



Commonwealth Edison
Byron Nuclear Station
4450 North German Church Road
Byron, Illinois 61010

March 16, 1994

LTR: BYRON 94-0103
FILE: 3.03.0800 (1.10.0101)

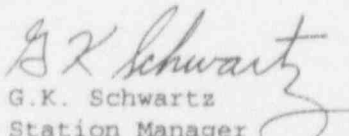
U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Dear Sir:

The Enclosed Licensee Event Report from Byron Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(i)(B).

This report is number 94-001; Docket No. 50-455.

Sincerely,


G.K. Schwartz
Station Manager
Byron Nuclear Power Station

GKS/DSK/ng

Enclosure: Licensee Event Report No. 94-001

cc: J. Martin, NRC Region III Administrator
NRC Senior Resident Inspector
INPO Record Center
CECo Distribution List

210000

(9962R/WPF/030994-6)
9403230273 940316
PDR ADOCK 05000455
S PDR

JE22

SIGNATURE PAGE FOR LICENSE EVENT REPORT

LER Number
455: 94-001

Title of Event: Room Temperature Reading taken at Wrong Location causing
a Missed Tech Spec Surveillance due to Personnel Error

Occurred: 02-19-94 / 1800
Date Time

OSR DISCIPLINES REQUIRED: ABla

LOS | 3/12/94
SES DATE

Acceptance by Station Review:

R. Wagner | ASG | 3/14/94
OB Date

Douglas Spitzer | 3/15/94
SES Date

D. Brink | 3/15/94
RAS Date

Arde Swanson | ASG | 3/15/94
OTHER Date

Approved by: G. Schwartz | 3/16/94
Station Manager Date

LICENSEE EVENT REPORT (LER)

FACILITY NAME BYRON NUCLEAR POWER STATION										DOCKET NUMBER 0 5 0 0 0 4 5 5					PAGE 1 OF 0 4		
TITLE ROOM TEMPERATURE READING TAKEN AT WRONG LOCATION CAUSING A MISSED TECH SPEC SURVEILLANCE DUE TO PERSONNEL ERROR																	
EVENT DATE			LER NUMBER				REPORT DATE			OTHER FACILITIES INVOLVED							
MONTH	DAY	YEAR	YEAR	SEQ. NUMBER	REVISION	MONTH	DAY	YEAR	FACILITY NAMES NONE		DOCKET NUMBER(S) 0 5 0 0 0						
0	2	1 9 9 4	9 4	- 0 0 1	- 0 0	0	3	1 6 9 4			0 5 0 0 0						
OPERATING MODE: 1 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (CHECK ONE OR MORE OF THE FOLLOWING)																	
POWER LEVEL		0	8	20.402(b)		20.405(a)		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 386A)							
				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)(ix)									
LICENSEE CONTACT FOR THIS LER																	
NAME B. JACOBSEN, OPERATING, EXT. 2622								TELEPHONE NUMBER 8 1 5 2 3 4 - 5 4 4 1									
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT																	
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS								
SUPPLEMENTAL REPORT EXPECTED								EXPECTED SUBMISSION DATE		MONTH	DAY	YEAR					
<input type="checkbox"/> YES, (If yes, complete EXPECTED SUBMISSION DATE)								<input checked="" type="checkbox"/> NO									

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

ABSTRACT

While investigating the operability of 2TIC-VX03 following repair, operators discovered that a Technical Specification required temperature reading for the Division 22 Cable Spreading Room was not being taken from the correct location in the room. The temperature was obtained from the correct location on third shift on February 19, 1994 by using a Doric hand held temperature probe. The temperature had last been taken from the correct location on first shift on January 30, 1994. There was approximately 21 days between properly obtained temperature readings in this area. Technical Specifications require checking the temperature every 12 hours.

The root cause of this event was an incorrect determination of the proper location for taking temperature readings during repair of 2TIC-VX03, due to confusion on the physical layout of the adjoining rooms and cable tunnel.

This event is reportable per 10CFR 50.73(a)(2)(i)(B) as operation prohibited by Technical Specifications.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME BYRON NUCLEAR POWER STATION	DOCKET NUMBER 0 5 0 0 0 4 5 5	LER NUMBER YEAR SEQ. NUMBER REVISION 8 4 - 0 0 1 - 0 0	PAGE 0 2 0 4
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TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]

A. PLANT CONDITIONS PRIOR TO EVENT:

Event Date/Time 02-19-94 / 1800

Unit 1 <u>Mode-1</u> - <u>Power Operation</u>	Rx Power <u>100%</u>	RCS Temp Press <u>NOT/NOP</u>
Unit 2 <u>Mode-1</u> - <u>Power Operation</u>	Rx Power <u>100%</u>	RCS Temp Press <u>NOT/NOP</u>

B. DESCRIPTION OF EVENT:

On January 30, 1994, during first shift, the temperature of the Division 22 Cable Spreading Room was taken from 2TIC-VX03, a temperature indicator on panel 2VX02J, located in the Division 22 Switchgear Room. During second shift on January 30, 1994, the Equipment Attendant taking rounds found the indication to be 62 Degrees Fahrenheit. Lightly tapping on the gauge to make sure that the indicating pointer wasn't just stuck caused the indicator to fall to the bottom of the gauge.

The Equipment Attendant returned to the Shift Engineer's Office, informed the Unit 2 Shift Supervisor of the problem and suggested that the Instrument Mechanics be called, as this is a Tech Spec required reading. The Unit 2 Shift Supervisor wanted to check the problem out first, so he and the Equipment Attendant returned to the Division 22 Switchgear Room. Determining that the gauge was indeed not operational, the Unit 2 Shift Supervisor indicated to the Equipment Attendant that the temperature would have to be taken locally. The Unit 2 Shift Supervisor asked the Equipment Attendant where the Division 22 Cable Spreading Room temperature could be taken. The Equipment Attendant answered that he wasn't positive of the location, but suggested the Division 22 Cable Tunnel and walked the Unit 2 Shift Supervisor over to the entrance. The cover for Division 22 cable tunnel entrance in the Division 22 Switchgear Room had been removed on May 17, 1993 for unrelated surveillance work. The Unit 2 Shift Supervisor put his hand in the opening and felt air movement. The Unit 2 Shift Supervisor thought that this indicated air flow from the Division 22 Cable Spreading Room and so he told the Equipment Attendant to get the Doric hand held temperature probe and to take his readings by dropping the probe down into the tunnel.

The Unit 2 Shift Supervisor and the Equipment Attendant returned to the Shift Engineers's Office. They got the temperature probe and verified that its calibration was current. The Equipment Attendant returned to the Division 22 Cable Tunnel Entrance and used the Doric probe to obtain a reading of 78.6 Degrees Fahrenheit.

This method of obtaining the temperature was relayed to subsequent shifts via the Unit Two Turbine Building Equipment Attendant Turnover Sheet, perpetuating the error.

The Tech Spec temperature limit for the Division 22 Cable Spreading Room is 108 Degrees Fahrenheit. During this period the adjoining Unit 2 Lower Cable Spreading Room temperature did not exceed 77 Degrees Fahrenheit as determined by a review of operator rounds. Additionally, the Division 22 Cable Spreading Room was entered every hour by Fire Watch personnel who have been instructed to report any abnormalities to the Main Control Room immediately. It is not considered credible that Fire Watch personnel would enter a room with a temperature of 108 Degrees Fahrenheit or greater or face a temperature change of over 30 Degrees Fahrenheit when entering a room and not view it as abnormal. No such abnormalities concerning the Division 22 Cable Spreading Room area were noted during this period.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME BYRON NUCLEAR POWER STATION	DOCKET NUMBER 0 5 0 0 0 4 5 5	LER NUMBER			PAGE	
		YEAR	SEQ. NUMBER	REVISION		
		9 4	- 0 0 1	- 0 0	0 3	OF 0 4

TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]

B. DESCRIPTION OF EVENT: (continued)

On third shift on February 19, 1994 a different Unit 2 Turbine Building Equipment Attendant asked a different Unit 2 Shift Supervisor if the repaired 2TIC-VX03 could be used to take the Division 22 Cable Spreading Room temperature. The Unit 2 Shift Supervisor accompanied the Equipment Attendant to the Division 22 Switchgear Room to check out the indicator. The Unit 2 Shift Supervisor asked the Equipment Attendant where they had been taking the temperature and when the Equipment Attendant told him, the Unit 2 Shift Supervisor realized that this was not the location required by Tech Specs.

The immediate corrective action was that the Unit 2 Shift Supervisor explained to the Equipment Attendant where the proper location for the temperature reading was and the Equipment Attendant took the correct temperature as instructed and turned the location information over on his turnover.

There was approximately 21 days between temperature readings in the Division 22 Cable Spreading Room. This exceeds the Tech Spec requirement of checking that temperature every 12 hours.

No manual or automatic safety system actuations occurred as a result of this event. Stable plant conditions were maintained at all times.

This event is reportable per 10CFR 50.73(a)(2)(i)(B) as operation prohibited by Technical Specifications.

C. CAUSE OF EVENT:

The cause of this event was the improper determination of the location for obtaining the temperature reading during repairs for the 2TIC-VX03. This was due to personnel error on the part of the first Unit 2 Shift Supervisor giving the first Equipment Attendant directions to take the temperature from the Division 22 Cable Tunnel. This error occurred because of confusion on the physical layout of the adjoining rooms and cable tunnel.

A contributing factor to the duration of the event was that after the first turnover of the modified method for obtaining the required temperature, the Equipment Attendants assumed that the Division 22 cable tunnel entrance cover had been removed to allow access for obtaining that required reading.

D. SAFETY ANALYSIS:

There were no safety consequences impacting plant or public safety as a result of this event.

During this period the adjoining Unit 2 Lower Cable Spreading Room temperature did not exceed 77 Degrees Fahrenheit as determined by a review of operator rounds. Additionally, the Division 22 Cable Spreading Room was entered every hour by Fire Watch personnel who have been instructed to report any abnormalities to the Main Control Room immediately. No such abnormalities concerning the Division 22 Cable Spreading Room area were noted during this period.

E. CORRECTIVE ACTIONS:

The Shift Supervisor who determined the incorrect location was counseled on attention to detail and on using available resources for making decisions effecting plant operations.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME	DOCKET NUMBER	LER NUMBER			PAGE	
		YEAR	SEQ. NUMBER	REVISION		
BYRON NUCLEAR POWER STATION	0 5 0 0 0 4 5 5	8 4	- 0 0 1	- 0 0	0 4	DF 0 4

TEXT Energy Industry Identification System (EIS) codes are identified in the text as [XX]

F. RECURRING EVENTS SEARCH AND ANALYSIS:

There have been two examples of missed Tech Spec Surveillances since 1992.

LER 455: 93-002, Verification of Unit 1 SX Availability to Unit 2 not Performed

This event was caused by an error in completing a surveillance. The surveillance was subsequently revised. These corrective actions would not have prevented this event.

LER 455: 93-006, Surveillance for Source Range Instrumentation not Performed due to Incorrect Status Update

The corrective actions for this event were for the surveillance tracking system and would not have prevented this event.

G. COMPONENT FAILURE DATA :

No component failed during this event.