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FACIL:50-410 Nine Mile Point Nuclear Station, Unit 2, Niagara Moha 05000410
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WIILIS,J.L. Niagara Mohawk Power Corp.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 89-016-00:on 890508,inaccurate surveillance activity due to personnel error resulting in TS violation.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 5 (W/8 ltr.)
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NMP52337

NINE MILE POINT NUCLEAR STATION / P.O. BOX 32 LYCOMING, NEW YORK 13093 / TELEPHONE (315) 343-2110

June 20, 1989

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

RE: Docket No. 50-410
LER 89-16

Gentlemen:

In accordance with 10CFR50.73, we hereby submit the following Licensee Event Report:

LER 89-16 Which is being submitted in accordance with 10CFR50.73(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 2.

Very truly yours,

J. L. Willis
General Superintendent
Nuclear Generation

JLW/GM/mjv
(0581V)

Attachment

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

IE22
1/1

NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Nine Mile Point Unit 2	0 5 0 0 0 4 1 0	1 OF 0 4

TITLE (4) Inaccurate Surveillance Activity Due to Personnel Error Resulting in a Technical Specification Violation

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)
									N/A	0 5 0 0 0
0 5	0 8	8 9	8 9	— 0 1 6	— 0 0	0 6	2 0	8 9	N/A	0 5 0 0 0

OPERATING MODE (9): 1

POWER LEVEL (10): 1 0 0

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

20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
Robert G. Smith, Operations Superintendent, NMP2	3 1 5 3 4 9 - 2 3 8 8

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

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

ABSTRACT

On May 19, 1989, during the second level review of the Daily Checks Procedure, N2-OSP-LOG-D001, for May 8 and 9, 1989 it was determined that Nine Mile Point Unit 2 (NMP-2) had been in violation of Technical Specification (T.S.) 3.1.5 Standby Liquid Control System (SLCS). At the time of the determination, NMP2 was in Operational Mode 1 "Run" at 100 percent rated power.

The root cause of the event has been determined to be personnel error on the part of Niagara Mohawk Power Corporation Operations personnel performing surveillance activities and shift management personnel performing the first level of review.

Immediate corrective action included verification that SLCS solution was within the Technical Specification prescribed limits, re-calibration of SLCS tank level instrumentation.

Long term corrective action included revision of operating and surveillance procedures to eliminate recurrences of this type of event as well as addition of a second Senior Reactor Operator (SRO) to the on shift review cycle for the Shift Checks Procedure.

Additionally, responsible operations personnel have been counseled as to proper performance of surveillance activities as well as review of completed surveillance activities.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
Nine Mile Point Unit 2	0 5 0 0 0 4 1 0	8 9	— 0 1 6	— 0 0	0 2 OF 0 4

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

I. DESCRIPTION OF THE EVENT

On May 19, 1989 at 1338 hours, during the second level review of the Daily Checks Procedure, N2-OSP-LOG-D001, for May 8 and 9, 1989, it was determined that Nine Mile Point Unit 2 (NMP2) had been in violation of Technical Specification (T.S.) 3.1.5 Standby Liquid Control System (SLCS). At the time of determination, NMP2 was in Operational Mode 1 "Run" at 100 percent rated power.

Technical Specification 3.1.5 requires that the available volume of sodium-pentaborate solution contained within the SLCS storage tank be within the limits of T.S. Figure 3.1.5-1. On May 8 and 9, 1989, the indicated sodium-pentaborate tank volume had exceeded the maximum limit allowed by T.S. Figure 3.1.5-1. This condition had gone unnoticed by Niagara Mohawk Power Corporation (NMPC) Operations personnel who performed the surveillance activity as well as the on-shift management personnel performing the first level review.

II. CAUSE OF THE EVENT

The root cause of the event has been determined to be personnel error on the part of NMPC Operators performing the surveillance activity and the shift management personnel who performed the first level of review.

III. ANALYSIS OF THE EVENT

This condition is considered reportable per 10CFR50.73(a)(2)(i)(B), "Any operation or condition prohibited by the plant's Technical Specifications".

The SLCS provides a back up capability for bringing the reactor from any power operation condition to a cold xenon-free shutdown condition, assuming that the withdrawn control rods remain in the rated power pattern. To meet this objective, it is necessary to inject a quantity of sodium-pentaborate which produces a concentration of 660 parts per million (ppm) in the reactor vessel. The required concentration is achieved by having a minimum available quantity of 4418 gallons of sodium-pentaborate solution containing a minimum of 5500 pounds of sodium-pentaborate.

Technical Specification surveillance requirements are established on a frequency which assures a high reliability of the system. Once the solution is established, sodium-pentaborate concentration will not vary unless more sodium-pentaborate or water is added or SLCS tank temperature decreases causing precipitation of sodium-pentaborate from the solution. A verification of tank temperature and volume once per twenty-four hours assures that the solution is available for use.

III. ANALYSIS OF THE EVENT (Cont'd)

Since water or sodium-pentaborate had not been added to the SLCS storage tank since the last chemistry concentration surveillance on April 27, 1989 and tank temperature remained within T.S. prescribed limits, the concentration of sodium-pentaborate solution is not in question. Additionally, since all components within the SLCS were fully operational during the duration of the event, the system, if called upon, would have initiated and completed its safety function, thus posing no threat to plant personnel or the general public.

IV. CORRECTIVE ACTIONS

1. Immediate corrective action included verification that water had not been added to the Standby Liquid Control Storage (SLCS) tank since the last chemistry concentration surveillance by reviewing Station Shift Supervisor (SSS) and Chief Shift Operator (CSO) logs.

2. Work Request (WR) #161499 had been written to calibrate SLCS tank level indicator (SLS*LIX103).

3. Standby Liquid Control Operating Procedure, N2-OP-36A, was changed to allow sounding the SLCS tank to verify level.

4. Daily Checks Procedure, N2-OSP-LOG-D001, was changed to include a copy of T.S. Figure 3.1.5-1 to provide better T.S. limit accessibility.

5. Responsible personnel, including operators and Shift Management Personnel have been counseled as to proper surveillance procedure i.e., no concurrent duties and diligence to task at hand. This concept applies to the actual performance of surveillance activities as well as review of completed surveillance results.

6. Action to prevent recurrence has included the addition of a second Senior Reactor Operator (SRO) in the on-shift review cycle. This review will be completed within the time frame of the shift which performed the Daily Surveillance Procedure N2-OSP-LOG-D001.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
Nine Mile Point Unit 2	0 5 0 0 0 4 1 0	8 9	— 0 1 6	— 0 0	0 4 OF 0 4

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

V. ADDITIONAL INFORMATION

A. Identification of Components

Component	IEEE 803 EIIS Funct	IEEE 805 System ID
Standby Liquid Control System	--	BR
Storage Tank	TK	BR
Control Rods	ROD	AA
Level Indicator	LI	BR

B. Failed Components

None

C. Previous Similar Events

NMP2 has experienced four similar events where personnel errors, i.e. failure to follow procedure resulted in violation of Technical Specifications. Details of these events are contained in (LERs) Licensee Event Reports 88-13, 89-04, 89-05, and 89-06.