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ACCESSION NBR: 8712290385 DOC. DATE: 87/12/22 NOTARIZED: NO DOCKET #
 FACIL: 50-220 Nine Mile Point Nuclear Station, Unit 1, Niagara Powe 05000220
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 RECIPIENT NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-023-00: on 870422, reactor bldg emergency ventilation initiation because of fuse failure.

W/8 ltr.

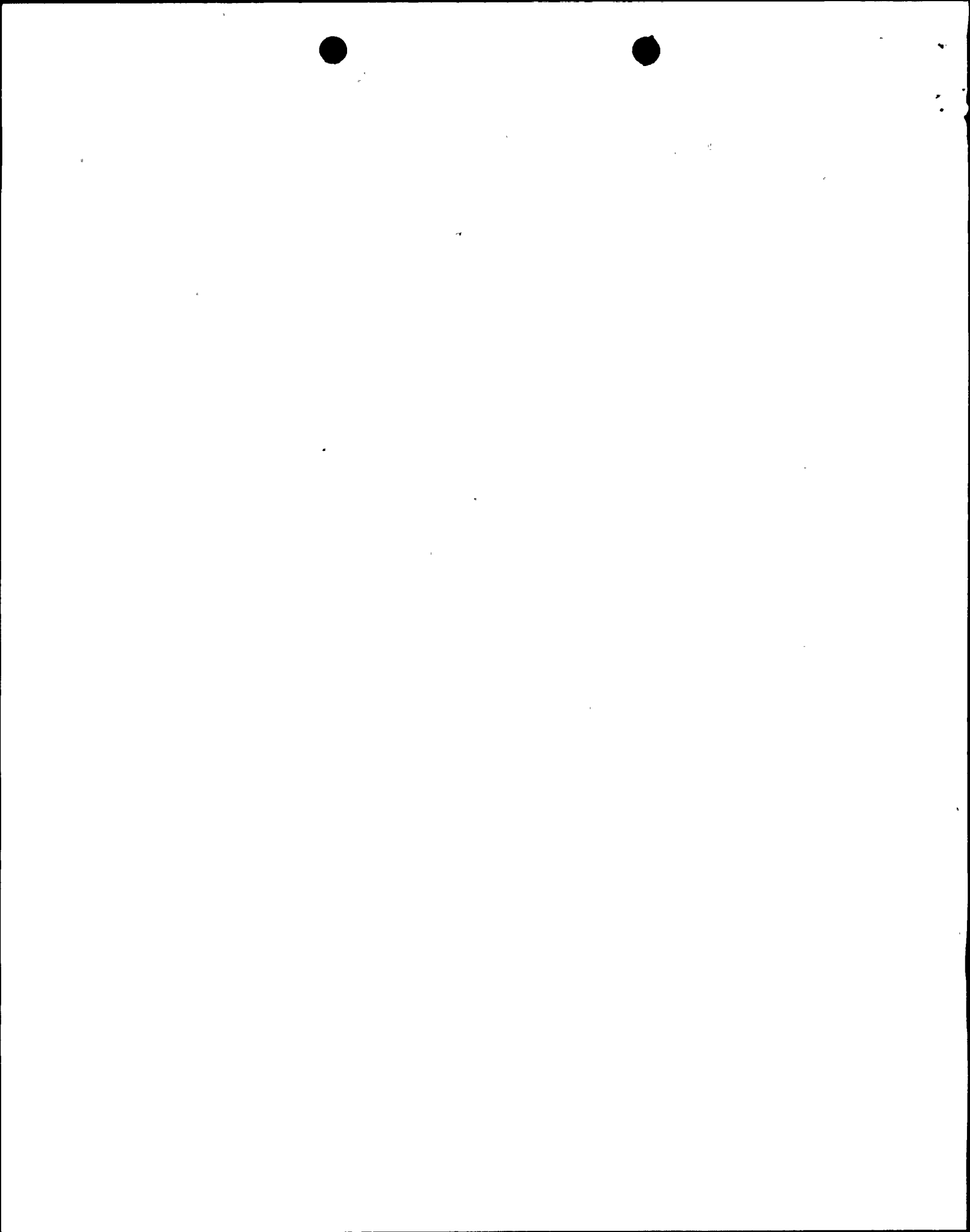
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 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

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	<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		FORD BLDG HOY, A	1	1	
	H ST LOBBY WARD	1	1		LPDR	1	1	
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Nine Mile Point Unit 1	DOCKET NUMBER (2) 05000220	PAGE (3) 1 OF 4
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TITLE (4) **Reactor Building Emergency Ventilation Initiation Because Of Fuse Failure And Failure To Report The Event With Respect To 10 CFR 50.73 As A Result Of Personnel Errors**

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	22	87	87	023	00	12	22	87			050000

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

OPERATING MODE (9) N	20.402(b)	20.405(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 1100	20.405(a)(1)(i)	50.38(c)(1)		50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	50.38(c)(2)		50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	50.73(a)(2)(ii)	<input checked="" type="checkbox"/>	50.73(a)(2)(viii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(iii)		50.73(a)(2)(viii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(ix)		50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Peter A. Mazzaferro, Assistant Supervisor Technical Support	315 349-1219

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
A	BHFU		M1715	N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

ABSTRACT

This Licensee Event Report reports two related events. The first event involved an Engineered Safety Feature actuation. On April 22, 1987, Nine Mile Point Unit 1 (NMP1) was operating at full power. At 1434 hours, the unit experienced a trip of the normal reactor building ventilation and an initiation of Reactor Building Emergency Ventilation (RBEV). The cause of this event was personnel error involving inadvertent shorting of a fuse to ground in the initiation circuit of the RBEV. Immediate corrective action involved replacing the fuse under a station work request. The RBEV was secured at 1645 hours on April 22 and the normal reactor building ventilation was returned to service.

On November 23, 1987, the NMP1 Technical Support Department became aware that the 10 CFR 50.73 report had not yet been submitted for the April 22 event. The cause of this event is personnel error. Immediate corrective action involved a discussion with the personnel involved as to how and why this event occurred. Subsequent corrective action will involve preparing a Lessons Learned Transmittal to inform the personnel of the affected departments of the need for attention to detail during work activities.

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		YEAR 8 7	SEQUENTIAL NUMBER - 0 2 3	REVISION NUMBER - 0 0 0			

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

DESCRIPTION OF EVENT

This Licensee Event Report (LER) reports two related events. The first event is an Engineered Safety Feature (ESF) initiation which occurred on April 22, 1987. The second event is the failure to report the first event in accordance with 10 CFR 50.73. Because of the period of time involved between the event date and the discovery date of the second event, it has been difficult to reconstruct the specifics of these events with respect to the exact causes. However, according to the persons involved and all available documentation, the following narrative is an accurate account of the events.

EVENT NUMBER ONE

On April 22, 1987, NMP1 was operating at full power with the mode switch in the "RUN" position. At 1434 hours, the unit experienced a trip of the normal reactor building ventilation system and the subsequent Reactor Building Emergency Ventilation System (RBEV) initiation. The cause of the initiation was deenergization of the Channel 11 Reactor Protection System (RPS) Reactor Building Ventilation System logic. The reason for the trip was not immediately obvious, since the channel 11 and channel 12 reactor building ventilation radiation monitors (Equipment Piece Numbers [EPNs] 202-11 and 202-12 respectively) indicated no high radiation condition present in the reactor building ventilation. A Station Work Request (WR), number 106300, was initiated to investigate the cause of the initiation. The RBEV, however, remained in service until the cause of the trip could be identified.

At the time of the RBEV initiation, an Instrument and Control Department (I&C) technician was performing an unrelated surveillance test within an area of the control panel which is common to the control circuits of several different process monitoring systems. During the performance of the test, the technician inadvertently shorted to ground a 6 amp fuse in one of the 24 volt control circuits. During the investigation of this event, it was found that this fuse was associated with auxiliary relay 18K1. Relay 18K1 is one of two relays that, when deenergized, trip the normal reactor building ventilation and initiate RBEV. The logic for this operation is noncoincident. The affected fuse and the portion of the circuit that operates relay 18K1 are not an integral part of the indication/trip unit of radiation monitor EPN 202-11 or an associated auxiliary trip unit. Therefore, the only indication that operations personnel received as a result of the fuse failure was an annunciator actuation reflecting the trip of the normal reactor building ventilation. The fuse was replaced, the RBEV was secured, and the normal reactor building ventilation was restored at 1645 hours on April 22, 1987.

EVENT NUMBER TWO

Under WR 106300, I&C personnel investigated the cause of the first event. The Occurrence Report (OR) initiated to track the event was inadvertently attached to WR 106300. When the WR was closed out, it was not noticed by any of the reviewers that the OR was still attached. The WR was then filed. As a



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

EVENT NUMBER TWO (Cont'd)

result, the OR was not logged and did not receive the required second level review in a timely manner. Therefore, the Technical Support Department, responsible for second level review and LER preparation, was not aware that there had been a reportable event.

On November 20, 1987, the NMP1 Technical Support Department was contacted by telephone by a Nuclear Regulatory Commission consultant. The subject of the call was the 10 CFR 50.72 notification made by the NMP1 Operations Department on April 22. The Technical Support Department had at that time no record of the occurrence. An investigation was then initiated.

At approximately 1100 hours on November 23, 1987, after the investigation had located the misplaced OR, Technical Support Department personnel became aware that although the initial telephone notifications regarding the event were made in a timely manner, the written (LER) report was not submitted within the required thirty day period. During the interval since the 10 CFR 50.72 notification, NMP1 had operated at up to full power. The second event was the failure to submit the 10 CFR 50.73 report within thirty days. This was a violation of Nine Mile Point Unit 1 Technical Specifications section 6.6.1a., which requires conformance to 10 CFR 50.73 reporting requirements.

CAUSE OF THE EVENT

EVENT NUMBER ONE

The root cause of the first event was equipment failure due to personnel error. The 6 amp fuse in the control circuit failed because it was inadvertently shorted to ground by an I&C technician.

EVENT NUMBER TWO

The root cause of the second event was personnel error. The OR was inadvertently attached to the WR. During closeout of the paperwork no one noticed that the original OR was attached.

ANALYSIS OF THE EVENT

There were no adverse safety consequences as a result of the first event. The RBEV operated as designed and in the conservative direction. This analysis would be valid under any normal operating configuration or power level.

The second event involved subsequent reporting requirements only. Since plant operations and public safety were not affected, there were no adverse safety consequences as a result of the second event.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 305A's) (17)

CORRECTIVE ACTIONS

Initial corrective action, with respect to the first event, involved initiating a WR to investigate the cause of the event. Subsequent corrective action consisted of replacing the blown fuse, securing the RBEV, and returning the normal Reactor Building Ventilation System to service.

Initial corrective action, with respect to the second event, involved locating WR 106300 and verifying the failure to report the event in accordance with 10 CFR 50.73. Subsequent corrective action on the second event included initiating an OR and performing an investigation into the event.

In addition, a Lessons Learned Transmittal is being prepared in order to call attention to the need for attention to detail during work activities. The transmittal will be reviewed by the departments involved.

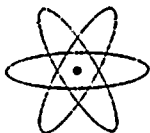
ADDITIONAL INFORMATION

Similar events were discussed in NMP1 LERs 86-10 (Actuation of Reactor Building Emergency Ventilation Resulting From Blown Fuse) and 85-07 (Initiation Of Reactor Building Emergency Ventilation Due To Power Supply Short).

The fuse which was shorted is believed to have been a BUSS type, class H, NON, 6 amp fuse rated at 250 volts or less. It was manufactured by McGraw Edison Company of St. Louis, Missouri. The following table lists the identifier codes of the involved equipment according to IEEE 805-1983, IEEE 803A-1983, and Table 9 of the NPRDS Reporting Procedures Manual.

<u>EPN</u>	<u>Component</u>	<u>Model Number</u>	<u>IEEE 805 System</u>	<u>IEEE 803 System</u>	<u>NPRDS Table 9 Manufacturer</u>
-	Fuse	NON, 6 AMP, BUSS Type	BH	FU	M175
-	Geiger-Mueller Tube	18550	BH	DET	A370
RN04B-5	Detector Sensor and Converter	194X927G2	BH	DET	G080
RN07B-5	Radiation Monitor	129B2802	BH	MON	G080
RN25	Trip Auxiliaries Unit	194X940G7	BH	MON	G080





NIAGARA MOHAWK POWER CORPORATION

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SYRACUSE, NY 13212

THOMAS E. LEMPGES
VICE PRESIDENT—NUCLEAR GENERATION

NMP30256

December 22, 1987

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

RE: Docket No. 50-220
LER 87-23

Gentlemen:

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

LER 87-23 Which 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" and

10 CFR 50.73 (a)(2)(i)(B), "Any operation or condition prohibited by the plant's Technical Specifications."

The 10 CFR 50.72 report was made at 1700 hours on April 22, 1987.

This report was completed in the format designated in NUREG-1022, Supplement 2, dated September 1985.

Very truly yours,

Thomas E. Lempges
Vice President
Nuclear Generation

TEL/meh

Attachment

cc: William T. Russell
Regional Administrator

CERTIFIED NO. P687403400

IE22
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