U.S. NUCLEAR REQULATORY COMMISSION # KC Form 366 APPROVED OMB NO. 3180-0104 EXPINES 8/31/85 LICENSEE EVENT REPORT (LER) DOCKET NUMBER (2) 0 |5 | 0 | 0 | 0 | 3 | 2 | 2 | 1 | OF | 0| Shoreham Nuclear Power Station Unit #1 CRAC "B" Initiation Signal Received Caused by Low Reactor Building Differential Pressur OTHER FACILITIES INVOLVED (8) REPORT DATE (7) LER NUMBER (6) EVENT DATE (8) FACILITY NAMES DOCKET NUMBER(S) SEGUENTIAL MONTH DAY MONTH DAY YEAR 0 15 10 10 10 1 0 1 0 | 5 | 1 | 5 | 8 | 8 17 0 006 0 15 10 10 10 1 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR & (Check one or more of the following) (11) MODE (8) 73.71(b) 20.406(a) 20.402(b) 80.73(a)(2)(v) 73.71(c) 80 38(a)(1) 20.408(4)(1)(1) OTHER (Specify in Abstract below and in Text, NRC Form 366A) 80 73(a)(2)(vil) 01010 20.406(a)(1)(li) 80 36(a)(2) 80 73(a)(2)(will(A) 80.73(a)(2)(I) 20.408(a)(1)(III) 20.408 (a) (1) (iv) 80.73(a)(2)(ii) 80 73(a)(2)(vill)(B) 80.73(e)(2)(x) 80.73(4)(2)(11) 20.408(a)(1)(v) LICENSES CONTACT FOR THIS LER (12) TELEPHONE NUMBER NAME AREA CODE 912191-18131010 1116 Robert W. Grunseich. Operational Compliance Engineer COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13) MANUFAC-TURER TO NPROS MANUFAC CAUSE SYSTEM COMPONENT CAUSE SYSTEM COMPONENT DAY YEAR MONTH SUPPLEMENTAL REPORT EXPECTED 114 EXPECTED

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (18)

YES (II yes, complete EXPECTED SUBMISSION DATE

On May 15, 1987 at 0848, an unplanned automatic initiation of the Control Room Air Conditioning (CRAC) "B" train occurred due to low reactor building differential pressure. The "A" trains of CRAC and Reactor Building Standby Ventilation System (RBSVS) were previously placed into operation for a planned outage of the "A" Reactor Protection System (RPS) Bus. RBSVS "B" was in "pull to lock" Plant was in Operational Condition 4 (Cold Shutdown) with all rods inserted into the core - secondary containment was not required. CRAC "B" initiated when both doors between the reactor building and turbine building were opened simultaneously. The interlock on the doors had malfunctioned; consequently, opening both doors allowed the reactor building to momentarily pressurize to the CRAC system initiation set point (0.3 inches water). Due to the failed interlock switch a security officer was stationed in the air lock between the buildings, a maintenance work request was issued to repair the interlock switch. CRAC "B" was left running until the RPS bus outage was complete. Plant Management was notified of the event and the NRC was notified at 1025 per 10CFR50.72.

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PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as [xx].

IDENTIFICATION OF THE EVENT

Automatic initiation of an Engineered Safety Feature (ESF); Control Room Air conditioning (CRAC) system [BH] due to low reactor building differential pressure.

Event Date: 5/15/87

Report Date: 6/12/87

CONDITIONS PRIOR TO THE EVENT

Operational Condition 4 (Cold Shutdown)

Mode Switch - Shutdown

RFV Pressure = 0 psig RPV Temperature = 102 Degrees F

POWER LEVEL - 0

All rods inserted in the core.

DESCRIPTION OF THE EVENT

On May 15, 1987 at 0848, an unplanned automatic initiation of the Control Room Air Conditioning (CRAC) "B" train occurred due to low reactor building differential pressure. The "A" trains of CRAC and Reactor Building Standby Ventilation System (RBSVS) were previously placed into operation for a planned outage of the "A" Reactor Protection System (RPS) Bus. RBSVS "B" was in "pull to lock". The Plant was in Operational Condition 4 (Cold Shutdown) with all rods inserted into the core - secondary containment was not required. CRAC "B" initiated when both doors between the reactor building and turbine building were opened simultaneously. The reactor and turbine buildings are seperated by an airlock, this airlock is a hallway, approximately 30 feet long with a door at each end. The doors are equipped with an iterlock mechanism which causes one door to lock closed if the other door is opened, door position indicating lights are provided also. The installation is meant to preclude personnel from opening both doors at the same time. The interlock on the

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doors had malfunctioned; consequently, opening both doors allowed the reactor building to momentarily pressurize to the CRAC system initiation set point (0.3 inches water). Due to the failed interlock, switch a security officer was stationed in the air lock between the buildings, a maintenance work request was issued to repair the interlock switch. CRAC "B" was left running until the RPS bus outage was complete. Plant Management was notified of the event and the NRC was notified at 1025 per 10CFR50.72.

CAUSE OF THE EVENT

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The cause of the event was a failed interlock switch installed on the two doors between the Reactor Building and Turbine Building. Due to the interlock switch malfunctioning, both doors were allowed to open simultaneously. The switch is supposed to cause one door to lock as the other is opened. The coincident openings allowed the Reactor Building to pressurize to the CRAC initiation set point.

ANALYSIS OF THE EVENT

This event resulted in an unplanned automatic initiation of an Engineered Safety Feature (CRAC) and is reportable per 10CFR50.73(a)(2)(iv). There is no safety significance to this event since the actuation signal was generated as designed (Low Reactor Building Differential Pressure) and the system operated as required. Secondary Containment was not required due to the plant being in cold shutdown and no core alterations being performed. Had this event occurred under a more severe set of circumstances (5% power), there would still be no safety significance.

CORRECTIVE ACTIONS

The switch which indicates the other door's position and provides an interlock between the doors has been repaired. In the interim, a security officer was stationed in the air lock between the two buildings to prevent personnel from opening both doors at the same time. CRAC "B" was left running until the end of the RPS Bus outage.

ADDITIONAL INFORMATION

- a. Manufacturer and model number of failed component (s)
 None
- b. LER numbers of previous similar events 85-011 and 85-016 occurred prior to installation of interlock device.



LONG ISLAND LIGHTING COMPANY

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TEL. (516) 929-8300

June 12, 1987

PM-87-158

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

Dear Sir:

In accordance with 10CFR50.73, enclosed is a copy of Shoreham Nuclear Power Station's Licensee Event Report LER 87-015.

Sincerely yours,

William E. Steiger, Jr.

Plant Manager

WES/pz

Enclosure

co: William T. Russell, Regional Administrator Clay Warren, Senior Resident Inspector Institute of Nuclear Power Operations, Records Center American Nuclear Insurers

SR.A21.0200

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