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)
Kewaunee Nuclear Power Plant	0 5 0 0 0 3 0 5	1 OF 0 3

TITLE (4)

Both Fire Pumps Out of Service Due to Personnel Failure to Follow Procedure

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 8	1 1	8 6	8 6	0 1 1	0 0	0 9	1 0	8 6	NA	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)	1 0 0	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)	X 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
Kris M. Shembarger - Associate Engineer	AREA CODE 4 1 4 — 3 8 8 - 2 5 6 0

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	NA			

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

On August 11, 1986, at 0230, with the plant at 100% power, both fire pumps were simultaneously out of service for approximately ten seconds. This event occurred during the performance of the monthly fire pump flow test, when one of the two plant operators performing the procedure opened the 1B pump breaker before the second operator closed the 1A pump breaker. The Control Room Operator, immediately recognizing the situation after receiving annunciators, initiated a call to the plant operators. However, before the call was completed, the 1A pump breaker was closed, returning the pump to service.

The corrective actions being implemented to prevent a reoccurrence of this event include the following: 1) the two operators involved were counseled on the cause and the consequences of the event; 2) the Administrative Control Directive detailing the operations group organization will be revised to designate the Shift Supervisor as responsible for the assignment of independent verification; 3) the Administrative Control Directive detailing the Independent Verification Program will be revised to more clearly identify requirements and responsibilities; this will be presented to each operating crew and discussed at a monthly safety meeting; 4) as a part of the Equipment Operator/Auxiliary Operator training accreditation program, a specific lesson will be presented on Technical Specifications during initial training and system related Technical Specifications will be emphasized during requalification training; 5) a quality circle group will include this event in their study of personnel errors and develop additional corrective actions as necessary.

This event is being reported pursuant to Technical Specification 3.15.b.4 on the Fire Water System.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Kewaunee Nuclear Power Plant	0 5 0 0 0 3 0 5	8 6	— 0 1 1	— 0 0	0 2 OF 0 3

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

DESCRIPTION OF EVENT

On August 11, 1986, at 0230, with the plant at 100% power, both fire pumps (P) were simultaneously out of service for approximately ten seconds. This event occurred during the performance of the monthly fire pump flow test, when one of the two plant operators performing the procedure opened the 1B fire pump breaker (BKR) before the second operator closed the 1A fire pump breaker. The Control Room Operator immediately recognized the situation when the annunciator (ALM) "FIRE PUMP 1B VOLTAGE LOW" actuated with the "FIRE PUMP 1A VOLTAGE LOW" annunciator already indicating that the 1A pump was out of service. As the Control Room Operator initiated a call to the plant operators performing the procedure, the 1A fire pump breaker was closed and the annunciator cleared.

The senior operator, who was just recently placed on shift after approximately a one-year absence while in training, was assigned the task of performing the manipulations. The junior operator, who was the normal shift equipment operator, was assigned the task of independent verification. The senior operator carried a copy of the procedure with him.

The procedure is designed to verify the operability of the 1A and 1B fire pumps. It first tests the 1A pump automatic start at 110 psig header pressure, then opens the 1A pump breaker to test the 1B pump automatic start at 102 psig header pressure. After completing the 1B train flow test the 1B pump is stopped, the breaker for the 1A pump is closed, and the breaker for 1B pump is opened to verify the control room annunciators.

The senior operator performed the flow test on the 1A train, opened the 1A pump breaker and verified that the 1B pump started. As he was proceeding to close the 1A pump breaker, a momentary breakdown in communication between the senior operator and junior operator occurred, resulting in the opening of the 1B pump breaker before the senior operator closed the 1A pump breaker. As a result, both fire pumps were removed from service for approximately ten seconds.

CAUSE OF EVENT

The root cause of the event was personnel failure to follow procedure. Other contributing factors were:

1) The operators were working in the screenhouse, which is a very noisy area, and the communication between them was not explicitly clear.

2) There was some confusion on the implementation of independent verification. It was not clearly understood that the second operator had been assigned to serve only as independent verification and was not to become involved in the performance of the procedure. Thus the senior operator, not being as familiar with the procedure as the junior operator, allowed him to extend his assigned duties of independent verifier and perform equipment manipulations without realizing the consequences.

3) The equipment operator did not fully understand the Technical Specification implications of having both fire pumps out of service at the same time, and that an open pump breaker caused the pump to be considered inoperable.

ANALYSIS OF EVENT

This event is being reported pursuant to Technical Specification 3.15.b.4 on the Fire Water System. The safety significance of this event is minimal due to:

1) The short time period that both pumps were out of service,

2) Fire water header pressure remained above the 1A fire pump automatic starting pressure of 110 psig, and

3) The Control Room Operator took immediate action based on the abnormal conditions as indicated by the control room annunciators.

CORRECTIVE ACTION

The following corrective actions have been or will be taken:

1) The two operators involved were counseled on the cause and the consequences of the event.

2) The Administrative Control Directive detailing the operations group organization will be revised to designate the Shift Supervisor as responsible for the assignment of independent verification.

3) The Administrative Control Directive detailing the Independent Verification Program will be revised to more clearly identify requirements and responsibilities. This will be presented to each operating crew and discussed at a monthly safety meeting.

4) As a part of the Equipment Operator/Auxiliary Operator training accreditation program, a specific lesson will be presented on Technical Specifications during initial training and system related Technical Specifications will be emphasized during requalification training.

5) A quality circle group will include this event in their study of personnel errors and develop corrective actions.

ADDITIONAL INFORMATION

There were no component failures associated with this event.

LER 84-17 was submitted on November 1, 1984 as a result of a similar event.

WPSC (414) 433-1234
TELECOPIER (414) 433-1297

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WISCONSIN PUBLIC SERVICE CORPORATION
600 North Adams • P.O. Box 19002 • Green Bay, WI 54307-9002

September 10, 1986

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

Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Reportable Occurrence 86-011-00

In accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System", the attached Licensee Event Report for reportable occurrence 86-011-00 is being submitted.

Very truly yours,

D. C. Hintz
Vice President - Nuclear Power

TJW/jms

Attach.

cc - INPO Records Center
Suite 1500, 1100 Circle 75 Parkway
Atlanta, GA 30339
Mr. Robert Nelson, NRC Resident Inspector
RR #1, Box 999, Kewaunee, WI 54216
Mr. G. E. Lear, PWR Project Directorate-1
US NRC, Washington, DC 20555
Mr. J. G. Keppler, Regional Administrator
Region III, US NRC, 799 Roosevelt Road
Glen Ellyn, IL 60137

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