

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) BYRON, UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 4 5 4 1	PAGE (3) OF 0 4
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TITLE (4)
INOPERABILITY OF BOTH SI TRAINS

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 1 1	1 8	5 8 5	0 1 1	0 0		0 2 0	8 8	5			0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) **3**

POWER LEVEL (10) **0 0 0**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 50. (Check one or more of the following) (11)

20.402(b)	20.406(a)	90.73(a)(2)(iv)	73.71(b)
20.406(a)(1)(ii)	90.38(a)(1)	90.73(a)(2)(vi)	73.71(a)
20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 90.38(a)(2)	90.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 398A)
20.406(a)(1)(iv)	90.73(a)(2)(ii)	90.73(a)(2)(viii)(A)	
20.406(a)(1)(v)	90.73(a)(2)(iii)	90.73(a)(2)(viii)(B)	
20.406(a)(1)(vi)	90.73(a)(2)(iii)	90.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Erich Wurz, Tech Staff Engineer, Ext. 250	TELEPHONE NUMBER AREA CODE 8 1 5
	2 3 4 - 5 4 4 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS
A	B	Q	/ / / / /	/ / / / /	N				

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)

At 1354 on January 11, 1985 while filling the Safety Injection Accumulators, it was observed by the Shift Control Room Engineer (SCRE) that both SI trains feeding the cold leg injection had been isolated. This violated a Technical Specification Limiting Condition for Operation, since both trains were inoperable.

The isolation occurred when the operator, concerned with overpressurizing the RCS, closed a valve in addition to those listed in the Accumulator Fill procedure.

To prevent recurrence of this situation, all department heads have been notified of the importance of procedural adherence and changes. All department heads will also be notified about addressing Technical Specifications requirement changes upon switching operational modes. Also, there is a station commitment to review all procedures where ECCS systems are involved to verify that the Technical Specifications are upheld.

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

On January 11, 1985, at approximately 1200 hours with the Unit in Mode 3 at 800 psig, an operator was instructed to fill the SI Accumulators. The job was later transferred to another operator. At 1354 while filling the Accumulators, the SCRE noticed that both SI trains feeding the cold leg injection had been isolated and were consequently inoperable. The applicable Limiting Condition for Operation (LCO 3.5.2) was violated due to both trains being inoperable in Mode 3. The isolation of both SI trains resulted from the operator closing both SI pumps A and B discharge line crosstie isolation valves, 1SI8821A and 1SI8821B instead of just 1SI8821A. When the SCRE observed this, he immediately informed the operator to open the B train isolation valve, 1SI8821B. The SI B train thus became operable. At 1411, the Accumulator Fill procedure was completed and the SI system was returned to normal.

The operator, concerned with the possibility of overpressurizing the RCS, closed both discharge lines crosstie isolation valves whereas the procedure stated to close only the A train isolation valve. The Main Body of the procedure was technically correct for the given conditions, so the deviation resulted from the procedure not being followed. The procedure was very restrictive allowing only the SI A pump to be used for raising the Accumulator level.

A temporary Procedure Change Request was immediately initiated to change the procedure to provide awareness of Technical Specifications LCO violations. The procedure has been since permanently revised to allow the use of either SI pump depending on the plant conditions. The procedure states under what conditions each pump can and/or must be used to prevent another LCO violation. In addition, the control board mimic of the Safety Injection System was reviewed and verified to be correct.

As a result of this event other corrective actions will be taken at the station wide level to prevent any similar type of occurrence. These are as follows:

- a). A Daily Orders Memo was written stressing the importance of procedural adherence. It was also noted, in another Daily Orders Memo, that any change to a procedure must be documented; i.e., a Temporary Change Request or a permanent procedure revision. This includes adding steps in an effort to make the procedure safer.
- b). All department heads have been notified of the importance of procedural changes and adherences during station meetings held at 1530, January 17, 1985 and 0800, January 18, 1985.
- c). The station has made a commitment for an initial SRO review of all procedures where ECCS systems are involved, even as a support system to determine those procedures where a similar situation could occur. This initial review has been completed and the operating department, to date, have revised approximately 90% of the affected procedures. The remaining procedures have revisions in progress.

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

d). In an effort to address Technical Specifications requirement changes upon switching operational modes, memos will be sent to all department heads. The department heads will inform respective personnel thereafter.

Because this event was prior to initial criticality, no danger was imposed on the plant nor the public.

Because the valves were operable at all times, the SI trains could have been made available by opening the valves if required.

Previous Occurrences. None

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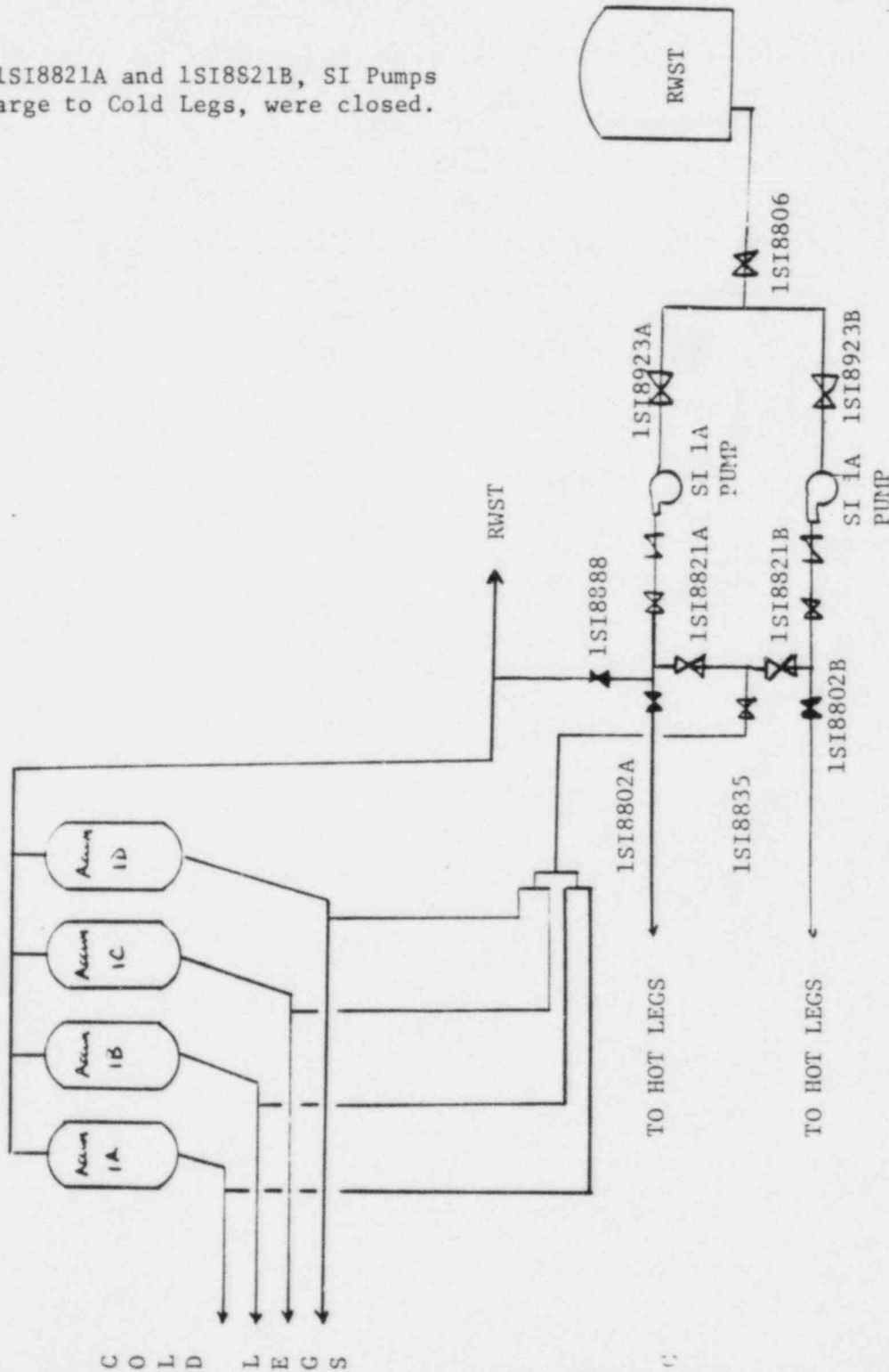
BYRON, UNIT 1

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

Both 1SI8821A and 1SI8821B, SI Pumps Discharge to Cold Legs, were closed.

ILLUSTRATION OF SI INOPERABILITY EVENT





Commonwealth Edison
Byron Nuclear Station
4450 North German Church Road
Byron, Illinois 61010

February 8, 1985

LTR: BYRON 85-0210

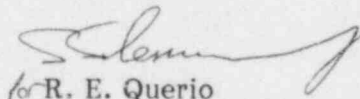
U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Dear Sir:

The enclosed Licensee Event Report from Byron Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.36(a)(2) which requires a 30 day written report.

This report is number 85-011-00, Docket No. 50-454.

Very truly yours,


for R. E. Querio
Station Superintendent
Byron Nuclear Power Station

REQ/vda

Enclosure: Licensee Event Report No. 85-011-00

cc: J. G. Keppler, NRC Region III Administrator
J. Hinds, NRC Resident Inspector
INPO Record Center
CECo Distribution List

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