James A. FitzPatrick
Nuclear Power Plant
P.O. Box 41
Lycoming, New York 13093
315 342-3840

New York Power Authority

Harry P. Salmon, Jr.
Resident Manager

June 18, 1992
JAFP-92-0476

United States Nuclear Regulatory Commission
Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: DOCKET NO. 50-333
LICENSEE EVENT REPORT: 92-026-00 - Radwaste Building Vent Isolation Due to Personnel Error

Dear Sir:

This Licensee Event Report is submitted in accordance with 10 CFR 50.73(a)(2)(iv).

Questions concerning this report may be addressed to Mr. W. Verne Childs at (315) 349-6071.

Very truly yours,

HARRY P. SALMON, JR.

HPS/WVC/mam

Enclosure

cc: USNRC, Region I
USNRC Resident Inspector
INPO Records Center

Cont No P06A705A86

IE22
1/1

NRC FORM 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
JAMES A. FITZPATRICK NUCLEAR POWER PLANT	0 5 0 0 0 3 3 3	1 OF 0 4

TITLE (4): Radwaste Building Vent Isolation Due to Personnel Error

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	DOCKET NUMBER(S)
0 5	1 9	9 2	9 2	–	0 2 6	– 0 0	0 6	1 8	9 2		0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 0 0	20.402(b)	20.405(c)	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 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)(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
	AREA CODE
W. Verne Childs, Senior Licensing Engineer	3 1 5 3 4 9 – 6 0 7 1

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)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

EIIS Codes are in [ ]

The plant was shutdown and in the cold condition for maintenance and refuel. On May 19, 1992, the Radwaste Building [NE] Ventilation System [VH] automatically isolated after receiving a downscale signal from both exhaust radiation monitors [IL]. This was caused by switching off power to monitor A when power to monitor B was already removed. Instead of tagging the B monitor off switch in the off position, an operator turned the A monitor switch off by mistake.

Automatic system functions associated with the event functioned as designed. Monitor A was returned to service, and Radwaste Building Ventilation was restored to normal. The person involved was counseled on the use of self-verification. LER90-021, 90-028, 89-003, 89-017, and 88-002 are similar events (since 1988) referencing Engineered Safety Feature actuation due to personnel error.

EIIS Codes are in [ ]

Event Description

The plant was shutdown and in the cold condition for maintenance and refuel. The B radiation monitor [IL] of the Radwaste Building [NE] Ventilation System [VH] was removed from service in order to perform preventative maintenance on the associated B exhaust monitor sample pump. The A radiation monitor was verified operable prior to removing the B radiation monitor from service. Instrument and Control personnel were instructed to decrease to a minimum the B radiation monitor detector high voltage according to approved procedure. The shift supervisor then authorized the hanging of two tags removing the equipment from service. An auxiliary operator was instructed to hang the tags for the B radiation monitor detector high voltage and the circuit breaker. Before leaving the main control room the auxiliary operator confirmed that the A radiation monitor was operable.

The operator proceeded to the area housing both radiation monitors and turned off the A radiation monitor detector high voltage switch and hung the Special Condition Tag for the B radiation monitor detector high voltage switch on the A radiation monitor detector high voltage switch.

The downward trend reading on the A radiation monitor was noticed in the main control room [NA]. Main control room [NA] personnel attempted to contact the operator using the plant Public Address system. Communication with the operator could not be established in sufficient time to have him correct the error and prevent system isolation.

The system isolated as designed and all activities to return the system to service were performed according to an approved procedure. A critique of the event was held within three hours of the occurrence.

Cause

Isolation of the system was caused by a personnel error (cause code A) when an operator inadvertently removed detector high voltage from the A monitor instead of tagging the detector high voltage switch on the B monitor, which had previously been removed from service in accordance with procedure.

The auxiliary operator did not perform a proper self-verification prior to turning off and tagging the wrong switch. The individual involved has been an operator at this plant for a number of years and is knowledgeable about the plant and the equipment. This event occurred at approximately eight hours into a ten hour shift. When questioned, the individual did not feel that fatigue was a factor.

Both radiation monitor switches are located in the same area, and approximately three feet apart. Lighting is adequate, and name plates are visible. Current name plates are white with black lettering. Color coded name plate placards are scheduled to replace the current labels.

When power was removed from the A monitor, a display in the control room alerted the control room operators and shift supervisor to the error. The main control room tried to contact the operator by using the plant-wide Public Address system. There was not much more than a minute available to correct the error and communications with the auxiliary operator hanging the tag could not be established in sufficient time to correct the error. The plant-wide Public Address system is the common method of communication used for routine operations activities. Other methods such as radio communication between the control room and operators are not used due to problems with radio signals causing undesired effects in the main control room.

The FitzPatrick Plant philosophy for the performance of independent review includes the review of protective tag preparation, and hanging the tag. Independent review was performed and signed off for the preparation and issuance of the protective tags. Independent review is also performed on the tags after they are placed on the equipment. In order to assure total independence, the second reviewer remains out of line of sight when the tag is hung. This practice is intended to ensure that the tag is hung in the correct location. In this event there was not enough time for the second operator to perform the independent review prior to the isolation occurring.

Analysis

The Radwaste Building Ventilation System automatically isolated as designed. All actions to return the system to service were performed according to approved procedure. System actuation and operator response to the actuation were all according to plant policy and procedures. No safety concerns or significant problems were identified by the event.

This report is being made pursuant to paragraph 50.73(a)(2)(iv), "Any event or condition that resulted in manual or automatic actuation of any Engineered Safety Features (ESF), including the Reactor Protection System (RPS). However, actuation of an ESF, including the RPS, that resulted from and was part of the preplanned sequence during testing or reactor operation need not be reported."

Corrective Action

1. The operator involved was immediately counseled by the Assistant Operations Manager for not using self-verification and disciplinary action is pending. FitzPatrick personnel are instructed to use the practice of self-verification to reduce the probability of this type of error.
2. The individual involved will receive special training from the JAF Training Department which emphasizes the use of self-verification. To be completed by June 30, 1992.

Additional Information

Failed Components: None.

Previously Similar Events:
LER90-021, 90-028, 89-003, 89-017, and 88-002 are similar events (since 1988) referencing Engineered Safety Feature actuation due to personnel error.