GPU Nuclear

GPU Nuclear Corporation
Post Office Box 388
Route 9 South
Forked River, New Jersey 08731-0388
609 971-4000
Writer's Direct Dial Number:

January 20, 1988

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

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report Revision

This letter forwards one (1) copy of Licensee Event Report (LER) No. 87-014, Revision 1. Vertical lines in the right side margin indicate those sections of the LER that have been revised.

Very truly yours,

Peter B. Fiedler
Vice President and Director
Oyster Creek

PBF:JR:dmd (#0312A)
Encs.

cc: Mr. William T. Russell, Administrator
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

NRC Resident Inspector
Oyster Creek Nuclear Generating Station
Forked River, NJ 08731

Mr. Alex Dromerick
U.S. Nuclear Regulatory Commission
7920 Norfolk Avenue, Phillips Bldg.
Bethesda, MD 20014
Mail Stop No. 316

IE22
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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Oyster Creek, Unit 1	0 5 0 0 0 2 1 9	1 OF 0 4

TITLE (4) DRYWELL ISOLATION CAUSED BY INCORRECTLY LIFTING A LEAD DUE TO USING A PLANT DRAWING WHICH HAD NOT BEEN UPDATED

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 0 0 0
0 3	0 3	8 7	8 7	0 1 4	0 1	0 1	2 0	8 8		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)	X 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
John Galanto, Operations Engineer	6 0 9 9 7 1 - 4 3 4 9

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)

On March 3, 1987, with the reactor shutdown, an electrical lead termination repair was in progress. An electrician lifted a lead supplying electrical power to the Containment High Range Radiation Monitoring (CHRM) System Channel 2. This caused a containment vent and purge valve isolation. The cause of the event has been attributed to the drawings utilized during the preparation and review of the detailed instructions which did not reflect recent plant modifications. The root cause of the event was a configuration control process deficiency caused by a backlog of documentation awaiting final close-out following system modification. The required information had not been finalized at the time of the event. The lead was relanded and the isolation reset. After reviewing the situation and prior to resuming maintenance, the control room operators bypassed the CHRM system isolation function. A revision to the computerized drawing control system has been implemented which will identify drawings affected by scheduled modifications. Procedures will be revised to require a summary of all drawing changes resulting from a modification to be available at the time the modification is turned over to the plant division. The safety significance of this event is considered minimal as the vent and purge valve isolations had no adverse effect on plant systems.

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

DATE OF OCCURRENCE

The event occurred March 3, 1987, at approximately 0955 hours.

IDENTIFICATION OF OCCURRENCE

A lifted lead caused an electrical power interruption to a Containment High Range Radiation Monitoring System relay (EIIS System Code JM, Component RLY-3) associated with channel 2. The result was a containment vent and purge valve isolation. This event is reportable under 10CFR50.73.a.2.iv.

CONDITIONS PRIOR TO OCCURRENCE

The reactor was in the SHUTDOWN mode with reactor coolant temperature approximately 160°F. As a result of a plant scram due to a loose wire termination, (LER 87-011), an extensive wire termination integrity inspection was being performed. Repairs to defective terminations were underway at this time.

DESCRIPTION OF OCCURRENCE

On March 3, 1987, at 0955 hours, a containment vent and purge valve isolation occurred when an electrician performing a repair lifted a lead supplying electrical power to the CHRM System channel 2 control relay, which deenergized causing the containment vent and purge valves to close. The lead was relanded and the isolation signal was reset. Steps were then taken to allow completion of the repair by bypassing the CHRM system isolation function. An immediate report was not filed as required by 10 CFR 72(b)(c)(vi)(2).

APPARENT CAUSE OF OCCURRENCE

The cause of this occurrence is attributed to an inadequate document update for recent plant modifications which led to incorrect instructions being provided by the job planner and engineer who reviewed and approved the planned evolution. This resulted in an unplanned challenge to the containment vent and purge isolation valves. The instructions to lift the lead were prepared by the job planner who performed a physical walkdown of the job. One lead inscalled at the termination did not appear on the wiring diagram as it was part of a newly installed modification. The lead number was identified and by using additional drawings, the planner determined that this lead supplied power to CHRM system channel 2. The job planner was unaware of any automatic functions associated with the CHRM system and did not research any further. The engineer performing the

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review was also unaware of the isolation function associated with deenergizing the CHRM system. The drawings reviewed did not provide any indication of an isolation function associated with the CHRM system. Additional reviews were not utilized because the assigned engineer believed that only the monitor would be affected and it was not required to be operable. The CHRM indication system and the valve isolation function were installed as two separate modifications during the last refueling outage. Although familiar with the CHRM indication System, the assigned engineer was unaware of any automatic valve isolations.

The root cause of the event was a configuration control process deficiency caused by a backlog of documentation awaiting final close-out following system modification. The required information had not been finalized and released at the time of the event.

ANALYSIS OF OCCURRENCE

The Containment High Range Radiation Monitoring System was installed to provide a backup to the existing containment isolation signals as required by NUREG 0737, (containment purge and vent isolation valves shall close on a containment high radiation signal). When electrical power was interrupted, the system performed as designed causing a containment vent and purge valve isolation. The safety significance of this event is considered minimal as the protective functions challenged had no adverse effect on plant related systems.

CORRECTIVE ACTION

The lead was relanded and the isolation signal reset. A review of electrical drawings was performed by the electricians and control room personnel. The Containment High Range Radiation Monitoring system isolation function was bypassed to prevent further challenges to the Reactor Protection System during the lead repair.

A revision to the computerized configuration control system (CARIRS) procedures has been implemented. It will identify As-Built drawings affected by construction drawings for scheduled modifications.

Procedures will be revised to require a summary of all drawing changes resulting from a modification to be available at the time the modification is turned over to the plant division.

With respect to the failure to make an immediate report as required, strict guidance was given to Operations management to be more aggressive in strictly interpreting the reporting requirements of 10CFR50.72, (i.e. when in doubt, report).

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SIMILAR EVENTS

LER 87-11 High RPV Level Turbine Trip/Scram Caused By Loss of Feedwater Signal Due to Procedural Inadequacy

LER 84-17 Inadvertant Repositioning of Containment Isolation Valves

0312A