

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9606260154 DOC.DATE: 96/06/20 NOTARIZED: NO DOCKET #
 FACIL:50-244 Robert Emmet Ginna Nuclear Plant, Unit 1, Rochester G 05000244
 AUTH.NAME AUTHOR AFFILIATION
 ST. MARTIN,J.T. Rochester Gas & Electric Corp.
 MECREDY,R.C. Rochester Gas & Electric Corp.
 RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 96-006-00:on 960521,discovered containment penetration
 not in required status.Caused by personnel error.Installed
 flange inside containment penetration 2.W/960620 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 9
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:License Exp date in accordance with 10CFR2,2.109(9/19/72). 05000244

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AREA CODE 716 546-2700

ROBERT C. MECREDY
Vice President
Nuclear Operations

June 20, 1996

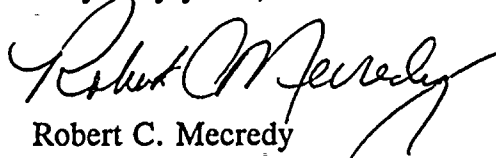
U.S. Nuclear Regulatory Commission
Document Control Desk
Attn: Guy S. Vissing
Project Directorate I-1
Washington, D.C. 20555

Subject: LER 96-006, Containment Penetration Not in Required Status, Due to Personnel Errors, Results in Potential for Uncontrolled Release of Radioactive Material
R.E. Ginna Nuclear Power Plant
Docket No. 50-244

In accordance with 10 CFR 50.73, Licensee Event Report System, items (a) (2) (ii), (a) (2) (v) (C) and (a) (2) (v) (D), which require a report of, "Any operation or condition prohibited by the plant's Technical Specifications" or "Any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to ... Control the release of radioactive material; or Mitigate the consequences of an accident", the attached Licensee Event Report LER 96-006 is hereby submitted.

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

Very truly yours,



Robert C. Mecredy

xc: U.S. Nuclear Regulatory Commission
Mr. Guy S. Vissing (Mail Stop 14C7)
PWR Project Directorate I-1
Washington, D.C. 20555

U.S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406

U.S. NRC Ginna Senior Resident Inspector

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PDR ADCK 05000244
S PDR

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NRC FORM 366 (4-95)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB NO. 3150-0104 EXPIRES 04/30/98 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT																																															
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TITLE (4) <div style="text-align: center;">Containment Penetration Not in Required Status, Due to Personnel Errors, Results in Potential for Uncontrolled Release of Radioactive Material</div>																																																			
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NAME <div style="text-align: center;">John T. St. Martin - Technical Assistant</div>			TELEPHONE NUMBER (Include Area Code) <div style="text-align: center;">(716) 771-3641</div>																																																
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																																			
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS																																															
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)																																																			
<p>On May 21, 1996, at approximately 0900 EDST, with the plant in Mode 6 with core alterations and movement of irradiated fuel assemblies within containment in progress, it was discovered that a containment penetration was not in the required status for refueling operations, allowing direct access from the containment atmosphere to the outside atmosphere.</p> <p>Immediate corrective action was taken in accordance with Ginna Improved Technical Specifications Limiting Conditions for Operation 3.9.3.A.1 and 3.9.3.A.2 to suspend core alterations and suspend movement of irradiated fuel assemblies within containment. The containment penetration was restored to the required status for refueling operations, and refueling operations were permitted to resume.</p> <p>The underlying cause of the penetration not being in the required status for refueling operations was personnel errors.</p> <p>This event is NUREG-1022 Cause Code (A).</p> <p>Corrective action to prevent recurrence is outlined in Section V.B.</p>																																																			

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

I. PRE-EVENT PLANT CONDITIONS:

Containment (CNMT) penetration #2 (referred to as P-2) is the "S/G Communications Flange Penetration" normally used for support of routine steam generator (S/G) maintenance and inspection activities during refueling outages. When in Modes 5 or 6, normally routed through P-2 are closed-circuit television (CCTV) cables and other communications cables.

For the 1996 Refueling outage, P-2 was also used to provide a route for additional CCTV cables and rigid pipes from the outside into CNMT, to provide services (communications, air and argon) for activities associated with replacement of the S/Gs. These pipes were a 3" line for service air and a 1 1/2" line for argon. Station Modification procedures SM-10034-10.01 (Temporary Service Air System for SGRP) and SM-10034-10.03 (Installation & Removal of Temporary CCTV and Communications) were used to control the temporary installation and subsequent removal of these services.

On May 19, 1996, in preparation for refueling the reactor, Ginna plant staff checked the configuration of P-2 and verified that the configuration complied with Ginna Improved Technical Specifications (ITS) Limiting Condition for Operation (LCO) 3.9.3.c, which states that each penetration providing direct access from the CNMT atmosphere to the outside atmosphere shall be isolated, or closed by an equivalent isolation method. These methods include use of material that can provide a temporary, atmospheric pressure, ventilation barrier. Contractor supervision were subsequently notified not to disturb the configuration of P-2 until after the completion of refueling.

During the dayshift on May 20, 1996, as directed by contractor supervision, contractor maintenance personnel removed much of the temporary service air and argon lines inside CNMT, as directed by procedure SM-10034-10.01. Contractor supervision had been cautioned by Ginna staff not to remove the 3" and 1 1/2" pipe spoolpieces that were inside the seal for P-2 and the first valves on each side of P-2 inside and outside of CNMT. Nevertheless, at the end of their shift (at approximately 1800 EDST), the contractor maintenance personnel removed these spoolpieces and valves. Additional piping outside CNMT was left in place until the next day.

On May 21, 1996, at approximately 0300 EDST, a utility non-licensed operator was performing Operating Procedure O-15.2 (Valve Alignment for Reactor Head Lift, Core Component Movement, and Periodic Status Checks), in preparation for the start of refueling operations. As part of this procedure, the operator performed Step 5.2.1 to verify that P-2 was "adequately sealed", and signed off Step 5.2.1 of procedure O-15.2. Satisfactory completion of this step ensures compliance with ITS LCO 3.9.3.c.

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II. DESCRIPTION OF EVENT:

A. DATES AND APPROXIMATE TIMES OF MAJOR OCCURRENCES:

- May 19, 1996: Ginna staff verify that the configuration of P-2 meets the required status of ITS LCO 3.9.3.c.
- May 20, 1996, 1800 EDST: Contractor maintenance personnel remove pipe spoolpieces from inside the seal for P-2. P-2 configuration does not meet the required status of ITS LCO 3.9.3.c.
- May 21, 1996, 0537 EDST: The plant enters Mode 6 and begins core alterations and movement of irradiated fuel assemblies within CNMT. Event date and time.
- May 21, 1996, 0900 EDST: Discovery date and time.
- May 21, 1996, 0937 EDST: All remaining cables are removed from P-2, and P-2 is flanged off.

B. EVENT:

On May 21, 1996, all preparations for refueling were completed. Procedure O-15.2 had been signed off at approximately 0505 EDST, and the Control Room operators notified the Senior Reactor Operator assigned to Refueling (Refueling SRO) to begin refueling. The plant entered Mode 6 at approximately 0537 EDST and began refueling operations (core alterations and movement of irradiated fuel assemblies within CNMT).

On May 21, 1996, at approximately 0800 EDST, contractor maintenance personnel continued their work from the previous day for removal of lines as per SM-10034-10.01. Since these lines were potentially contaminated, a Radiation Protection (RP) technician was requested to survey the removed lines prior to disposal.

On May 21, 1996, at approximately 0900 EDST, with the plant in Mode 6 and refueling operations in progress, the RP technician approached P-2 to survey some materials and discovered that P-2 was not in the required status for refueling operations. He observed that P-2 was not completely sealed where the 3" and 1 1/2" spoolpieces had been, appearing to allow direct access from the CNMT atmosphere to the outside atmosphere.

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The RP technician notified his supervision. RP supervision notified a member of the plant Outage Management staff, who inspected P-2 and confirmed that it was not adequately sealed. The Control Room operators were notified of the status of P-2 as observed from outside CNMT. Immediate actions were taken per ITS LCO ACTIONS 3.9.3.A.1 and 3.9.3.A.2 to suspend core alterations and suspend movement of irradiated fuel assemblies within CNMT. The Refueling SRO inside CNMT was also notified that P-2 needed to be inspected from inside CNMT for the presence of a flange. The Refueling SRO inspected P-2 and confirmed that the penetration was not isolated inside CNMT by use of a material that can provide a temporary, atmospheric pressure, ventilation barrier. The RP technician verified that the actual flow of air was from the outside into CNMT.

Ginna and contractor electricians were notified to remove all remaining cables routed through P-2. When the cables were removed and the penetration was unobstructed inside CNMT, Ginna pipefitters installed a flange over P-2. These actions restored P-2 to the required status for refueling operations, and refueling operations were permitted to resume at approximately 0937 EDST on May 21, 1996.

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

None

D. OTHER SYSTEMS OR SECONDARY FUNCTIONS AFFECTED:

None

E. METHOD OF DISCOVERY:

While performing routine monitoring activities for the removal of potentially contaminated materials from CNMT, a Radiation Protection technician discovered that P-2 was not completely sealed as observed from outside CNMT. The Refueling SRO confirmed that P-2 was not in the required status for refueling operations.

F. OPERATOR ACTION:

The Control Room operators, upon being notified that P-2 was not in the required status for refueling operations, immediately complied with the requirements of ITS LCO ACTIONS 3.9.3.A.1. and 3.9.3.A.2, which require that if one or more CNMT penetrations are not in required status, "Suspend CORE ALTERATIONS" and "Suspend movement of irradiated fuel assemblies within containment".

Subsequently, the Control Room operators notified higher supervision and the NRC Senior Resident Inspector. At approximately 1226 EDST on May 21, 1996, a 4 hour non-emergency notification was made to the NRC Operations Center as per 10 CFR 50.72 (b) (2) (iii) (C) and 10 CFR 50.72 (b) (2) (iii) (D).

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G. SAFETY SYSTEM RESPONSES:

None

III. CAUSE OF EVENT:

A. IMMEDIATE CAUSE:

The immediate cause of CNMT penetration P-2 not being in the required status for refueling operations was openings in the foam seal where a 3" pipe and 1 1/2 " pipe had been removed. This condition was not identified by Operations personnel during performance of procedure O-15.2.

B. INTERMEDIATE CAUSE:

The intermediate cause of the openings in the foam seal for P-2 was the unauthorized removal of the pipe spoolpieces and associated valves from the penetration. The intermediate cause of not identifying this condition during the performance of O-15.2 was inadequate verification by Operations personnel.

C. ROOT CAUSE:

The underlying cause of the unauthorized removal of the spoolpieces was personnel error. The underlying cause of the inadequate verification by Operations personnel was also personnel error. A Human Performance Enhancement System (HPES) evaluation was performed to determine the causal factors that contributed to these personnel errors. This event is NUREG-1022 Cause Code (A), "Personnel Error".

Personnel errors were made by contractor maintenance personnel and a utility non-licensed operator. These errors were cognitive personnel errors on the part of both groups. The contractor maintenance personnel did not recognize the impact on refueling operations of removing the pipe spoolpieces from P-2. The Operations personnel did not recognize the actual configuration of the foam seal in P-2 during O-15.2 verifications, perceived that they had accurately verified the configuration, and thought that P-2 was in the required status for refueling operations, when, in fact, P-2 was not adequately sealed.

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The contractor maintenance error was contrary to approved procedure SM-10034-10.01, and the operator error was contrary to approved procedure O-15.2. Unusual conditions present during the performance of O-15.2 included nighttime darkness, a lightning storm, limited access to P-2 (P-2 was enclosed by a wooden protective enclosure), additional cable routed through P-2 for the 1996 outage, and some of the remaining piping and valves still being within the enclosure around P-2. These environmental factors may have obscured the view of the foam seal from outside CNMT, where the 3" and 1 1/2" spoolpieces had been. Access to view P-2 from inside CNMT was partially blocked, due to equipment inside CNMT for the S/G replacement.

This condition does not meet the NUMARC 93-01, "Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants", definition of a "Maintenance Preventable Functional Failure".

IV. ANALYSIS OF EVENT:

This event is reportable in accordance with 10 CFR 50.73, Licensee Event Report System, items (a) (2) (ii), (a) (2) (v) (C) and (a) (2) (v) (D), which require a report of, "Any operation or condition prohibited by the plant's Technical Specifications" or "Any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to ...Control the release of radioactive material; or Mitigate the consequences of an accident". Having a CNMT penetration not in the required status for refueling operations with refueling operations in progress is a condition prohibited by the ITS. It is postulated that, in the event of a fuel handling accident at this condition, the resultant radioactive release could be uncontrolled, and that the CNMT could have been ineffective in mitigating the consequences of this postulated accident.

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 this condition because:

- Though the CNMT penetration allowed direct access from the CNMT atmosphere to the outside atmosphere, a condition did not exist that could have resulted in an uncontrolled radioactive release. A release to the outside atmosphere would have required CNMT pressurization. Since the fuel had a low decay heat rate due to a sixty day off load and since there was only a small amount of fuel in the core at the time, the energy source to effect a CNMT pressurization was low, making a pressurized conditions unlikely. It was verified that the actual flow of air was from the outside into CNMT.
- CNMT isolation is not credited in the event of a fuel handling accident per the applicable safety analyses bases for ITS LCO 3.9.3. The Ginna Station Updated Final Safety Analysis Report (UFSAR), Section 15.7.3.3, shows that without credit for CNMT and utilizing the conservative assumptions of NRC Regulatory Guide (RG) 1.25, the offsite dose consequences following a fuel handling accident are ninety-six (96) REM thyroid, which is within 10 CFR 100 limits for Ginna Station.

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

- Ginna Station recently received Amendment 62 to the ITS, which modified the requirements for the CNMT equipment hatch during Mode 6. Included within this ITS amendment request (dated February 9, 1996) was an evaluation of offsite doses, with the following assumptions:

- a. CNMT was initially pressurized by 0.5 PSIG above the outside atmosphere for the first three minutes following a fuel handling accident,
- b. a CNMT leakage rate, based on extreme temperature differences between the inside and the outside of CNMT, existed for the next two hours, and
- c. a hole equivalent to 1.83 square feet existed to the outside atmosphere.

Using these and other assumptions of RG 1.25, the thyroid dose at the exclusion area boundary was calculated to be only 8.1 REM, which is well within 10 CFR 100 limits. The condition of P-2 being open during movement of irradiated fuel assemblies is bounded by this analysis since no fuel handling accident occurred, the CNMT was not pressurized, and the increased leakage path through P-2 was less than 0.1 square foot. Therefore, this condition would not lead to exceeding the dose limits.

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

V. CORRECTIVE ACTION:

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

- All remaining cables were removed from P-2 and a flange was installed on P-2 inside CNMT, restoring P-2 to compliance with ITS LCO 3.9.3.c.
- Refueling operations were permitted to resume.

B. ACTION TAKEN OR PLANNED TO PREVENT RECURRENCE:

- Procedure O-15.2 will be revised to require additional controls at P-2, to prevent the configuration of P-2 from being changed during refueling operations.
- A Nuclear Training Work Request will be initiated to train on the lessons learned from this event.

VI. ADDITIONAL INFORMATION:

A. FAILED COMPONENTS:

None

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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

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 Nuclear Power Plant could be identified.

C. SPECIAL COMMENTS:

None