WRC FORM 366 U.S. NUCLEAR REG (5-92)						REGULATOR	RY COMM	ISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95					
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TITLE (4) Au	tomat	ic Clos	ure of four	Drywel	ll Chi	lled	Water	r Syste	m Inboard	Contai	nmen	t	
Isol	ation	Valv	es Due	to an Inady	vertent	Loss	of Po	wer	to a Re	lay in th	e Closi	ng C	ircuit	
EVEN	T DATE	(5)		LER NUMBER (6)		REPOR	RT DATE	(7)		OTHER FACILITIES INVOLVED (8)			(8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME			DOCKET NUMBER		
01	27	95	95 -	003	0	02	27	95	FACILITY NAME			DOCKET NUMBER		
OPERA	TING	T	THIS REP	PORT IS SUBMITTE	D PURSUANT	TO THE	REQUIR	EMENTS	OF 10 CFR	S: (Check of	one or more	e) (11)	
MODE (9) 3 20.402(b)			20.405(c)			X 50.73(a)(2)(1v)			73.71(b)					
POW	ER	T	20.40	05(a)(l)(i)		50.36(c)(1)	-		()	73.71(c)			
LEVEL (10) 000 20.4			20.405(a)(1)(11)			50.36(c)(2)			50.73(a)(2)(v11)			OTHER		
			20.40	20.405(a)(1)(111)			50.73(a)(2)(1)			50.73(a)(2)(V111)(A)		- Abstract below		
			20.40)5(8)(1)(1V)		50.73(8)(2)(11)			50.73(a)(2)(V111)(B)			and in Text.		
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J. L	. Kan	tner,	Manage	er - Experie	ence As	sessme	nt, I	GS		(610)718	3-3400			
			COMP	LETE ONE LINE FO	DR EACH CO	MPONENT I	FAILURE	DESCR	IBED IN TH	HIS REPORT (1	3) T			
CAUSE	SYST	EM C	OMPONENT	MANUFACTURER	TO NPRD	S	0	AUSE	SYSTEM	COMPONENT	MANUFACT	URER	TO NPRDS	
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YES (If yes, complete EXPECTED SUBMISSION DATE).				x	ON		SUBMISSION DATE (15)							

On January 27, 1995, at 1145 hours, while investigating an apparent loss of power to a main control room (MCR) recorder, a licensed Operations Supervisor attempted to reset the circuit breaker feeding power to the recorder which appeared to be in the "tripped" condition. This action caused a momentary loss of power to an interposing relay in the closure circuit for four Drywell Chilled Water (DWCW) System containment isolation valves that resulted in inadvertent closure of the valves. This cause of the valve closure was immediately recognized by MCR Operations personnel, and the valves were reopened. There was no adverse effect on the plant, and there was no release of radioactive material to the environment as a result of this event. The breaker handle was in the mid-position even though the breaker was closed in. The breaker was subsequently examined and determined to now be functioning properly. No further actions for the breaker are planned.

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NRC FORM 366A (5-92)	U.S. NUCLEAR	APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95						
	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION			ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001. AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104). OFFICE OF MANAGEMENT AND BUDGET WASHINGTON DC 20503				
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Unit Conditions Prior to the Event

At 1000 hours on January 27, 1995, Unit 2 was shut down for its scheduled third refueling outage. At the time of this event, the unit was in Operational Condition (OPCON) 3 (Hot Shutdown) with reactor pressure at 500 psig and temperature at approximately 465 degrees F. Main control room (MCR) personnel noted that the 2B Post Accident Monitor (PAM) recorder (EIIS:LR/PR) was not responding to reactor vessel pressure and water level changes. Although this recorder is not required to be operable in OPCON 3, Operations personnel identified the malfunction during post scram review following plant shutdown and were deliberately investigating this condition at the time of this event.

Description of the Event

Operations personnel initially suspected that the condition of the 2B PAM recorder was due to a loss of power. An Operations Support Engineer investigated the recorder's electrical power supply, and at approximately 1130 hours, called the MCR and identified the power supply as circuit breaker 23 (EIIS:52/BKR) located in 120 Vac instrument panel 20Y102 (EIIS:PI). A licensed Operations Supervisor was dispatched to the electrical panel for further investigation. Upon arrival at the panel, the Operations Supervisor noted that circuit breaker 23 appeared to be in the tripped-free condition. He purposely contacted the Unit 2 MCR Shift Supervisor to report his findings and to obtain permission from the Unit 2 Shift Supervisor to reset the breaker.

Permission was granted, and at 1145 hours on January 27, 1995, the Operations Supervisor attempted to reset the circuit breaker by opening and then closing the breaker. The breaker properly reset to the full closed position. The Operations Supervisor then contacted the Unit 2 MCR Shift Supervisor to determine the results of resetting the breaker. The Unit 2 Shift Supervisor reported that the 2B PAM recorder was still not functioning properly. The Unit 2 Shift Supervisor also stated that he had just received a low cooling water flow alarm (EIIS:FA) for the Drywell Chilled Water (DWCW) System (EIIS:KM).

The low cooling water flow alarm was the result of four (4) DWCW system supply and return line valves (EIIS:ISV) (HV-087-222, 223, 228 and 229) closing. Operations personnel recognized this condition as the result

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of resetting the circuit breaker, and immediately opened the four valves.

A four hour notification was made to the NRC at 1531 hours on January 27, 1995, in accordance with the requirements of 10CFR50.72(b)(2)(ii) since these valves are part of the Primary Containment Isolation System (EIIS:JM), an engineered safety feature (ESF). This report is submitted in accordance with the requirements of 10CFR50.73(a)(2)(iv).

Analysis of the Event

Subsequent investigation revealed that the four DWCW valves closed due to the momentary loss of power to an interposing relay (EIIS:RLY) in the valve closure circuits when the 20Y102 panel, circuit breaker 23 was cycled opened and closed. The valves responded as expected for a loss of power to the interposing relay in the valve closure circuit.

The ongoing communications between the Operations Supervisor at the local electrical panel and MCR Operations personnel resulted in timely identification of the cause for the loss of cooling water flow alarm and subsequent actions to restore the DWCW system to service within minutes thereby preventing any adverse effects on the plant. There was no release of radioactive material to the environment as a result of this event.

If corrective actions had not been taken quickly by licensed MCR Operations personnel, the potential existed for temperatures to increase in the drywell. This would have resulted in a high drywell temperature alarm and subsequent response by the operators.

Cause of the Event

The cause of this event was false circuit breaker status indication which led the Operations Supervisor to reach an inaccurate conclusion about the status of the circuit breaker. Upon arrival at the electrical panel, the Operations Supervisor noted that circuit breaker 23 appeared to be in the "tripped" position, i.e., the breaker handle was in mid-position rather than in the full closed position as would be expected for a "live" breaker. The resultant impact of resetting the breaker on other plant equipment indicates that the breaker was not actually tripped free. However, the Operations Supervisor was able to

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successfully return the breaker handle to the full closed position after resetting the breaker.

The following contributing factors to this event were also identified.

The Operations Supervisor was biased by the initial determination as to the cause of the recorder's condition. Operations personnel initially suspected that the condition of the recorder was due to a loss of power. When the Operations Supervisor approached the local electrical panel, he found exactly what he expected to find, and that was a "tripped" breaker.

The communications between the Operations Support Engineer and the Operations Supervisor was less than adequate. These communications failed to include relevant information such as other devices that are also supplied 120 Vac electrical power from circuit 23 of panel 20Y102.

The Operations Supervisor failed to follow appropriate guidelines for resetting protective devices. Operations Manual (OM), Chapter OM-C-7.2, "Resetting Protective Devices and Restoring Power," includes expectations for performing an appropriate technical review to identify and prevent inadvertent actuations prior to resetting protective devices. In this situation, electrical prints were not reviewed by the Operations Supervisor to determine other devices that are supplied 120 Vac power from circuit 23 on panel 20Y102. He believed that the circuit was already in the "tripped" condition and resetting the breaker would have no impact on other plant equipment.

Corrective Actions

The 2B PAM recorder was replaced with a new device.

Upon resetting the circuit breaker 23, the Operations Supervisor was able to return the breaker to the normal full closed position. Therefore, no further immediate action was taken at that time. The breaker was subsequently examined and determined to now be functioning properly. No further actions for the breaker are planned. All other breakers in the 20Y102 panel were observed to be in the correct position.

Each Shift Manager reviewed OM-C-7.2 with their work teams. The following items were stressed: ensuring a technical review, using

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prints, to identify or prevent inadvertent actuations prior to resetting a device and ensuring a technical review is performed on components and logic circuits prior to reenergization.

A training bulletin was issued on February 27, 1995, which highlights the need to ensure complete communications and reinforce the need to have a questioning attitude when performing plant activities.

Previous Similar Occurrences

None