NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Salem Generating Station - Unit 2	0 5 0 0 0 3 1 1	1 OF 0 4

TITLE (4)
Tech. Spec. 3.9.12 Non-Compliance 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)
										0 5 0 0 0
1 0	0 1	8 8	8 8	0 2 0	0 0	1 1	0 1	8 8		0 5 0 0 0

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
6	R E F	20.402(b)	20.405(c)	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 (Specify in Abstract below and in Text, NRC Form 366A)
		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
M. J. Pollack - LER Coordinator	6 0 9 3 3 9 - 4 0 2 2

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

On October 2, 1988 it was discovered that fuel assembly insert changeouts in the Fuel Handling Building (FHB) was being conducted with the No. 21 FHB Exhaust Fan {VG} inoperable. The Updated Final Safety Analysis Report (UFSAR), requires both FHB Exhaust Fans to be operable to consider the FHB Ventilation System operable. Each fan has 50% capacity. Technical Specification 3.9.12 requires that the FHB Ventilation System be operable if the FHB crane is to be operated over the pool. The root cause of this event has been attributed to personnel error. The Senior Nuclear Shift Supervisor (SNSS) failed to inform the Unit 2 Shift Supervisor of the fuel assembly insert changeouts being conducted in the Fuel Handling Building. This event has been reviewed by Operations Department management. Appropriate corrective disciplinary action with the individual(s) involved has been taken. This event will be reviewed with Operations Department personnel. A standard tagout of the FHB Ventilation System will be prepared. This tagout will include tagging the FHB crane subsequently preventing its use when the ventilation system is inoperable. This event will be reviewed by the PSE&G Nuclear Training Center for incorporation in appropriate training programs. Station management will investigate other corrective action to prevent future occurrence of similar events.

IE22
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PLANT AND SYSTEM IDENTIFICATION:

Westinghouse - Pressurized Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as {xx}

IDENTIFICATION OF OCCURRENCE:

Non-Compliance With Technical Specification 3.9.12 Due to Personnel Error

Event Date: 10/01/88

Report Date: 11/01/88

This report was initiated by Incident Report No. 88-421.

CONDITIONS PRIOR TO OCCURRENCE:

Refueling Outage

DESCRIPTION OF OCCURRENCE:

On October 2, 1988 it was discovered that fuel assembly insert changeouts in the Fuel Handling Building (FHB) was being conducted with the No. 21 FHB Exhaust Fan {VG} inoperable.

The Updated Final Safety Analysis Report (UFSAR), requires both FHB Exhaust Fans to be operable to consider the FHB Ventilation System operable. Each fan has 50% capacity. Technical Specification 3.9.12 requires that the FHB Ventilation System be operable if the FHB crane is to be operated over the pool.

Technical Specification 3.9.12 states:

> "The Fuel Handling Area ventilation system shall be OPERABLE."

Technical Specification Action Statement 3.9.12.a states:

> "With no Fuel Handling Area ventilation system OPERABLE, suspend all operations involving movement of fuel within the storage pool or crane operation with loads over the storage pool until the Fuel Handling Area ventilation system is restored to OPERABLE status"

APPARENT CAUSE OF OCCURRENCE:

The root cause of this event has been attributed to personnel error. The Senior Nuclear Shift Supervisor (SNSS) failed to inform the Unit 2 Shift Supervisor of the fuel assembly insert changeouts being conducted in the Fuel Handling Building. This information should have

APPARENT CAUSE OF OCCURRENCE: (cont'd)

been addressed with the operating shift during the briefing conducted each day after the return of the SNSS from the morning (0700 hours) planning meeting.

To ensure continued support of FHB operations, during a planned "A" Vital Bus outage, the power supply for No. 21 FHB Exhaust Fan was to be changed from "A" Vital Bus to "C" Vital Bus. The SNSS was aware of this need on the morning of October 1. Since insert changeouts were being conducted during day shift, the SNSS decided to delay the change of power supply, for the No. 21 FHB Exhaust Fan, to the back shift. The Shift Supervisor also aware of the need to change the power supply for No. 21 FHB Exhaust Fan but not aware of the insert changeouts, initiated the change of power supply job at 1130 hours on October 1. The No. 21 FHB Exhaust Fan was made operable again at 1312 hours on October 2.

ANALYSIS OF OCCURRENCE:

The limitations on the FHB ventilation system ensure that radioactive material released from an irradiated fuel assembly will be filtered through the HEPA filters and charcoal adsorber prior to discharge to the atmosphere. The operability of this system and the resulting iodine removal capacity are consistent with the assumptions of the accident analysis. To ensure the appropriate negative pressure within the FHB is maintained, which ensures minimal release of radioactive materials during an event, both exhaust fans are required (i.e., 50% capacity each).

During the time period when the No. 21 FHB Exhaust Fan was not operable, the No. 22 FHB Exhaust Fan was operable. Additionally, no significant increase in the FHB airborne radioactivity levels occurred. Therefore, this event did not affect the health or safety of the public, however, this event is reportable in accordance with Code of Federal Regulations 10CFR 50.73(a)(2(i)(B).

CORRECTIVE ACTION:

This event has been reviewed by Operations Department management. Appropriate corrective disciplinary action with the individual(s) involved has been taken.

This event will be reviewed with Operations Department personnel.

A standard tagout of the FHB Ventilation System will be prepared. This tagout will include tagging the FHB crane subsequently preventing its use when the ventilation system is inoperable.

This event will be reviewed by the PSE&G Nuclear Training Center for incorporation in appropriate training programs.

CORRECTIVE ACTION: (cont'd)

Station management will investigate other corrective action to prevent future occurrence of similar events. This additional corrective action will be implemented as appropriate.

General Manager -
Salem Operations

MJP:pc

SORC Mtg. 88-098

PSE&G

Public Service Electric and Gas Company P.O. Box E Hancocks Bridge, New Jersey 08038

Salem Generating Station

November 1, 1988

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

Dear Sir:

SALEM GENERATING STATION
LICENSE NO. DPR-75
DOCKET NO. 50-311
UNIT NO. 2
LICENSEE EVENT REPORT 88-020-00

This Licensee Event Report is being submitted pursuant to the requirements of the Code of Federal Regulations 10CFR 50.73(a)(2)(i)(B). This report is required within thirty (30) days of discovery.

Sincerely yours,

L. K. Miller
General Manager-
Salem Operations

MJP:pc

Distribution

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