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November 10, 1995
NPD1VPO:0402

Beaver Valley Power Station, Unit No. 1
Docket No. 50-334, Licensee No. DPR-66
LER-95-008-00

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

In accordance with Appendix A, Beaver Valley Technical Specifications, the following Licensee Event Report is submitted:

LER 95-008-00, 10 CFR 50.73.a.2.i.B, "Technical Specification 3.0.3 Entry Due to Isolation of Control Room Emergency Habitability System".

T. P. Noonan
Division Vice President
Nuclear Operations/Plant Manager

JHK/jcd

Attachment

cc: Mr. T. T. Martin, Regional Administrator
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FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Beaver Valley Power Station Unit 1	05000334	1 OF 3

Technical Specification 3.0.3 Entry Due to Isolation of Control Room Emergency Habitability System

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 NAME	DOCKET NUMBER
10	13	95	95	008	00	11	10	95	Beaver Valley Unit 2	05000412
									FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 20 CFR ξ (Check one or more) (11)							
POWER LEVEL (10)	100		20.402(b)		20.405(c)		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
			20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in abstract below and in Text NRC Form 366A)
			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)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (include Area Code)
T. P. Noonan, Division Vice President Nuclear Operations/Plant Manager	(412) 393-7622

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS				COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
X	IL	XXXX	XXXX	N						

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (if yes, complete EXPECTED SUBMISSION DATE)	X	NO				

ABSTRACT (Limited to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On 10/13/95 at 0914 hrs., with both Units at full power, a spurious Train A Control Room Emergency Habitability System (CREHS) actuation occurred during a radiation monitor source check. A health physics technician was performing a quarterly source check on the monitors, per an inventory verification procedure which allows for inference of source material by verifying monitor response. The check source button is depressed which inhibits control room alarms and blocks a CREHS actuation on high control room radiation. The source check was performed on the Train B monitor first without any problems or alarms. During the check of the Train A monitor a spurious CREHS actuation occurred, and the air bottles began discharging into the common Beaver Valley control rooms. After verifying that no valid actuation signals existed, an operator was dispatched to isolate the air bottles. This was performed to maintain the air bottles above the Technical Specification (TS) limit of 1825 psig, and to eliminate the need to recharge the air bottles prior to returning them to service. The bottles were isolated at 0917 hrs., which intentionally placed both Beaver Valley Units in TS 3.0.3. After the high radiation alarm cleared, the Train A signal was reset and the air bottles were unisolated at 0936 hrs., and TS 3.0.3 was exited. All of the air bottles remained above the TS value of 1825 psig.

DESCRIPTION OF EVENT

On October 13, 1995 at 0914 hours, with both Units in Operational Mode 1 at full power, a spurious Train A Control Room Emergency Habitability System actuation occurred during a radiation monitor source check. A health physics technician was performing a source check on the control room radiation monitors, RM-1RM-218A and RM-1RM-218B, in accordance with a quarterly source inventory verification procedure. The health physics procedure allows for inference of source material contained in radiation monitoring equipment by verifying a proper operational response check. The check source pushbutton is depressed which inhibits control room annunciators and blocks a Control Room Emergency Habitability System actuation on high control room radiation while the radiation source is exposed to the detector. The radiation source strength is greater than the high alarm setpoint for the radiation monitor.

The source check was performed on the Train B monitor (RM-1RM-218B) first without any problems or alarms. During the check of the Train A monitor (RM-1RM-218A), as the detector's response rose above the high alarm setpoint, a spurious Control Room Emergency Habitability System actuation occurred, and the Control Room Emergency Habitability Air Bottles began discharging into the control rooms. Both Beaver Valley control rooms share a common pressure boundary envelope. After verifying that no valid actuation signals existed at either Unit, an operator was dispatched to isolate the air bottles. This action was taken to maintain the air bottles above the Technical Specification limit of 1825 psig, and to eliminate the need to recharge the air bottles prior to returning them to service. The bottles were isolated at 0917 hours, which intentionally placed both Beaver Valley Units in Technical Specification 3.0.3.

After the high radiation alarm cleared, the Control Room Emergency Habitability System was restored in accordance with operating manual procedure 1/2OM-44A.4A.A, Post Control Room Habitability System Actuation/Recovery. The Train A signal was reset and the air bottles were unisolated at 0936 hours, and Technical Specification 3.0.3 was exited at this time. All of the air bottles remained above the Technical Specification value of 1825 psig.

It should be noted that prior to this event, on October 12, 1995, an Operations Surveillance Test, 1/2OST-43.17A, Control Room Area Monitor [RM-1RM-218A] Functional Test, was performed. The surveillance test performs a source check of the monitor. No abnormal alarms or actuations occurred during the source check.

CAUSE OF EVENT

An investigation into the cause of the spurious Control Room Emergency Habitability System is continuing by the Instrumentation and Control Department. Operations Surveillance Test 1/2OST-43.17A was performed on RM-1RM-218A on November 2, 1995. No abnormal alarms or actuations occurred during the source check.

CORRECTIVE ACTIONS

1. As an interim measure, a caution tag was placed on the check source pushbutton for RM-1RM-21[illegible] to prevent operation without authorization from the Nuclear Shift Supervisor.

2. Additional corrective actions will be implemented following the ongoing investigation by the Instrumentation and Control Department.

3. Health Physics will eliminate the quarterly source check, and instead will rely on the source check conducted by Operations during routine surveillance testing.

REPORTABILITY

Entry into Technical Specification 3.0.3 is considered a condition prohibited by Technical Specifications. This written report is being submitted in accordance with 10 CFR 50.73.a.2.i.B.

SAFETY IMPLICATIONS

There were no safety implications as a result of this event. The Control Room Emergency Habitability System functioned as designed upon receipt of an actuation signal. Since the bottles were isolated in a timely manner, the air bottle subsystem remained above the Technical Specification limit of 1825 psig. This minimized the time in Technical Specification 3.0.3 by eliminating the need to repressurize the air bottles. The subsystem was inoperable solely because it was manually isolated for 19 minutes, during which it could have been returned to service if a valid need arose, as an operator was stationed at the bottle isolation valves for this purpose.

SIMILAR EVENTS

The following similar events have been previously reported regarding the isolation of the Control Room Emergency Habitability System air bottles and entry into Technical Specification 3.0.3:

Beaver Valley Power Station Unit 1:

LER 93-003 - involved a spurious signal on a radiation monitor while manipulating a monitor control switch during testing.

LER 95-005 - involved an electrical noise spike on either the control room radiation monitor drawer or a containment high range monitor drawer, which are physically adjacent in the rack in the control room.

Beaver Valley Power Station Unit 2:

LER 95-001 - involved a spurious signal on a radiation monitor during reconnection of a power connector on a containment high range radiation monitor.

LER 95-002 - involved a spurious signal caused by an alligator clip accidentally contacting an adjacent terminal while installing an electrical jumper for testing.