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Management was notified and the NRC was notified at 2400 hrs per 8904240116 890413 PDR ADDCK 05000322 PNU

A procedure change has been implemented to correct this. Plant

restored the system. An equipment operator was dispatched to the HX to ensure the drains were closed. No spillage had occurred. The procedure used for the EDG test did not caution operators that manual reset of the valve's logic was required to prevent operation.

10CFR50.72.

NRC Form 366A

### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)

Shoreham Nuclear Power Station - Unit 1

DOCKET NUMBER (2)

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LER NUMBER (6) SEQUENTIAL YEAR

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819

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PAGE (3)

TEXT (If more space is required, use additional NRC Form 385A's) (17)

## PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

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

## IDENTIFICATION OF THE EVENT

Reactor Building Closed Loop Cooling Water (RBCLCW) [CC] Isolation/Split on Low Head Tank Level After Conducting a Diesel Surveillance Test

Event Date:

March 14, 1989

Report Date:

April 13, 1989

## CONDITIONS PRIOR TO THE EVENT

Operational Condition 4 (Cold Shutdown)

Mode Switch - Shutdown

RPV Pressure = 0 psig RPV Temperature = 105 Degrees F

POWER LEVEL - 0

#### DESCRIPTION OF THE EVENT

On March 14, 1989 at 2325, an inadvertent RBCLCW isolation/split occurred after performing a Technical Specification surveillance test on Emergency Bus 101. Prior to performing the black start test on Emergency Diesel Generator (EDG) 101 per station procedure SP 24.307.02 ("TDI DG Emergency AC Power Load Sequencing Tests"), maintenance was being performed on the "A" main heat exchanger (HX) of RBCLCW. The maintenance included leak investigation which required isolating the HX by closing the RBCLCW inlet valve 1P42\*MOV-042A, and draining the demineralized water from the shell side. The service water (seawater) from the HX was secured with outlet valve 1P41\*MOV-037A. The controls for the valves were tagged with 'CAUTION' tags to prevent control operation, but power to the valves remained available.

NRC Form 386A

#### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)			
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The performance of the EDG test required deenergizing Emergency Bus 101, which feeds power to the above mentioned valves and other emergency loads. Upon deenergizing the bus, the EDG is expected to start, come up to speed, and begin accepting loads.

It was realized by the operators before the surveillance test began that the motor operated valves secured for the maintenance would receive an undervoltage signal when the bus was deenergized. accident mode of 1P42\*MOV-042A and 1P41\*MOV-037A is to stroke full open to assure maximum cooling of safety related heat loads. To allow the test to occur without any valve actuation, the power supply breakers to the two valves were opened.

After the successful conclusion of the EDG black start and run test, the electrical line ups were restored to their pre test configurations. This included reclosing the breakers for the subject valves. Upon repowering up the valves, the valves stroked open. This allowed the "A" RBCLCW Head Tank to drain into the HX. Low Head Tank Level is an ESF signal which causes RBCLCW to isolate its nonessential loads and split into two redundant loops.

Upon realizing what had happened, the operators refilled the head tank through the make up line and restored the system. An equipment operator was dispatched to the HX to ensure the vents and drains were closed. No spillage had occurred.

Plant Management was notified and the NRC was notified at 2400 hrs per 10CFR50.72.

#### CAUSE OF THE EVENT

The cause of the event was inadequate procedural guidance in SP 24.307.02. The procedure, through Appendix 12.4, informed the operators that 1P42\*MOV-042A would receive an open signal on bus undervoltage. The procedure failed to warn the operators that the undervoltage signal would not clear until operators took one of two actions, either allow the valve to stroke full open or reset the logic relay manually prior to restoring power. A note exists on the electrical prints indicating that hand reset is required, but the operators relied on the procedure for this simple evolution.

NRC Form 366A

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104 EXPIRES: 8/31/88

FACILITY NAME (1)				DOCKET NUMBER (2)							LER NUMBER (6)									PAGE (3)			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

## ANALYSIS OF THE EVENT

The event resulted in automatic unplanned initiation of an ESF (RBCLCW Isolation/Split) and is reportable per 10CFR50.73(a)(2)(iv).

There was minimal safety significance to the event. The system operated as designed and would have fulfilled its safety function had it needed to. The operators quickly ascertained the cause of the event and took the necessary actions to restore the system. The potential for a spill was quickly realized and an operator was dispat and to ensure none existed. If a spill had occurred, the Reactor Suilding sumps would have handled it.

In addition, the EDG Black Start Test would not be performed during power operation: The probability of Bus 101 deenergizing is minimal in light of back up by the arternate offsite AC source through a fast transier

## CORRECTIVE ACTIONS

- A procedure change to SP 24.307.02 was implemented to caution operators about equipment logic that must be manually reset if the equipment is deenergized to prevent upwanted actuation.
- This LER will become required reading for licensed operators. 2.
- The SECP (Station Equipment Clearance Fermit) procedure will be reviewed and guidance will be provided as necessary such that when equipment is reenergized, automatic actuations are prevented.

# ADDITIONAL INFORMATION

a. Manufacturer and model number of failed component (s)

None

b. LER numbers of previous similar events

LER 88-018



# LONG ISLAND LIGHTING COMPANY

SHOREHAM NUCLE AR POWER STATION . P.O. BOX 628 . WADING RIVER, NEW YORK 11792

TEL. (516) 929-8300

April 13, 1989

PM-89-064

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

Dear Sir:

In accordance with 10CFR50.73, enclosed is Shoreham Nuclear Fower Station's Licensee Event Report (LER 89-004).

Sincerely yours,

John A. Scalice Plant Manager

DAS/jp

Enclosure

cc: William T. Russell, Regional Administrator
Frank Crescenzo, Senior Resident Inspector
Institute of Nuclear Power Operations Records Center
American Nuclear Insurers

SR.A21.0200

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