LICENSEE EVENT REPORT (LER)

Facility Name (1)	Docket Number (2)	Page (3)
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Title (4)
WEEKLY BATTERY SURVEILLANCE PERFORMED LATE DUE TO PERSONNEL ERROR

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(s)
										NONE	0 5 0 0 0
1 0	2 7	8 5	8 5	---	0 9 3	0 0	1 1	2 6	8 5		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)			
	5	___ 20.402(b)	___ 20.405(c)	___ 50.73(a)(2)(iv)	___ 73.71(b)
POWER LEVEL (10)	0 0 0	___ 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 (Specify in Abstract below and in Text)
		___ 20.405(a)(1)(iii)	X 50.73(a)(2)(i)	___ 50.73(a)(2)(viii)(A)	
		___ 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
	AREA CODE
Dennis L. Robison, Operations Dept. Surveillance Coordinator Extension 2622	8 1 5 2 3 4 - 5 4 4 1

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	
A											

SUPPLEMENTAL REPORT EXPECTED (14)		Expected Submission Date (15)	Month	Day	Year
___ Yes (If yes, complete EXPECTED SUBMISSION DATE)	___ X NO				

ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)

The 125 VDC Battery Bank and Charger Operability Weekly Surveillance affecting both 111 and 112 125 VDC Battery Bank and Chargers was not performed within the required time interval as prescribed in Technical Specifications. This delay was caused by personnel error due to inadequate review of the surveillances listed to be performed on the Station Surveillance Schedule.

This event has been reviewed with the shift personnel involved and will be addressed by training to be conducted in the form of a copy of this LER, and the associated DVR, which will be routed to each Shift Engineer and to each Equipment Operator with a cover letter stressing the importance of performing the assigned surveillances when scheduled or to implement the LCO ACTION requirement as required.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT

On October 28, 1985, at 1330, with the plant in Cold Shutdown (Mode 5), it was discovered that the '125 VDC Battery Bank and Charger Operability Weekly Surveillance', IBOS 8.2.1.2.a-1, had exceeded its allowable performance frequency. This violated Technical Specification 3.8.2.2 which requires one 125 VDC battery (EJ) and its associated charger to be OPERABLE in Modes 5 and 6. This omission was discovered when updated surveillance schedules were delivered to the Control Room and was brought to the attention of the Shift Foreman. The Shift Foreman directed the performance of the surveillance and it was successfully completed at 1354 on October 28, 1985. The surveillance tests both the 111 and 112 battery banks and chargers.

The performance of the surveillance was scheduled (per the Station surveillance schedule) for October 26, 1985, with a critical date determined to be October 27, 1985. The critical date is established by applying the limiting criteria of 125% of the stated performance frequency or 325% of the total interval for the last three (3) performances of the surveillance.

Permission to conduct the surveillance was initially granted at 2230 on October 25, 1985, with the plant operating at 92% power. The surveillance was not performed at this time due to the 112 battery being on "EQUALIZE" charge as opposed to "FLOAT" charge as required by the procedure. The procedure, however, addresses this condition and authorizes the battery charge to be changed to "FLOAT" for the performance of the surveillance and returned to "EQUALIZE" upon surveillance completion. The Equipment Operator overlooked this and chose to delay the surveillance. Subsequently, inadequate review of the surveillance schedule by Operating personnel on shift resulted in both the scheduled date and critical date for performance of the surveillance being missed. This was a cognitive personnel error.

As a result of the delay in discovering the nonperformance of the surveillance the ACTION statement for Technical Specification 3.8.2.2 was also exceeded. When the surveillance was not performed, the batteries became inoperable as of 2359 on 27 October 1985. The ACTION statement requires the Station to immediately suspend operations involving core alterations, positive reactivity changes or movement of irradiated fuel (no such operations were in progress); initiate corrective action to restore the required battery bank and full-capacity charger to OPERABLE status as soon as possible (which was accomplished immediately upon discovery); and within 8 hours depressurize and vent the Reactor Coolant System (AB) through at least a 2 square inch vent. The Reactor Coolant System had been depressurized within 8 hours in the course of the plant shutdown and cooldown in preparation for a subsequent maintenance outage; however, a 2 square inch vent had not been established prior to completion of the battery surveillance.

This event did not adversely affect plant or public safety since, as shown by the successfully completed surveillance, the batteries were capable of fulfilling their assigned functions.

In order to prevent reoccurrence of this problem the Byron Quality Control Department has instituted a temporary program to monitor the Station's surveillance system in an attempt to gather data for improving the surveillance completion record and to help educate on-shift personnel to the surveillance scheduling requirements

This event has been reviewed with the shift personnel involved emphasizing the importance of timely surveillance performance and the need to review the impact of planned evolutions on the surveillance schedule. Further, the need to track surveillance items authorized for performance and to throughly review the surveillance schedule was stressed. In the future, as a standard practice, surveillances must be done by the Due Date vs. the Critical Date. If unable to perform the surveillance by the due date the Shift Engineer will he informed. Additionally, surveillances will be marked with the due date by shift personnel authorizing the performance of the surveillance. This procedure has been revised to separate the two trains surveillances into separate procedures. The surveillance procedures will be further revised to incorporate the "FLOAT" to "EQUALIZE" authorization into the main body of the procedure. The importance of this event will be further emphasized by the distribution of this report with a cover letter reemphasizing the importance of timely performance of surveillance items, tracking the assigned surveillances to ensure timely completion, and implementing the Technical Specification ACTION requirements as required. Additionally, this report will be included within the Station's required reading program.

Previous incidents of exceeding the allowable surveillance frequencies were reported in LER's 85-3, 85-5. 85-13, 85-19, 85-25, 85-38, 85-44, 85-83.

Failure Data: None

Commonwealth Edison
Byron Nuclear Station
4450 North German Church Road
Byron, Illinois 61010

November 26, 1985

LTR: BYRON 85-1512

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

Dear Sir:

The enclosed Licensee Event Report from Byron Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(i)(b) which requires a 30 day written report.

This report is number 85-093-00; Docket No. 50-454.

Very truly yours,

R. E. Querio
Station Manager
Byron Nuclear Power Station

REQ/bf

Enclosure: Licensee Event Report No. 85-093-00

cc: J. G. Keppler, NRC Region III Administrator
J. Hinds, NRC Resident Inspector
INPO Record Center
CECO Distribution List

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