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ACCESSION NBR:8910250228 DOC.DATE: 89/10/20 NOTARIZED: NO DOCKET #
 FACIL:50-244 Robert Emmet Ginna Nuclear Plant, Unit 1, Rochester G 05000244
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SUBJECT: LER 89-011-00:on 890920,spurious actuation of containment
 ventilation isolation.

W/8 ltr.

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 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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October 20, 1989


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

Subject: LER 89-011, Spurious Actuation of Containment Ventilation Isolation R.E. Ginna Nuclear Power Plant
Docket No. 50-244

In accordance with 10 CFR 50.73, Licensee Event Report System, item (a)(2)(iv), which requires a report of, "any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF) including the Reactor Protection System (RPS)", the attached Licensee Event Report LER 89-011 is hereby submitted.

This event has in no way affected the public's health and safety.

Very truly yours,


Robert C. Mecredy
General Manager
Nuclear Production

xc: U.S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406
Ginna USNRC Senior Resident Inspector

8910250228 891020
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)

R.E. Ginna Nuclear Power Plant

DOCKET NUMBER (2)

0 5 0 0 0 2 4 4 1 OF 0 6

PAGE (3)

TITLE (4) Spurious Actuation of Containment Ventilation Isolation

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 (8)																		
0	9	2	0	8	9	8	9	-	0	1	1	-	0	0	1	0	2	0	8	9			0	5	0	0	0		
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)																										
N			20.402(b)			20.406(a)			<input checked="" type="checkbox"/> 50.73(a)(2)(iv)			72.71(b)																	
POWER LEVEL (10)			20.406(a)(1)(i)			50.36(a)(1)			<input type="checkbox"/> 50.73(a)(2)(v)			72.71(a)																	
0			9			20.406(a)(1)(ii)			50.36(a)(2)			<input type="checkbox"/> 50.73(a)(2)(vi)			OTHER (Specify in Abstract below and in Text, NRC Form 306A)														
			20.406(a)(1)(iii)			50.73(a)(2)(i)			<input type="checkbox"/> 50.73(a)(2)(vii)(A)																				
			20.406(a)(1)(iv)			50.73(a)(2)(ii)			<input type="checkbox"/> 50.73(a)(2)(vii)(B)																				
			20.406(a)(1)(v)			50.73(a)(2)(iii)			<input type="checkbox"/> 50.73(a)(2)(viii)																				

LICENSEE CONTACT FOR THIS LER (12)

NAME

Wesley H. Backus

Technical Assistant to the Operations Manager

TELEPHONE NUMBER

AREA CODE

3 1 5 5 1 2 1 4 1 4 1 4 1 6

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

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)

On September 20, 1989 at 0519 EDST with the reactor at approximately 99% full power, an inadvertent containment ventilation isolation occurred due to a spurious event.

All containment ventilation isolation valves that were open, closed as designed.

Immediate operator action was to perform the applicable alarm response procedures actions. This included verifying automatic actions, attempting to determine cause of containment ventilation isolation, and making appropriate notifications.

The immediate cause of the event was determined to be spurious.

Corrective action taken was to return the containment ventilation isolation system to service followed by a troubleshooting effort by the Instrument and Control Department. Further investigation to determine the root cause is continuing.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES 8/31/89

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (3)		
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TEXT (If more space is required, use additional NRC Form 308A-2 (1/77))

I. PRE-EVENT PLANT CONDITIONS

The plant was at approximately 99% steady state full power with no major activities in progress.

II. DESCRIPTION OF EVENT

A. DATES AND APPROXIMATE TIMES FOR MAJOR OCCURRENCES:

- o September 20, 1989, 0519 EDST: Event date and time.
- o September 20, 1989, 0519 EDST: Discovery date and time.
- o September 20, 1989, 0520 EDST: Control Room operators verified all containment ventilation isolation functions took place.
- o September 20, 1989, 0522 EDST: Control Room operators reset containment ventilation isolation and restored system to normal.

B. EVENT:

On September 20, 1989 at 0519 EDST with the reactor at approximately 99% full power, the following control board alarms were received, E-24 (RMS Area Monitor High Activity), and A-25 (Containment Ventilation Isolation). The Control Room operators, responding to the above alarms, observed that no Radiation Monitoring System (RMS) monitor indicated an alarm condition. Subsequently at 0520 EDST control board alarm E-20 (CNMT or Plant Vent Rad Mon Pump Trip) was received. This alarm was due to the containment ventilation isolation which trips the containment radiation monitor pump and isolates the containment valves to and from this pump.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMS NO. 3150-0104

EXPIRES 8/31/85

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R.E. Ginna Nuclear Power Plant

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TEXT (If more space is required, use additional NRC Form 308A's) (17)

The Control Room operators verified that all containment ventilation isolation valves that were open, closed as designed.

Subsequently, the Control Room operators checked the Plant Process Computer System (PPCS) computer and observed that no alarms were generated from the RMS, thus verifying this as a spurious event.

C. INOPERABLE STRUCTURES, COMPONENTS, OR SYSTEMS THAT CONTRIBUTED TO THE EVENT:

None.

D. OTHER SYSTEMS OR SECONDARY FUNCTIONS AFFECTED:

With the containment ventilation isolation, the following major components were isolated:

- o R-10A, Containment Iodine RMS Monitor
- o R-11, Containment Particulate RMS Monitor
- o R-12, Containment Gas RMS Monitor

E. METHOD OF DISCOVERY:

The event was immediately apparent due to control board annunciator alarms, and containment ventilation isolation valve position indication in the Control Room.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES 8/31/95

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TEXT (If more space is required, use additional NRC Form 308A's) (17)

F. OPERATOR ACTION:

Control room operators responded to the event by performing the applicable actions of alarm response procedures, E-24, A-25, and E-20. This included the following:

- o Verifying that all containment ventilation isolation valves that were open, closed as designed.
- o Determining that the containment ventilation isolation actuation and the E-24 alarm was spurious.
- o Resetting the containment ventilation isolation signal and restarting R-10A, R-11, and R-12 sample pump and verifying sample flow was re-established.
- o Verifying that R-10A, R-11, and R-12 RMS monitor readings returned to normal.
- o Notifying the NRC and Higher Supervision of the ESF actuation.

III. CAUSE OF EVENT

A. IMMEDIATE CAUSE:

The containment ventilation isolation was apparently caused by a spurious event.

B. ROOT CAUSE:

The root cause has not yet been determined, and investigations for root cause are continuing.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/89

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TEXT (If more space is required, use additional NRC Form 308A's) (17)

IV. ANALYSIS OF EVENT

This event is reportable in accordance with 10 CFR 50.73, Licensee Event Report System, item (a)(2)(iv), which requires reporting of, "any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF) including the Reactor Protection System (RPS)". The containment ventilation isolation due to the spurious event was an automatic actuation of an ESF sub-system.

An assessment was performed considering both the safety consequences and implications of this event with the following results and conclusions:

There were no operational or safety consequences or implications attributed to the inadvertent containment ventilation isolation because:

- o The containment ventilation isolation system operated as designed.
- o The components affected were capable of withstanding the isolation.
- o The containment ventilation isolation was in the conservative direction.

Based on the above, it can be concluded that the public's health and safety was assured at all times.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMS NO. 3150-0104

EXPIRES 8/31/89

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TEXT (If more space is required, use additional NRC Form 366A-1/117)

V. CORRECTIVE ACTION

A. ACTION TAKEN TO RETURN AFFECTED SYSTEMS TO PRE-EVENT NORMAL STATUS:

- o The Control Room operators, after determining that the containment ventilation isolation was spurious, reset the containment ventilation isolation signal and restored the system to pre-event status.
- o The Instrument and Control (I&C) Department, after troubleshooting the containment ventilation isolation actuation system, determined that the problem was of a spurious nature as they could find nothing that might have caused the containment ventilation isolation.

B. ACTION TAKEN OR PLANNED TO PREVENT RECURRENCE:

Several potential sources of spurious signals have been proposed by I&C. Troubleshooting will be performed, and tracked by CAR 1979, in an effort to determine the root cause.

VI. ADDITIONAL INFORMATION:

A. FAILED COMPONENTS:

None.

B. PREVIOUS LERS ON SIMILAR EVENTS:

A similar LER event historical search was conducted with the following results: No documentation of similar LER events with the same root cause at Ginna Station could be identified. However, LER 87-005 and LER 88-007 were similar events with different root causes.

C. SPECIAL COMMENTS:

None.