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FACIL:50-316 Donald C. Cook Nuclear Power Plant, Unit 2, Indiana M 05000316
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RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-008-00:on 911105,containment pressure relief valves opened w/radiation monitoring switches in block position. Caused by personnel error.Ltrs issued to all reactor operators stressing responsibility.W/911127 ltr.

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

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INDIANA MICHIGAN POWER

November 27, 1991

United States Nuclear Regulatory Commission
Document Control Desk
Rockville, Maryland 20852

Operating Licenses DPR-74
Docket No. 50-316

Document Control Manager:

In accordance with the criteria established by 10 CFR 50.73 entitled Licensee Event Report System, the following report is being submitted:

91-008-00

Respectfully,

A. Alan Blind

A.A. Blind
Plant Manager

Attachment

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NRC FORM 366 (6-89) | U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH 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.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
D. C. Cook Nuclear Plant - Unit 2	0 5 0 0 0 3 1 6	1 OF 0 4

TITLE (4) Containment Pressure Relief Performed with the Radiation Monitor Trip Function Blocked 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)
										0 5 0 0 0
1 1	0 5	9 1	9 1	— 0 0 8	— 0 0	1 1	2 7	9 1		0 5 0 0 0

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)	1 0 0	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
J. R. Sampson, Operations Superintendent	AREA CODE 6 1 6 — 4 6 5 - 5 9 0 1

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)

On November 5, 1991 at 1906 hours, the containment pressure relief valves were opened to perform a containment pressure relief while the valve's associated radiation monitoring system trip/block switches were in the BLOCK position. The pressure relief valves are allowed to be opened by Technical Specification 3.6.3.1, Containment Isolation Valves, on an intermittent basis under administrative control. The opening of these valves with the radiation monitoring system switches in BLOCK was not the proper administrative control for the conditions that existed at the time.

Due to a misinterpretation of a procedure step, a Reactor Operator (RO) trainee signed off the step in the containment pressure relief procedure while the switches were in the BLOCK position; however, the switches should have been in the NORMAL position. This error was not identified by the Unit Supervisor (US) or the RO until the containment pressure relief was completed. The cause of this event was improper trainee control. Neither the US nor the RO were in direct contact with the RO trainee when the procedural error occurred. The Operations Department Superintendent issued letters to all licensed operators, RO trainees and shift supervisors emphasizing individual responsibility for controlling trainee activities in the control room. This event did not adversely impact the public health and safety.

Condition Prior to Occurrence

Unit 1 in mode 1 at 100% power.

Unit 2 in mode 1 at 99.5% power.

Description of Event

On November 5, 1991 from 1906 to 1930 hours, a containment pressure relief was performed in unit 2 with the radiation monitoring system (RMS) (IEEE/IL) trip/block (IEEE/IL-HS) switches in BLOCK position. Procedure 2-OHP 4021.028.004 (Operation of the Containment Pressure Relief System) requires the trip/block switches to be placed in NORMAL for all operable radiation monitors to provide automatic containment ventilation isolation valve closure for a containment radiation monitor high radiation alarm condition.

Containment pressure was identified as being at .2 psig by the Unit Supervisor (US) during shift turnover control board walkdown. The US notified the Reactor Operator (RO) that a containment pressure relief (CPR) would need to be performed after shift turnover was completed.

An RO trainee was allowed to perform the CPR under the direction of a licensed RO. The licensed RO instructed the RO trainee to review the procedure and revision check the data sheet. After reviewing the procedure and revision checking the data sheet, the US assisted the RO trainee in obtaining the required RMS data prior to performing the CPR.

After collecting the RMS data, the RO trainee signed the step that requires all operable radiation monitors trip/block switches be verified in NORMAL. The RO trainee, knowing that the normal position was BLOCK, signed the step with the switches in the BLOCK position. The RO trainee thought that the procedure would instruct them at a later time to reposition the switches.

The RO trainee returned to the front of the control room and discussed the method of determining the operability of the radiation monitors with the RO and US. The RO had observed the RO trainee and the US at the RMS control terminal and the RO assumed that the US had verified the accuracy of the data recorded and that data sheet 1 was properly filled out. The RO trainee had the procedure out and indicated that they were at the step to start the pressure relief. The RO observed the RO trainee open the containment isolation valves (IEEE/JM-ISV) 2-VCR-107 and 2-VCR-207, and start the pressure relief fan (IEEE/JM-FAN), 2-HV-CPR-1.

Description of Event (Continued)

When containment pressure reached 0 psig, the pressure relief fan was stopped and the containment isolation valves were closed by the RO trainee under the direction of the RO. At this time, the trip/block switches were noted to be mispositioned..

At all times during the containment pressure relief, radiation monitors (IEEE/IL/45) VRS-2101, VRS-2201, ERS-2300, ERS-2400, and VRS-2500 remained operable with high radiation alarm capabilities available in the control room.

Cause of Event

The cause of this event was inadequate RO trainee control. With the RMS trip/block switches in the BLOCK position, an RO trainee incorrectly signed a procedure step requiring the RMS trip/block switches to be placed in the NORMAL position. The RO trainee was not under the direct supervision of a licensed operator at the time the procedure step was incorrectly signed.

In addition, the data collected by the RO trainee and signoffs completed were not adequately reviewed with the trainee by licensed personnel to ensure complete understanding of the steps and verification of the trainee's actions. Trainees signing procedure steps is an acceptable practice in the Operations Department; however, the data recorded and steps signed must be verified by a licensed individual.

Analysis of Event

This event is considered reportable in accordance with the requirements of 10 CFR 50.73 (a)(2)(i)(B), operation prohibited by the plant's Technical Specifications, in that the pressure relief valves were opened without adequate administrative controls as allowed for by Technical Specification 3.6.3.1, Containment Isolation Valves. The automatic closure of the containment relief valves on a phase A or phase B signal was available at all times during the relief activity.

Although the containment radiation monitor's trip function was not available, the review of this event reveals that all applicable radiation monitors were in service during the time of the containment pressure relief. With the RMS trip/block switches in BLOCK, high radiation alarm capability in the control room was available; which would have alerted the control room operators to manually close the containment ventilation isolation valves.

Analysis of Event (Continued)

A review of the containment vent stack radiation monitor's 10-minute average printout (VRS-2505) indicates that all readings for the time of this pressure relief were below the alert and high alarm setpoints. In addition, the review noted no elevated readings attributable to the pressure relief.

Based on the above analysis, the RMS trip/block switches being in the BLOCK position for containment pressure relief is considered to have no adverse impact on public health and safety.

Corrective Actions

No immediate corrective actions could be performed; the containment pressure relief was complete prior to discovering that the switches were not in the correct position.

The Operations Superintendent issued letters to all RO replacement class trainees, licensed operators and shift supervisors stressing each individual's responsibility and accountability for control room trainees. The requirements contained in these letters will be incorporated into the Operations Head Instruction on Training.

Failed Component Identification

None

Previous Similar Events

A review of previous License Event Reports was completed to identify similar events. No similar events were identified during this review.