

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Wolf Creek Generating Station										DOCKET NUMBER (2) 0 5 0 0 0 4 8 2				PAGE (3) 1 OF 0 3											
TITLE (4) Engineered Safety Features Actuation - Control Room 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(S)												
1	0	0	9	8	5	8	5	0	7	1	0	0	1	1	0	6	8	5	0	5	0	0	0		
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																							
3		20.402(b)				20.406(c)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)				73.71(b)											
POWER LEVEL (10)		0 1 0 1 0				20.406(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)							
		20.406(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)											
		20.406(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(viii)(A)															
		20.406(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)															
		20.406(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)															
LICENSEE CONTACT FOR THIS LER (12)																									
NAME Merlin G. Williams - Superintendent of Regulatory, Quality and Administrative Services										TELEPHONE NUMBER AREA CODE 3 1 1 6 3 1 6 4 - 1 8 1 3 1 1															
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)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR									
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO													
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																									
<p>On October 9, 1985, at approximately 1015 CDT a Control Room Ventilation Isolation Signal (CRVIS) was initiated due to a radiation monitor in the Control Building Heating, Ventilating and Air Conditioning system sensing a momentary low voltage condition. All required Engineered Safety Features equipment responded properly. During this event the plant was in Mode 3, Hot Standby.</p> <p>The event occurred due to a nearby lightning strike causing a momentary low voltage condition at the radiation monitor which responded per design by initiating the CRVIS. The low voltage condition immediately cleared and the monitor returned to normal operation indicating normal background radiation levels.</p> <p>No radiation above normal background was present as confirmed by a redundant Control Building ventilation radiation monitor. A previous similar occurrence is described in LER 85-055-00.</p> <p>A design change which should indirectly minimize future occurrences due to lightning strikes in the general plant area is currently being evaluated.</p> <p>There was no damage to plant equipment or release of radioactivity due to this event, and at no time was there a threat to the health or safety of the public.</p>																									
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Wolf Creek Generating Station	0 5 0 0 0 4 8 2	8 5	- 0 7 1	- 0 0	0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 365A's) (17)

On October 9, 1985, at approximately 1015 CDT a Control Room Ventilation Isolation Signal (CRVIS) occurred due to radiation monitor GK-RE-05 [IL-MON] in the Control Building Heating, Ventilating, and Air Conditioning system [VI] sensing a momentary low voltage condition. Upon receipt of the CRVIS, all Engineered Safety Features equipment required to operate responded properly.

At the time of the event the plant was in Mode 3, Hot Standby, and the general plant area was in the midst of a thunderstorm.

The cause of this event was a lightning strike on the plant site, which resulted in tripping a 13,800 volt breaker supplying general site power. This caused voltage fluctuations on some in-plant power supplies, including NG01B, a 480 volt class 1E Motor Control Center [ED] which provides 120 volt power to radiation monitor GK-RE-05. This resulted in a momentary low voltage condition at the radiation monitor which responded per design by initiating the CRVIS. The low voltage condition cleared immediately and the monitor returned to normal operation indicating normal background radiation level.

No radiation above normal background was present as confirmed by redundant radiation monitor GK-RE-04. The Control Building Heating, Ventilating and Air Conditioning system was restored to a normal configuration per plant procedures after verification that radiation above normal background was not present.

Indications were also present that two additional radiation monitors powered from the NG01B Motor Control Center may have experienced similar momentary low voltage conditions. Testing of these radiation monitors confirmed they were functioning properly and all Engineered Safety Features equipment responded properly when power was removed from these monitors during testing.

An investigation conducted following a previous similar occurrence, discussed in Licensee Event Report 85-055-00, confirmed that individual radiation monitors can respond differently to power supply voltage fluctuations. Differences in the location and method of grounding of each radiation monitor can reduce the magnitude of the difference between the power supply voltage and the ground potential during a lightning strike when ground potential is raised. During this event, the momentary low voltage condition sensed by the two additional radiation monitors were not of sufficient magnitude or duration to cause initiation of the Engineered Safety Features equipment.

The accomplishment of the testing described above confirming that no equipment failures had occurred led to reporting this event approximately 14 minutes beyond the 4 hour time limit specified in 10CFR 50.72. The delay beyond the 4 hour limit was due to an oversight by the Shift Supervisor. Notification to the NRC Resident Inspector was made within the 4 hour limit.

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TEXT (If more space is required, use additional NRC Form 365A's) (17)

A design change is being developed which should indirectly minimize future similar occurrences due to lightning strikes in the general plant area.

There was no damage to plant equipment or release of radioactivity as a result of this event, and at no time did conditions develop that may have posed a threat to the public health or safety.



KANSAS GAS AND ELECTRIC COMPANY

GLENN L. KOESTER
VICE PRESIDENT - NUCLEAR

November 6, 1985

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

Mr. E.H. Johnson, Acting Director
Division of Reactor Safety and Projects
U.S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011

KMLNRC 85-249
Re: Docket No. STN 50-482
Subj: Licensee Event Report 85-071-00

Gentlemen:

The enclosed Licensee Event Report is submitted pursuant to 10 CFR 50.73 (a) (2) (iv) concerning an Engineered Safety Feature Actuation.

Yours very truly,

Glenn L. Koester
Vice President - Nuclear

GLK:see

Enclosure

xc: PO'Connor (2), w/a
JCummins, w/a

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