

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9806080365 DOC. DATE: 98/05/26 NOTARIZED: NO DOCKET #
 FACIL: 50-410 Nine Mile Point Nuclear Station, Unit 2, Niagara Moho 05000410
 AUTH. NAME AUTHOR AFFILIATION
 PISANO, L.E. Niagara Mohawk Power Corp.
 DAHLBERG, N.A. Niagara Mohawk Power Corp.
 RECIPIENT NAME RECIPIENT AFFILIATION

SUBJECT: LER 98-010-00: on 980423, entry into TS 3.0.3 due to incorrect latching mechanisms installed in emergency switchgear, was determined. Caused by personnel error. Insp & replacement of incorrect latching mechanisms on switchgear. W/980526 ltr.

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

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NIAGARA MOHAWK

GENERATION
BUSINESS GROUP

NINE MILE POINT NUCLEAR STATION/LAKE ROAD, P.O. BOX 63, LYCOMING, NEW YORK 13093

May 26, 1998
NMP2L 1785

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

RE: Docket No. 50-410
LER 98-10

Gentlemen:

In accordance with 10CFR50.73 (a)(2)(i) and 10CFR50.73 (a)(2)(ii), we are submitting LER 98-10, "Entry into Technical Specification 3.0.3 Due to Incorrect Latching Mechanisms Installed in Emergency Switchgear."

Very truly yours,

Kim A. Dahlberg
Plant Manager - NMP2

KAD/GJG/kap
Attachment

xc: Mr. H. J. Miller, Regional Administrator, Region I
Mr. B. S. Norris, Senior Resident Inspector
Records Management

9806080365 980526
PDR ADBCK 05000410
S PDR

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IE22



LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (150-0104); OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

FACILITY NAME (1)

Nine Mile Point Unit 2

DOCKET NUMBER (2)

05000410

PAGE (3)

1 OF 4

TITLE (4)

Entry into Technical Specification 3.0.3 Due to Incorrect Latching Mechanisms Installed in Emergency Switchgear

| 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) | |
| 04 | 23 | 98 | 98 | 10 | 00 | 05 | 26 | 98 | N/A | 05000 | |
| | | | | | | | | | N/A | 05000 | |

OPERATING MODE (9)

1

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

| | | | | |
|-------------------------|---|--|---|--|
| POWER LEVEL (10) 091 | <input type="checkbox"/> 20.2201(b) | <input type="checkbox"/> 20.2203(a)(2)(v) | <input checked="" type="checkbox"/> 50.73(a)(2)(i) | <input type="checkbox"/> 50.73(a)(2)(viii) |
| | <input type="checkbox"/> 20.2203(a)(1) | <input type="checkbox"/> 20.2203(a)(3)(i) | <input checked="" type="checkbox"/> 50.73(a)(2)(ii) | <input type="checkbox"/> 50.73(a)(2)(x) |
| | <input type="checkbox"/> 20.2203(a)(2)(i) | <input type="checkbox"/> 20.2203(a)(3)(ii) | <input type="checkbox"/> 50.73(a)(2)(iii) | <input type="checkbox"/> 73.71 |
| | <input type="checkbox"/> 20.2203(a)(2)(ii) | <input type="checkbox"/> 20.2203(a)(4) | <input type="checkbox"/> 50.73(a)(2)(iv) | <input type="checkbox"/> OTHER |
| | <input type="checkbox"/> 20.2203(a)(2)(iii) | <input type="checkbox"/> 50.36(e)(1) | <input type="checkbox"/> 50.73(a)(2)(v) | (Specify in Abstract below and in Text, NRC Form 366A) |
| | <input type="checkbox"/> 20.2203(a)(2)(iv) | <input type="checkbox"/> 50.36(e)(2) | <input type="checkbox"/> 50.73(a)(2)(vi) | |
| | | | <input type="checkbox"/> 50.73(a)(2)(vii) | |

LICENSEE CONTACT FOR THIS LER (12)

NAME

L. E. Pisano, Manager Maintenance - Unit 2

TELEPHONE NUMBER

(315) 349-2073

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)

 YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH

DAY

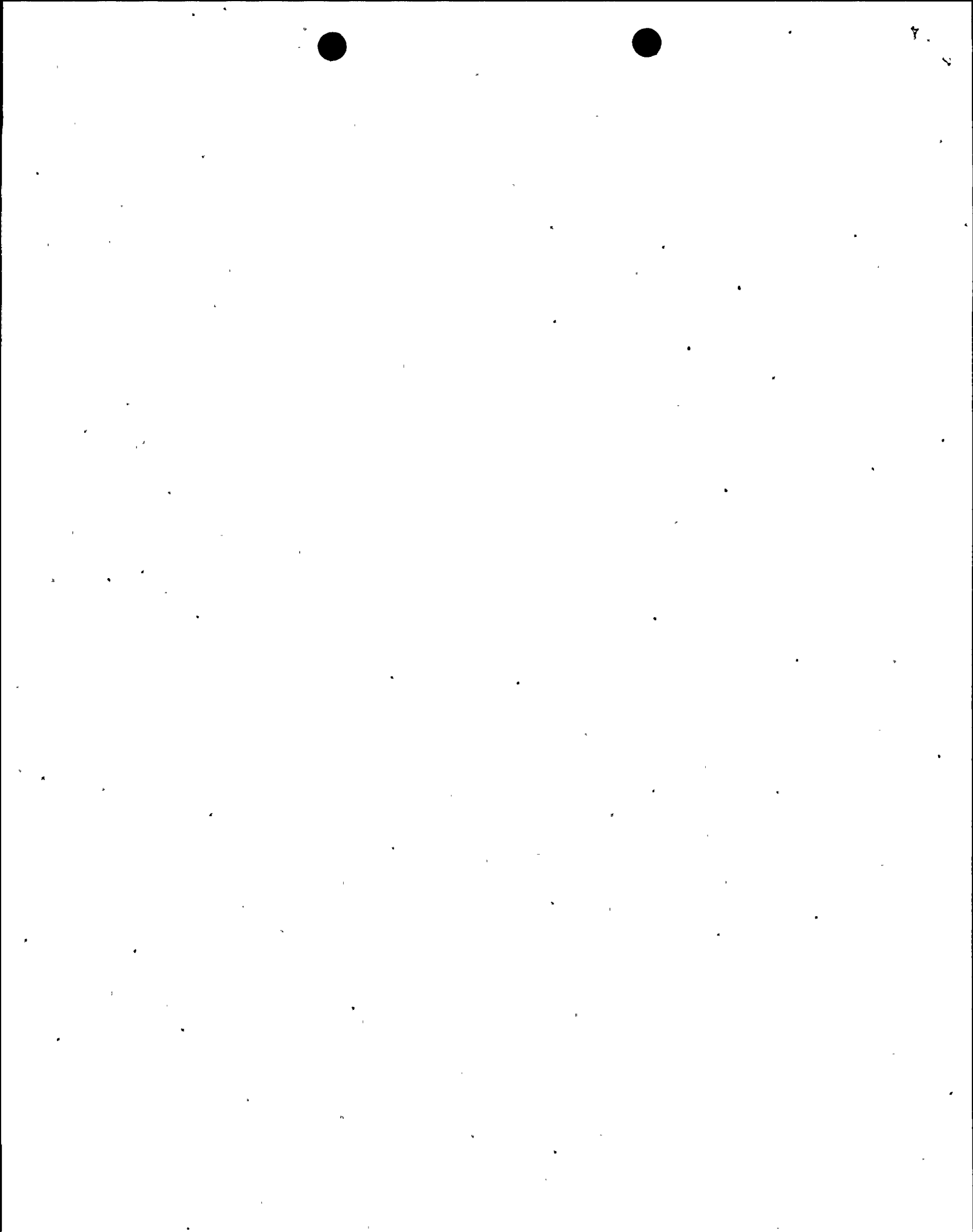
YEAR

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

On April 23, 1998, the Nine Mile Point Unit 2 (NMP2) Station Shift Supervisor (SSS) determined that NMP2 was in a condition outside the design basis of the plant as a result of numerous incorrect latching mechanisms being installed in 4160 volt Emergency Switchgear cubicle doors. In addition, entry into Technical Specification (T.S.) 3.0.3 was made due to the declarations of Emergency Core Cooling System Actuation Instruments - Loss of Power being inoperable and the actions of T.S. 3.3.3 not addressing this condition.

The cause of the incorrect latching mechanisms being installed during original construction was personnel error. The incorrect latches were installed in eight of seventeen cubicle doors in the Division II switchgear. Contributing to this event was that information relative to the latching mechanisms was not provided to personnel working on the switchgear and that procurement controls were not adequate to ensure the correct parts were installed.

Corrective actions included inspection and replacement of the incorrect latching mechanisms on the 4160 volt Emergency Switchgear. The knowledge level of plant personnel and the procurement control process have previously been enhanced. A drawing will be revised to depict the proper configuration. The applicable procedures will be revised to include the drawing and to add steps for verifying the proper latches are installed.



LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | | | PAGE (3) |
|------------------------|-------------------|----------------|-------------------|-----------------|----------|
| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | |
| Nine Mile Point Unit 2 | 05000410 | 98 | 10 | 00 | 02 OF 04 |

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

I. DESCRIPTION OF EVENT

On April 23, 1998, the Nine Mile Point Unit 2 (NMP2) Station Shift Supervisor (SSS) determined that NMP2 was in a condition outside the design basis of the plant as a result of numerous incorrect latching mechanisms being installed in 4160 volt Emergency Switchgear cubicle doors. In addition, entry into Technical Specification (TS) 3.0.3 was made due to the declarations of Emergency Core Cooling System Actuation Instruments - Loss of Power being inoperable and the actions of TS 3.3.3 not addressing this condition.

At approximately 0730 hours on April 22, 1998, the Division II Emergency Diesel Generator (EDG) neutral breaker indicated tripped in the control room. Operations and maintenance personnel investigated the trip and determined that the neutral breaker had tripped when electricians closed the breaker cubicle door. During the investigation of the trip, it was also determined that incorrect latching mechanisms were installed in the cubicle door.

In the period between 0730 hours on April 22, 1998 and 2200 hours on April 23, 1998, Niagara Mohawk Power Corporation (NMPC) engineering, maintenance and operations personnel performed actions to assure that other switchgear had the correct latching mechanisms to meet seismic qualification requirements. Throughout the inspections where deviations were found, the appropriate TS actions were taken until the issues were resolved. At 2010 hours on April 23, 1998, TS Table 3.3.3, Emergency Core Cooling Actuation Instrumentation Trip Function 'D', Loss of Power could not be met. Therefore, TS 3.0.3 was entered until repairs were made at 2030 hours on April 23, 1998, at which time TS 3.0.3 was exited.

At approximately the same time on April 23, 1998, it was also determined that NMP2 was in a condition outside the design basis of the plant due to the number of incorrect latching mechanisms installed and the extensive length of time that the condition had apparently existed. Eight of seventeen cubicle doors were unsatisfactory due to the incorrect latching mechanisms in the Division II switchgear. One broken latch was identified in Division I. All other Division I and III latches were found to be correct.

A historical records search was performed to determine when the latching mechanisms had been installed. It was determined that the incorrect latching mechanisms had been installed during original construction. Latching mechanisms that had been installed since construction were the correct latching mechanisms.



LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

| FACILITY NAME (1) | DOCKET NUMBER (2) | LER NUMBER (6) | | | PAGE (3) |
|------------------------|-------------------|----------------|-------------------|-----------------|----------|
| | | YEAR | SEQUENTIAL NUMBER | REVISION NUMBER | |
| Nine Mile Point Unit 2 | 05000410 | 98 | 10 | 00 | 03 OF 04 |

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

II. CAUSE OF EVENT

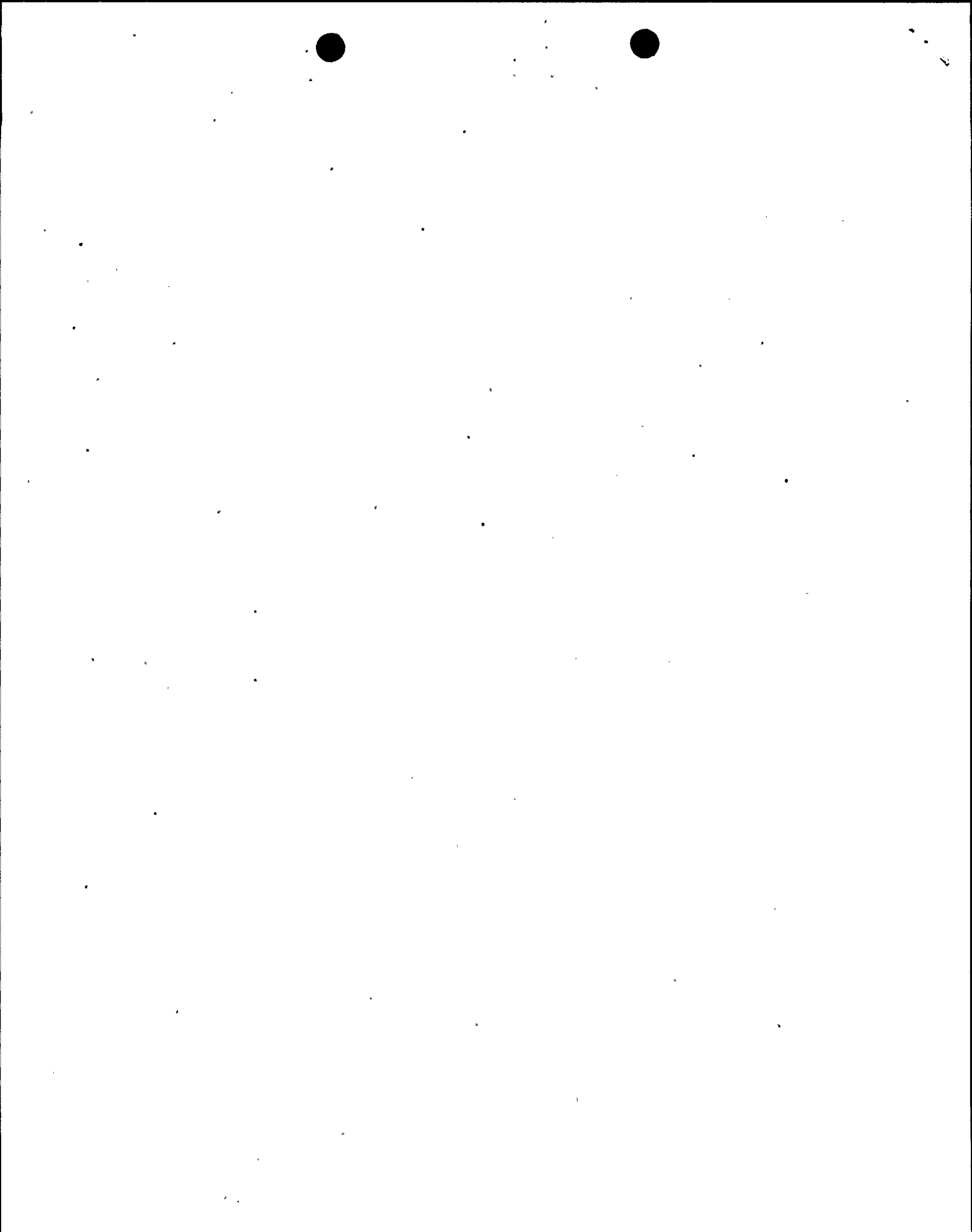
The cause of the incorrect latching mechanisms being installed during original construction was personnel error. The incorrect latches were installed in eight of seventeen cubicle doors in the Division II switchgear. Contributing to this event was that information relative to the latching mechanisms was not provided to personnel working on the switchgear and that procurement controls were not adequate to ensure the correct parts were installed. The latching mechanisms are two lengths; the shorter mechanisms are to be installed in the upper and lower latch locations, and the longer mechanisms are for the middle latch locations. These mechanisms were intermixed since personnel were not aware of this requirement and drawings did not show the proper configuration.

III. ANALYSIS OF EVENT

This event is reportable in accordance with 10CFR50.73(a)(2)(i)(B), "any operation or condition prohibited by the plant's Technical Specifications" due to the entry into TS 3.0.3 and due to the condition existing for a time longer than permitted by TS. This event is also reportable in accordance with 10CFR50.73(a)(2)(ii), "any event or condition that resulted in the condition of the nuclear power plant, including its principal safety barriers, being seriously degraded; or that resulted in the nuclear power plant being: (B) In a condition that was outside the design basis of the plant" due to the incorrect latching mechanisms being installed for an extended period of time and thus impacting equipment operability.

The results of the inspection revealed that one breaker cubicle on Division I switchgear had a broken latching mechanism on the lower portion of one cubicle door. The broken latching mechanism on the one cubicle door did not affect operability, since the deficiency was that the mechanism rotated 360 degrees but was the proper length. It was latched and would have performed its function. Division II switchgear had numerous cubicles which were unsatisfactory (i.e., incorrect latching mechanisms). Division III switchgear cubicles were all satisfactory.

Therefore, Division I and III equipment would have been available to mitigate the consequence of an accident. In addition, portions of Division II equipment would have been available. There were times that Division I and III equipment would have been inoperable in conjunction with Division II equipment. The cause of the Division II equipment inoperability was the lack of capability to function due to seismic inadequacy. The probability of a seismic event is very small. A Probabilistic Risk Assessment (PRA) was performed to evaluate the maximum potential impact on Core Damage Frequency (CDF) and resulted in an increase in CDF of 1.7 E-5 per year. This value is relatively small and does not credit the ability of plant personnel to operate circuit breakers to restore equipment once a postulated seismic event subsides. The probability of a seismic event in conjunction with other equipment important to safety being inoperable is even smaller. Equipment inoperability times are limited per the TS and appropriate compensatory actions are taken, as required, when this equipment is removed from service. Based on the above conclusions, this event had no adverse consequences on the health and safety of the public or plant personnel.



LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-330), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20535, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

| | | | | | |
|---|-----------------------------------|----------------|-------------------------|-----------------------|--------------------------|
| FACILITY NAME (1) Nine Mile Point Unit 2 | DOCKET NUMBER (2) 05000410 | LER NUMBER (6) | | | PAGE (3) 04 OF 04 |
| | | YEAR 98 | SEQUENTIAL NUMBER 10 | REVISION NUMBER 00 | |

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

IV. CORRECTIVE ACTIONS

- The Division I, II and III 4160 volt Emergency Switchgear was inspected and the incorrect latching mechanisms on Division II were replaced as required. The broken latch on Division I was replaced.
- The knowledge level of electrical and other plant personnel regarding seismic adequacy have been enhanced since original construction. All seismic latches installed since 1990 were found to be correct. This deficiency was self-identified. The need to self-check and ensure proper configuration are routinely reinforced. No additional actions are required in this area.
- All parts used for safety related components are issued and controlled by procedure. No additional actions are required in this area.
- A drawing will be revised to depict the proper latching mechanism configuration by September 30, 1998.
- The applicable procedures will have the drawing incorporated and steps added to verify the proper latches are installed by October 30, 1998.

V. ADDITIONAL INFORMATION

- A. Failed components: none.
- B. Previous similar events:

LER 97-13, "Prior to 1992, Emergency Switchgear Not Seismically Qualified with Breakers Racked Out" reported that prior to April 30, 1992, NMP2 had racked out breakers from a 4160 volt switchgear in a manner which did not meet the seismic qualification requests. In addition, NMPC reported that the event had not reported in 1992 even though it had been marked reportable by Station Shift Supervisor (SSS). The corrective actions in that LER focused on the procedure changes resulting from "Breaker Configuration Restrictions" matrix issued by engineering and changes to NMPC's Corrective Action Program. There was no indication from that event that latching mechanisms was a concern.

- C. Identification of components referred to in this LER:

| COMPONENT | IEEE 803 FUNCTION | IEEE 805 SYSTEM ID |
|----------------------|-------------------|--------------------|
| Emergency Switchgear | SWGR | EB |

