

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Prairie Island Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 0 6	PAGE (3) 1 OF 0 2
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TITLE (4)
Both SI Suction Valves from RWST Inadvertently Opened

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
0 6	1 8	8 4	8 4	0 0 1	0 0	0 7	1 8	8 4	
									DOCKET NUMBER(S) 0 5 0 0 0

OPERATING MODE (9) N

POWER LEVEL (10) 1 0 0

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

20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(e)(1)	50.73(a)(2)(v) <input checked="" type="checkbox"/>	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 366A)
20.405(a)(1)(iii)	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)(vii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Arne A Hunstad, Staff Engineer	TELEPHONE NUMBER AREA CODE 6 1 2 3 8 8 - 1 1 2 1
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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

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)

During normal operation and with No. 21 Boric Acid Storage Tank out of service, a safeguards logic test was performed. During the test, due to a procedural inadequacy, the logic for opening the safety injection suction valves from the refueling water storage tank was satisfied. Upon discovery of the open valves they were immediately closed. Procedures were revised to prevent recurrence.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Prairie Island Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 0 6	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	0 0 1	0 0	0 2	OF	0 2

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

Each unit has a dedicated boric acid storage tank (TK) (BAST), No. 11 for Unit 1, No. 21 for Unit 2. There is also an installed spare tank, No. 121, which can be aligned to either unit to allow maintenance on a unit's dedicated tank.

On June 18th No. 21 BAST was out of service for tank level instrument calibration; all the tank level bistables were tripped. Unit 2 was aligned to No. 121 BAST and Unit 1 to No. 11. At 0740 the monthly safeguards logic test was started on Unit 1. Part of the procedure calls for repositioning of the BAST selector switch so that actuation logic of No. 121 BAST can be tested for Unit 1. This switch position also aligns Unit 2 to No. 21 BAST. The procedure cautions the operator to verify adequate levels in all tanks before repositioning the selector switch; this was done, but the operator had no information to indicate the No. 21 BAST level bistables were tripped. When the selector switch was repositioned, the low level logic for No. 21 BAST was satisfied and the safety injection (SI) (BQ) suction valves (ISV) from the refueling water storage tank (TK) (RWST) then opened. The only Control Room indication of this action was valve position lights; no audible alarm is generated. The BAST selector switch was returned to its previous position within two minutes, but the valves remained open since manual action is required to close them. About one hour and 55 minutes after the event, a Shift Supervisor noticed the valve position light indications (IL) and took action. The valves were immediately closed.

If an SI had been initiated during the time the valves were open, both the BAST and RWST could have been open to the suction of the SI pumps (P) and since the RWST had a higher head, only RWST water at 1950 ppm boron would have been supplied instead of the 20000 ppm boron from the BAST. Concentrated boric acid is required only for the large steam line break accident, and then is only significant at end of core life at hot shutdown.

Cause of the event was procedural. Corrective actions were:

1. The valves were immediately closed.
2. A SECURE card was placed on the BAST selector switch.
3. Involved personnel have reviewed the event.
4. All procedures related to BAST switching and logic testing were reviewed and changed where necessary.



Northern States Power Company

414 Nicollet Mall
Minneapolis, Minnesota 55401
Telephone (612) 330-5500

July 18, 1984

U S Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

PRAIRIE ISLAND NUCLEAR GENERATING PLANT
Docket No. 50-306 License No. DPR-60

Both SI Suction Valves From RWST Inadvertently Opened

The License Event Report for this occurrence is attached.

This event was reported via Emergency Notification System per 10 CFR Part 72 on June 18, 1984.

Eugene F. Eckholt

for David Musolf
Manager - Nuclear Support Services

DMM/EFE/bd

c: Regional Administrator-III, NRC
NRR Project Manager, NRC
Resident Inspector, NRC
MPCA
Attn: J W Ferman

Attachment

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