GPU Nuclear

GPU Nuclear Corporation
Post Office Box 388
Route 9 South
Forked River, New Jersey 08731-0388
609 971-4000
Writer's Direct Dial Number:

C321-94-2162
October 21, 1994

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

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report

Enclosed is Licensee Event Report 94-018.

If you should have any questions or require further information, please contact Mr. Terry Sensue, Oyster Creek Licensing Engineer at 609-971-4680.

Sincerely yours,

John J. Barton
Vice President and Director
Oyster Creek

JJB/TS/jc
cc: Administrator, Region 1
Senior NRC Resident Inspector
Oyster Creek NRC Project Engineer

IE22

NRC FORM 366N
(5-92)

LICENSEE EVENT REPORT (LER)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Oyster Creek, Unit 1	05000219	1 OF 3

TITLE (4)
INADVERTENT ISOLATION OF CONTAINMENT EXHAUST VALVES DUE TO IMPROPER SWITCH POSITION

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 NAME	DOCKET NUMBER
09	24	94	94	018	0	10	21	94	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
POWER LEVEL (10)			20.402(b)		20.405(c)	X	50.73(a)(2)(iv)		73.71(b)
			20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
			20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER
			20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		Specify in Abstract below and in Text, NRC Form 366A)
			20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
			20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
MARK BRADLEY, I&C SUPERINTENDENT	609-971-2359

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO				

ABSTRACT (16))

On September 24, 1994 the reactor was defueled during a refueling outage. During performance of the High Range Radiation Monitoring System calibration, the Channel I monitor function selector switch was inadvertently turned to the OFF position causing four automatic drywell and torus nitrogen inerting/ventilation exhaust isolation valves to close at approximately 1026 hours.

This event was caused by a fabrication deficiency. The monitor function selector switch knob does not have an indication on the side of the knob to show an accurate position reading.

This event was not safety significant since the isolation function of these valves are not required to be operable during present plant conditions.

The four isolated valves were reopened. Additional corrective actions include purchasing a monitor function selector switch knob with a position indicator and revising the surveillance procedure.

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DATE OF OCCURRENCE

This event occurred on September 24, 1994 at 1026 hours.

IDENTIFICATION OF OCCURRENCE

While performing a surveillance test on the Containment High Range Radiation Monitor System (CHRRMS) (EIIS-IL), the Channel I monitor function selector switch (CFI-HS) was inadvertently turned to the OFF position. This condition caused four automatic drywell and torus nitrogen inerting (EIIS-JM) exhaust isolation valves (CFI-ISV) to close. This event is reportable based on 10 CFR 50.73(a)(2)(iv).

CONDITION PRIOR TO OCCURRENCE

The "Containment High Range Radiation Monitoring System Calibration" surveillance, 621.3.030, was in progress. The reactor was defueled with the mode switch in the REFUEL position. The Reactor Building Ventilation System (RBVS)(EIIS-VA) was supplying fresh air to the drywell and exhausting air from the drywell and torus.

DESCRIPTION OF OCCURRENCE

Instrument and Control (I&C) technicians were performing surveillance 621.3.030, the refueling outage CHRRMS calibration. To perform the electronic check source test, the monitor function selector switch for both Channel I and Channel II were placed in the 1-10E3R/HR position. After performing the electronic check source test, both monitor function selector switches were to be returned to the ALL position.

The Channel II monitor function selector switch was placed in the ALL position without incident. However, for Channel I, the technician inadvertently went past the ALL position to the OFF position with the monitor function selector switch. This caused four air isolation valves from the drywell and torus exhaust path to cycle closed.

The Control Room operating crew responded to the containment isolation alarm received due to the CHRRMS actuation. They reset the initiation logic and opened the four isolation valves to re-establish air flow from the drywell and torus.

APPARENT CAUSE OF OCCURRENCE

This event was caused by a fabrication deficiency of the monitor function selector switch knob. The Channel II monitor function selector switch has an indication on the side of the knob to show an accurate position reading. The Channel I monitor function selector switch does not have this indication on the side of the knob making it hard to determine the position reading.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

Drywell high radiation signals are used to initiate an isolation of the drywell and torus nitrogen inerting/ventilation valves. Various valves will close on a drywell high radiation signal through two redundant high radiation isolation logic channels. This provides an added assurance in preventing offsite doses from exceeding 10 CFR 100 limits under accident conditions.

During a refueling outage when the reactor is not critical and reactor water temperature is below 212°F, primary containment integrity is not required to be maintained. Thus, the CHRRMS isolation function is not required by technical specifications to be operable. The Reactor Building Ventilation System (RBVS) remains in service providing fresh air to and exhausting air from the containment during a refueling outage only to assist with worker comfort while bulk work activities are ongoing within the drywell. This event is not safety significant.

CORRECTIVE ACTIONS

Immediate corrective actions were taken to restore the Channel I monitor function selector switch to the ALL position and reopen the four closed air exhaust isolation valves.

An order has been placed with the vendor for a monitor function selector switch knob. In the interim, the Channel I monitor function selector switch has been marked on the side of the knob to show the proper position indication. Also the surveillance procedure will be revised to bypass CHRRMS while performing the electronic check source test to prevent inadvertent actuations.

SIMILAR EVENTS

LER 88-033 "Containment High Range Radiation Monitor Causes Partial Containment Isolation Due to Spurious Signal Attributed to Signal Cable Flexing".