

LICENSEE EVENT REPORT

CONTROL BLOCK: 1

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

1 | T | N | S | P | 1 | 2 | 0 | 0 | - | 1 | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 1 | 5

1 | L | 6 | 0 | 5 | 10 | 10 | 10 | 3 | 2 | 7 | 2 | 0 | 0 | 1 | 1 | 8 | 2 | 0 | 0 | 9 | 2 | 4 | 8 | 2 | 2

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

2 | Unit 1 in mode 3 with RCS temperature and pressure at 450 degrees F and 1600 psig
3 | commencing with routine shutdown operations. The annulus door (A65) was left open
4 | along with the access door (A64) causing both trains of the emergency gas
5 | treatment system (EGTS) to be declared inoperable. This caused entry into
6 | LCO 3.0.3 from LCO 3.6.1.3. Previous occurrences - none.

7 |
8 |
9 |

SYSTEM CODE: S | C | 11
 CAUSE CODE: A | 12
 CAUSE SUBCODE: X | 13
 COMPONENT CODE: Z | Z | Z | Z | Z | Z | 14
 COMP. SUBCODE: Z | 15
 VALVE SUBCODE: Z | 16
 LE/RD REPORT NUMBER: 17
 EVENT YEAR: R | 2 | 27
 SEQUENTIAL REPORT NO: 1 | 0 | 7 | 24
 OCCURRENCE CODE: 0 | 1 | 28
 REPORT TYPE: T | 30
 REVISION NO.: 0 | 32
 ACTION TAKEN: R | 18 | X | 19 | Z | 20
 FUTURE ACTION: Z | 21
 EFFECT ON PLANT: Z | 25
 SHUTDOWN METHOD: Z | 26
 HOURS: 0 | 0 | 0 | 0 | 37
 ATTACHMENT SUBMITTED: Y | 23
 NPD-4 FORM SUB.: N | 24
 PRIME COMP. SUPPLIER: L | 25
 COMPONENT MANUFACTURER: X | 9 | 9 | 9 | 44

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 | The interlocks on door A64 and A65 apparently were inoperable. The interlocks are
11 | being investigated and will be repaired or modified at the earliest possible time
12 | and necessary administrative controls will be established to ensure that all
13 | doors required to maintain auxiliary building or annulus pressures are operated
14 | properly.

FACILITY STATUS: D | 78 | 0 | 0 | 0 | 29 | OTHER STATUS: NA | 30
 METHOD OF DISCOVERY: A | 31 | DISCOVERY DESCRIPTION: Operator observation | 32

ACTIVITY RELEASED: Z | 33 | Z | 34 | AMOUNT OF ACTIVITY: NA | 35
 LOCATION OF RELEASE: NA | 36

PERSONNEL EXPOSURES: 0 | 0 | 0 | 0 | 37 | Z | 38 | DESCRIPTION: NA | 39

PERSONNEL INJURIES: 0 | 0 | 0 | 0 | 40 | DESCRIPTION: NA | 41

LOSS OF OR DAMAGE TO FACILITY: Z | 42 | DESCRIPTION: NA | 43

PUBLICITY ISSUED: N | 44 | DESCRIPTION: NA | 45

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NRC USE ONLY

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LER SUPPLEMENTAL INFORMATION

SQRO-50-327/82107 Technical Specification Involved: 3.0.3

Reported Under Technical Specification: 6.9.1.12.b

Date of Occurrence: 09/11/82 Time of Occurrence: 2200 CST

Identification and Description of Occurrence:

During shutdown operations, the annulus door (A65) was left open along with the access door (A64) causing both trains of the emergency gas treatment system (EGTS) to be declared inoperable. This caused entry into LCO 3.0.3 from LCO 3.6.1.8.

Conditions Prior to Occurrence:

Unit 1 in mode 3, 0% power, with RCS temperature and pressure at 450 degrees F and 1600 psig.

Background:

Offsite test personnel had come onsite to test penetrations as required by surveillance instruction (SI) 157, "Testable Penetrations."

On September 11, 1982, the shift engineer was notified that the test group would be performing SI-157 which involves annulus entry. The test group proceeded to the annulus access area and security personnel unlocked the annulus door for them. The annulus door (A65) was opened with relative ease by an individual in the test group. Door A65 was left open for access of personnel and a test line into the annulus. Door A64 (an access door into the penetration room where the annulus door is) was also left open.

At 2200 hours on September 11, 1982, the shift engineer was notified by telephone that the annulus door was open. The shift engineer took action to verify this and an assistant unit operator was sent down to shut and secure the door. This area at the time was a dress out area. Door A65 was eventually closed and secured at 2320 hours.

Causes of Occurrence:

The interlocks on doors A65 and A64 were inoperable allowing both doors to be opened at the same time. The test personnel were not aware that opening both doors would cause the EGTS to be inoperable. There were no signs on doors A64 and A65 to indicate that if A65 is open A64 should be closed and vice versa. The SI-157 required shift engineer notification and signature but did not contain precautions regarding the significance of the doors.

Analysis of Occurrence:

A contributing factor to A65 being left open was the fact that the test personnel opened the door with relative ease. This was due to the fact that an annulus purge was in progress and the normal pressure differential causing the A65 door to be difficult to open did not exist. When the door was closed, the vacuum was returned because purging operations had stopped.

An analysis was performed to evaluate the consequences of a loss of coolant accident with the EGTS inoperable as described above. The analysis was performed using conservative assumptions. The results of this analysis indicated that less than one tenth of one percent of 10 CFR 100 limits would be reached.

The unit one reactor continued shutdown to mode 5 and will eventually go to mode 6 for this refueling outage.

Immediate Corrective Actions:

The door was closed and secured at 2320 hours on 09/11/82. An investigation was initiated to determine the causes and contributing factors to this event.

Corrective Actions to Prevent Recurrence:

Investigation revealed that the interlocks on doors A64 and A65 may not be strong enough for normal use. The interlocks will be modified or replaced to ensure that doors A64 and A65 are operated properly. Also, interlocks on other doors required to maintain auxiliary building or EGTS operability will be evaluated. A preventive maintenance or surveillance program will be established on these interlocks. Administrative controls in the form of signs will be posted on these vital doors to prevent inadvertent opening if interlocks fail. SI-157 will be revised to include the significance of the annulus doors with regard to EGTS operability.