ACCESSION NBR: 8708130217 DOC. DATE: 87/08/10 NOTARIZED: NO

FACIL: 50-400 Shearon Harris Nuclear Power Plant, Unit 1, Carolina

AUTH. NAME AUTHOR AFFILIATION

SCHWABENBAUER WATSON, R. A.

RECIP. NAME

Carolina Power & Light Co. Carolina Power & Light Co. RECIPIENT AFFILIATION

SUBJECT: LER 87-042-00: on 870709, wrong fuses pulled during process of placing Clearance OP-87-1290 resulting in automatic reactor/turbine trip. Caused by personnel error. Operator training conducted re fuse labeling conventions. W/870810 ltr.

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NOTES: Application for permit renewal filed.

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LICENSEE EVENT REPORT (LER)

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

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The plant was operating in Mode 1 at 100 percent reactor power on July 9, 1987. Operations personnel were preparing a clearance to work on the solenoid of valve 1AF-161, which is for the Ammonia Supply to Steam Generator 'C'. The clearance was to be implemented by pulling 2 fuses, L5B/1967 and L6B/1967, which are located in Auxiliary Relay Panel 1B-SB.

Due to a misinterpretation of plant prints and the physical location of the fuses, the wrong fuses were pulled. This caused the Feedwater Regulating Valve for Steam Generator 'C' to shut, stopping all feedwater flow to Steam Generator 'C'.

This resulted in an automatic reactor/turbine trip at 1007 hours due to Steam Generator low-low level coincident with steam flow-feed flow mismatch.

Plant response to the trip was normal except three Steam Generator blowdown valves did not automatically shut and were manually isolated.

Steam Generator water levels were restored with the Auxiliary Feedwater System.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)			
SHEARON HARRIS PLANT UNIT 1	0 5 0 0 0 4	OLO 817 - 0 4 2 - 0 0	0 2 OF 0 4			

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

DESCRIPTION:

The plant was operating in Mode 1 at 100 percent reactor power on July 9, 1987. Operations personnel were in the process of placing clearance OP-87-1290 to accomplish repairs to the solenoid of valve 1AF-161. This valve is the isolation valve for an ammonia supply to Steam Generator (SG) 'C'. The clearance was to be implemented by pulling fuses L5B/1967 and L6B/1967 located in Auxiliary Relay Panel (ARP) 1B-SB.

The clearance request as submitted, required the removal of fuses FU/6 ARP-1BSBF2 and FU/5 ARP-1BSBF2. The clearance center operator realized that this designation was not consistent with the current drawings and partially corrected the request to read L6B ARP-1BSBF2 and L5B ARP-1BSBF2. As shown on the drawing, the fuse numbers were L5B/1967 and L6B/1967; he failed to include the Control Wire Diagram (CWD) sheet number designation of 1967 on the clearance. Two auxiliary operators were dispatched to the ARP to pull the fuses. The auxiliary operators understood the F2 designation to refer to the physical location of the fuses in the ARP. Plant vendor drawings showing the physical locations and layout of the fuse blocks within the ARP were not used. When the operators proceeded to ARP 1B-SB, they located fuses "5" and "6" in Front Rack 2 (F2) and assumed these to be the fuses to be pulled. These fuses are actually L5B/0803 and L6B/0803. This circuit enables the air supply to the Feedwater Regulating Valve for SG 'C'.

When the operators pulled the wrong fuses, it caused the Feedwater Regulating Valve for SG 'C' to shut, stopping feedwater flow to SG 'C'. This resulted in an automatic reactor/turbine trip at 1007 hours due to SG low-low level coincident with feedwater flow - steam flow mismatch.

Subsequent to the trip, both Main Feedwater Pumps tripped actuating the Auxiliary Feedwater System. This same anticipatory signal also initiated an isolation of SG Blowdown. Three SG blowdown valves did not shut as required and were manually isolated.

Prior to plant restart, it was determined that these valves would properly respond to a safety isolation signal. The logic for the Blowdown valve isolation is different based on the input signal. For the case of Blowdown Isolation on loss of both Main Feed Pumps signal or one Steam Generator with low-low level signal, the initiating signal to Blowdown isolation drops out after 5 seconds. The logic relies on the valves' control circuit to complete the valve closure. If less than full open indication is not obtained, the valve returns to the open position after the 5 second timer has expired. For the case of Blowdown isolation on Safety Injection signal or two Steam Generators with low-low level signal, the initiating signal is sealed in and assures Blowdown valve closure.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)		LE	ER NUMBER (6)	PAGE (3)						
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION (continued)

Blowdown Isolation on a loss of both Main Feedwater Pumps is an anticipatory signal which is not assumed in safety analysis and is not required. The failure of Blowdown isolation on loss of level in only one Steam Generator is bounded by FSAR Section 15.1.4 and 15.2.8 analyses (Steam Line Break and Feedwater Line Break Analyses). Blowdown isolation on only one Steam Generator Low-Low level signal is again only an anticipatory signal and is not required.

SG water levels were restored with the Auxiliary Feedwater System and the plant stabilized in Mode 3.

Following the event, an investigation was conducted into the cause of the event. This review found:

- (1) The Control Wiring Diagram (CWD) correctly indicated the fuse numbers as L5B/1967 and L6B/1967, although the designation F2 led to confusion on the part of the operators who thought the fuses were located in Front Rack 2.
- (2) The panel vendor drawing for ARP 1B-SB correctly illustrated that the correct fuses were located in Front Rack 1 in the panel and that the fuses pulled affected the C Main Feedwater Reg. valve.
- (3) ARP 1B-SB included placards internal to the cabinet which included the CWD designation for each fuse. The placards were located adjacent to the fuse blocks but not in a direct line-of-sight from the front of the panel. Such placards were added to safety-related ARP's during construction in concert with revisions to the CWD's to include the CWD sheet number in the fuse designation.
- (4) The personnel involved in the event were not aware of the significance of the CWD sheet number in the fuse number, and the fact that the "1BSBF2" designator was not meant to indicate the physical location of the fuses.

CAUSE

The cause of the event was determined to be personnel error. The error was caused by a lack of attention to detail and a lack of systematic training on locating fuses in ARP's.

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· ·	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

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

ANALYSIS:

No safety consequences resulted from this event other than a challenge to the Reactor Protection system and the Engineered Safety Features Actuation system. Plant safety systems responded as required, and the plant stabilized in Mode 3.

This event is being reported in accordance with 10CFR50.73(a)(2)(iv) as an Engineered Safety Features Actuation and an actuation of the Reactor Protection System.

CORRECTIVE ACTIONS:

1) Operator training has been conducted concerning fuse labeling conventions and correct methods of determining component locations within equipment panels.



P.O. Box 165 New Hill, NC 27562

AUG 10 1987

File Number: SHF/10-13510C Letter Number: HO-870482 (0)

U.S. Nuclear Regulatory Commission ATTN: NRC Document Control Desk Washington, DC 20555

SHEARON HARRIS NUCLEAR POWER PLANT UNIT 1

DOCKET NO. 50-400

LICENSE NO. NPF-63

LICENSEE EVENT REPORT 87-042-00

Gentlemen:

In accordance with Title 10 to the Code of Federal Regulations, the enclosed Licensee Event Report is submitted. This report fulfills the requirement for a written report within thirty (30) days of a reportable occurrence and is in accordance with the format set forth in NUREG-1022, September, 1983.

Very truly yours,

R. A. Watson Vice President

Harris Nuclear Project

RAW:1kd

Enclosure

cc: Dr. J. Nelson Grace (NRC - RII)

Mr. B. Buckley (NRR)

Mr. G. Maxwell (NRC - SHNPP)

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