/PSB	1 1
	NRR/DEST/RSB	1 1	NRR/DEST/SGB	1 1
	NRR/DLPQ/HFB	1 1	NRR/DLPQ/QAB	1 1
	NRR/DOEA/EAB	1 1	NRR/DREP/RAB	1 1
	NRR/DREP/RPB	2 2	NRR/DRIS/SIB	1 1
	NRR/PMAS/ILRB	1 1	<u>REG FILE</u> 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



LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>Nine Mile Point Unit 2</b>	DOCKET NUMBER (2) <b>0 5 0 0 0 4 1 0</b>	PAGE (3) <b>1 OF 04</b>
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TITLE (4) **Automatic Initiation of the Standby Gas Treatment System Due to a Personnel Error Caused by Improper Communications**

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)																															
08	29	87	87	050	00	09	25	87	N/A		0 5 0 0 0																															
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">OPERATING MODE (9)</td> <td style="width:15%;">1</td> <td style="width:15%;">20.402(b)</td> <td style="width:15%;">20.406(c)</td> <td style="width:15%; text-align:center;"><input checked="" type="checkbox"/></td> <td style="width:15%;">50.73(a)(2)(iv)</td> <td style="width:15%;">73.71(b)</td> </tr> <tr> <td rowspan="5">POWER LEVEL (10)</td> <td rowspan="5">023</td> <td>20.406(a)(1)(i)</td> <td>50.38(c)(1)</td> <td></td> <td>50.73(a)(2)(v)</td> <td>73.71(c)</td> </tr> <tr> <td>20.406(a)(1)(ii)</td> <td>50.38(c)(2)</td> <td></td> <td>50.73(a)(2)(vi)</td> <td rowspan="4">OTHER (Specify in Abstract below and in Text, NRC Form 366A)</td> </tr> <tr> <td>20.406(a)(1)(iii)</td> <td>50.73(a)(2)(i)</td> <td></td> <td>50.73(a)(2)(vii)(A)</td> </tr> <tr> <td>20.406(a)(1)(iv)</td> <td>50.73(a)(2)(ii)</td> <td></td> <td>50.73(a)(2)(vii)(B)</td> </tr> <tr> <td>20.406(a)(1)(v)</td> <td>50.73(a)(2)(iii)</td> <td></td> <td>50.73(a)(2)(ix)</td> </tr> </table>												OPERATING MODE (9)	1	20.402(b)	20.406(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)	POWER LEVEL (10)	023	20.406(a)(1)(i)	50.38(c)(1)		50.73(a)(2)(v)	73.71(c)	20.406(a)(1)(ii)	50.38(c)(2)		50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)	20.406(a)(1)(iii)	50.73(a)(2)(i)		50.73(a)(2)(vii)(A)	20.406(a)(1)(iv)	50.73(a)(2)(ii)		50.73(a)(2)(vii)(B)	20.406(a)(1)(v)	50.73(a)(2)(iii)		50.73(a)(2)(ix)
OPERATING MODE (9)	1	20.402(b)	20.406(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)																																				
POWER LEVEL (10)	023	20.406(a)(1)(i)	50.38(c)(1)		50.73(a)(2)(v)	73.71(c)																																				
		20.406(a)(1)(ii)	50.38(c)(2)		50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)																																				
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		20.406(a)(1)(v)	50.73(a)(2)(iii)		50.73(a)(2)(ix)																																					

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

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>Robert G. Randall, Supervisor Technical Support</b>	TELEPHONE NUMBER <b>315 349-2445</b>
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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)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)						
		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>MONTH</th><th>DAY</th><th>YEAR</th> </tr> <tr> <td> </td><td> </td><td> </td> </tr> </table>	MONTH	DAY	YEAR			
MONTH	DAY	YEAR						

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

On August, 29, 1987 at 0016 with the reactor in RUN (Operational Condition 1) and at a power level of approximately 23% rated thermal capacity, Nine Mile Point Unit 2 experienced an automatic initiation of the Standby Gas Treatment System (SBGTS) while performing the monthly surveillance test on the Reactor Building ventilation process radiation monitors. The SBGTS system was secured by 0028 that same day, ending the event.

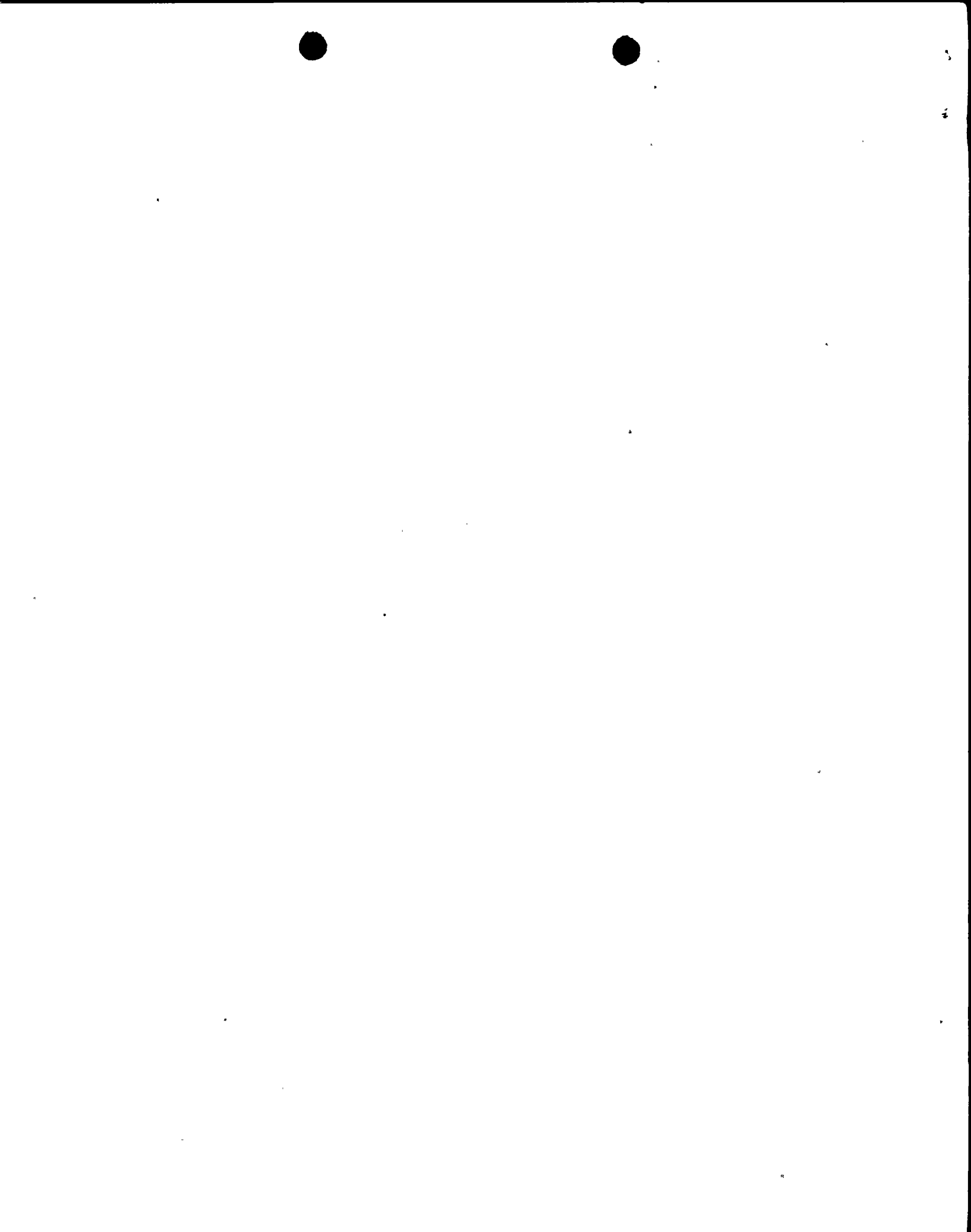
The root cause for this event is personnel error due to improper communication.

The corrective actions for this event are:

1. A Training Modification Recommendation (TMR) has been initiated, requesting communications training for operators and technicians.
2. A TMR has been submitted requesting discussion of this event in operator and technician training.
3. A summary of this event will be included in the Operations Department Lessons Learned book.

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PDR ADOCK 05000410  
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Nine Mile Point Unit 2	DOCKET NUMBER (2)  0   5   0   0   0   410	LER NUMBER (6)			PAGE (3)		
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		87	050	00	02	OF	04

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

I. DESCRIPTION OF EVENT

On August 29, 1987 at 0016 with the reactor in RUN (Operational Condition 1) and at a power level of approximately 23% rated thermal capacity, Nine Mile Point Unit 2 (MP2) experienced an automatic initiation of the Standby Gas Treatment System (SBGTS) while performing the monthly surveillance test on the Reactor Building (RB) ventilation process radiation monitors. (Specifically the Below the Refuel Floor Monitor 2HVR\*RE32B). The Standby Gas Treatment System was secured by 0028 that same day, ending the event.

There were no other inoperable systems which contributed to this event.

II. CAUSE OF EVENT

The root cause for this event is personnel error due to improper communication.

The monthly channel functional surveillance test procedure for the RB Ventilation Process Radiation Monitor 2HVR\*RE32B, specifies that the SBGTS Train B should be placed in a bypass mode called "Pull to Lock" (PTL) if this system is not already in operation prior to testing. This is done to prevent an unnecessary automatic startup of the SBGTS system.

The Chief Shift Operator (CSO) directed a licensed operator to place the RB Emergency Recirculation Fan 2HVR\*UC413B and the SBGTS Train B into Pull to Lock to support surveillance testing. The licensed operator placed the emergency recirculation fan in PTL but did not hear the CSO's request to put the SBGTS Train B in PTL. Therefore, he failed to do this. The CSO, thinking that the SBGTS Train B was in PTL, gave his approval to begin testing to the personnel performing the surveillance. But, the CSO failed to verify that his request was actually done.

While performing the surveillance, Radiation Monitor 2HVR\*RE32B was de-energized by Niagara Mohawk technicians as specified by the procedure. De-energizing 2HVR\*RE32B results in an automatic initiation signal to the SBGTS Train B; which subsequently started. (All systems performed as designed.)

The automatic startup of SBGTS-B would not have occurred if it was bypassed (in PTL) as required by the surveillance procedure. Additionally, this event could have been avoided if there was positive communication between the CSO and the licensed operator. Specifically, the CSO should have verified that his request was understood and properly performed.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Nine Mile Point Unit 2	DOCKET NUMBER (2)  0   5   0   0   0   410	LER NUMBER (6)			PAGE (3)	
		YEAR 87	SEQUENTIAL NUMBER 050	REVISION NUMBER 00	03	OF 04

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

III. ANALYSIS OF EVENT

An undesirable challenge to a plant Engineered Safety Feature (ESF) system occurred due to the SBGTS Train B not being bypassed. However, an automatic initiation of the Standby Gas Treatment System is a conservative ESF response, (see note) and does not have an adverse impact on plant or public safety.

NOTE: The SBGTS system is designed; (1) to limit the release of radioactive gases from the RB to the environment within the guidelines of 10CFR100 in the event of a loss of coolant accident and, (2) to maintain a negative pressure in the RB under accident conditions. Therefore, an automatic initiation of the SBGTS system is considered conservative since its proper function serves to limit and contain radioactive releases from the primary and secondary containments.

This event is considered reportable via 10CFR50.73 (a)(2)(iv) because the automatic initiation of the SBGTS Train B is an automatic ESF actuation.

The elapsed time for this event, from the automatic initiation of the SBGTS Train B to it being secured by Operations, was approximately 12 minutes.

IV. CORRECTIVE ACTIONS

1. A Training Modification Recommendation (TMR # 02-87.224) has been initiated requesting verbal communication training for operators and technicians. This training shall include acknowledgement that instructions are understood and verifications that the instructions have been performed. A completion date for this corrective action item has not been determined at this time, since the logistics for this training have not been finalized. However, it is anticipated that this training will be completed by June, 1988.

2. It is Niagara Mohawk's position that relying on assumptions, in order to operate the plant safely, cannot be tolerated. Therefore, a Training Modification Recommendation (TMR # 02-87.225) has been initiated requesting discussion of this event in operator and technician training. In particular, this training shall emphasize that delegated tasks must be verified by the sign off man, otherwise signature authority shall be delegated to the person performing the task. The anticipated completion date for this corrective action item concerning operator training is November 16, 1987. The anticipated completion date for the technician training is February, 1988.

3. A summary of the event will be included in the NMP2 Operations department Lessons Learned book. This particular entry will also discuss the responsibility of the signoff man and proper communications technique. This book is required reading for all Operations personnel. The anticipated completion date for this corrective action item is October 15, 1987.

These corrective actions should be effective in preventing a future occurrence of a similar event.





LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

V. ADDITIONAL INFORMATION

Two other LERs (87-08 and 87-25) involve events where ineffective communications was a root or contributing cause of the event.

Identification of Components Referred to in this LER

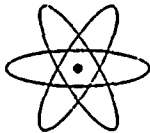
Component	IEEE 803 EIIS Funct	IEEE 805 System ID
Radiation Monitor	MON	VA
Reactor Building Ventilation System	N/A	VA
Standby Gas Treatment System	N/A	BH
Reactor Building	N/A	NG
Emergency Recirculation Unit	FAN	VA



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2

3



NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

301 PLAINFIELD ROAD  
SYRACUSE, NY 13212

THOMAS E. LEMPGES  
VICE PRESIDENT—NUCLEAR GENERATION

September 25, 1987

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

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

Gentlemen:

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

LER 87-50 Is being submitted in accordance with 10 CFR 50.73 (a) (2) (iv), "Any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS). However, actuation of an ESF, including the RPS, that resulted from and was part of the preplanned sequence during testing or reactor operation need not be reported."

A 10 CFR 50.72 report for this event was made at 0136 hours on August 29, 1987.

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/POB/mjd

Attachments

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

JE22  
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