

Follow Up Report - Previous Report Date 3/22/83
LICENSEE EVENT REPORT

LER 83-09/1T

CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	V	T	V	Y	S	1	2	0	0	-	0	0	0	0	-	0	0	3	4	1	1	1	1	4	5																	
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LICENSEE CODE														LICENSE NUMBER										LICENSE TYPE										CAT 55									

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REPORT SOURCE														DOCKET NUMBER										EVENT DATE										REPORT DATE									

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During the refueling outage, planned modifications of the RPS MG Set resulted in a

0 3 PCIS isolation of the Containment Ventilation System. Slide links TAC-3 and TP-1

0 4 were opened on Control Room panel 9-26 to restore ventilation while allowing work on

0 5 the MG sets to continue. This action resulted in the loss of SBGT auto-start capa-

0 6 bility from 0817-1023. Contrary to T.S. 3.7.C.1, irradiated fuel was moved during

0 7 that time period in the Rx. bldg. with SBGT (and therefore, secondary containment)

0 8 inoperable.

0	9	S	C	11	A	12	C	13	Z	Z	Z	Z	Z	Z	14	Z	15	Z	16	8	3	0	0	9	0	1	T	0	Z	9	9	9	26
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SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE										COMP SUBCODE		VALVE SUBCODE		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.					

17 LER NO. REPORT NUMBER

18 ACTION TAKEN

19 FUTURE ACTION

20 EFFECT ON PLANT

21 SHUTDOWN METHOD

22 HOURS

23 ATTACHMENT SUBMITTED

24 NPRD-4 FORM SUB

25 PRIME COMP. SUPPLIER

26 COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The slide links were removed before completing the full review and approval of the

1 1 lifted lead and jumper request. When it was discovered that this action resulted in

1 2 the loss of SBGT all fuel handling activities were suspended until the auto-start

1 3 capability of the SBGT System was returned to service.

1	5	H	28	0	0	0	29	NA	A	31	Review of lifted lead request	32																																																				
7	8	9	10	11	12	13	14	15	16	17	18	19																																																				
FACILITY STATUS													% POWER													OTHER STATUS													METHOD OF DISCOVERY													DISCOVERY DESCRIPTION												

1 6 Z 33 Z 34 NA NA

1 7 0 0 0 37 Z 38 NA

1 8 0 0 0 40 NA

1 9 Z 42 NA

2 0 N 44 NA

21 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION

22 PERSONNEL INJURIES NUMBER DESCRIPTION

23 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION

24 PUBLICITY DESCRIPTION

25 ISSUED DESCRIPTION

8304180256 830404
PDR ADOCK 05000271
S PDR

NRC USE ONLY

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DESCRIPTION OF THE OCCURRENCE:

Reactor shutdown for refueling with all fuel removed from the reactor vessel. "A" SBT System considered inoperable due to P/M work in progress on "A" Diesel Generator. "B" SBT System operable. Reactor Protection System Bus "A" removed from service for preventative maintenance and planned modifications. With RPS Bus "A" out of service, SBT Systems A and B auto started and Reactor Building HVAC auto isolated due to power loss and subsequent downscale indication on refuel floor radiation monitor. With the loss of normal RB ventilation (1 volume change per day versus 75 volume changes per day) and the extensive work being performed in the Reactor Building, it was expected that ambient temperature would increase thereby deteriorating working environments.

At approximately 0715 the oncoming Shift Supervisor (SS), upon noting the isolation of normal R/B ventilation, requested a senior I & C technician to see what could be done to restore normal R/B ventilation. The SS then left the Control Room to attend the morning outage status meeting, leaving the SCRO in command. At approximately 0817 following applicable circuit diagram review and discussion with the SCRO, the senior I&C technician opened slide links TAC-3 and TP-1 in CRP 9-28 while being observed by the SCRO. No approved Lifted Lead/Jumper Request per AP 0020 was issued at this time. After verifying a successful restart of the RB HVAC, the I&C technician then returned to the shop to process the Lifted Lead/Jumper Request. When the SS returned to the Control Room at approximately 0830, he was made aware of the change in status in the RB ventilation but not of the slide link repositioning without a Lifted Lead/Jumper Request. A second SCRO was already in route to the refuel floor to support spent fuel pool fuel moves. At approximately 0915 when the Lifted Lead/Jumper Request was approved by the I&C Supervisor and forwarded to the Operations Supervisor in the Control Room, the Shift Supervisor first became aware that the change in R/B ventilation status was due to earlier slide link repositioning. Discussion of the proposed Lifted Lead/Jumper Request between the Operations Superintendent, Technical Services Superintendent, Engineering Support Supervisor, and Operations Supervisor raised the concern that if implemented, this would defeat the SBT auto-start features. At approximately 1020, plant management was made aware that the RB ventilation system had previously been altered. Fuel movement operations in the spent fuel pool were halted once a stable fuel condition was achieved, and no further moves were made until after the SBT auto-start had been restored. NRC notification required by 10 CFR 50.72 was not performed.

PROBABLE CONSEQUENCES OF THE EVENT:

With the slide links TAC-3 and TP-1 open, the automatic initiation function for the Standby Gas Treatment and Rx Bldg. auto isolation were removed rendering the systems inoperable. During the time the systems were disabled, fuel was being moved in the spent fuel pool. Had a high airborne radiation condition occurred which would have required the Reactor Building Ventilation System to isolate and Standby Gas Treatment to start, this would not have functioned automatically. These systems would have had to be aligned manually.

CORRECTIVE ACTION

1. Immediate Actions

Immediately following suspicion of compromised secondary containment all fuel moves were terminated (fuel pin move in progress was allowed to be completed) and the improperly positioned slide links were repositioned. Once secondary containment status was verified satisfactory, permission was granted to continue fuel moves. A properly initiated, reviewed, and approved Lifted Lead/Jumper Request (No. 83-0050) was issued to restore normal RB ventilation without defeating SBTG auto start or RB ventilation auto-isolation logic.

2. Subsequent Actions

- A) A critique was held with all parties involved with the situation and with plant management. The purpose of the critique was to determine the chronology of the events and to try and understand how these events occurred. The senior I&C technician and the I&C Supervisor were questioned on their roles in the matter. The Plant Manager and Maintenance Superintendent gained assurance that they showed an understanding of the errors made, and their responsibilities to comply in the future to all administrative requirements and they were allowed to continue normal duties. The involved licensed personnel have been removed from license duties until management can be assured that they understand their duties and responsibilities and will implement them in the future.
- B) Additional clarification was made to the two administrative procedures involved in the situation.
 - 1) AP 0020, Lifted Lead/Jumper Request, was modified by Departmental Instruction to specifically address the fact that the originating department head review must constitute an independent detailed technical evaluation of the necessity for the lifted lead, the methodology for obtaining the desired end result, and the consequences of implementing the request as far as loss of function and impact to other plant operations. Signature by the originating department now specifies that all the above reviews are complete and satisfactory.
 - 2) AP 0010, Occurrence Reports, was clarified by note in the Operations Department night orders specifying that the Shift Supervisor is primarily responsible for making the one hour notification to the NRC for events identified in Appendix D of this procedure. A detailed review of these procedures is to be completed and available for PORC review by April 1, 1983.
- C) The Engineering Support Supervisor was directed to review an adequate and random sampling of previously issued Lifted Lead/Jumper Requests to ensure that adequate technical reviews were completed on each request. Also to review the description of loss of function and consequences associated with each request to ensure completeness and correctness. The results of this investigation is to be presented to the Plant Manager and PORC by April 9, 1983.

D) A meeting of plant Department Heads and Superintendents was held on 3/26/83 to thoroughly review the facts in the situation and to assess the problems identified. Each Department Head and Superintendent was tasked with relaying the below listed information to each and every member of their departments and to document such briefing/training sessions and present the results of this action to the Plant Manager by April 2, 1983. Key topics to be incorporated into the discussion are:

- 1) Factors which could influence personnel to bypass procedural requirements.
- 2) Approach people take with the Operations Department. Differential between when you should be requesting permission vs. notifying. Operators should be aware of this as well.
- 3) The necessity for thorough understanding prior to doing work even when the event seems insignificant.
- 4) The need to comply with procedures.