PSE&G

Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038-0236

Nuclear Business Unit

March 27, 1995

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

Attn: Document Control Desk

SALEM GENERATING STATION
LICENSE NO. DPR-70
DOCKET NO. 50-272
UNIT NO. 1

LICENSEE EVENT REPORT NO. 95-002-00

This Licensee Event Report is being submitted pursuant to the requirements of Code of Federal Regulation 10CFR50.73(a)(2)(i)(B). Issuance of this report is required within thirty (30) days of event discovery.

Sincerely,

Michael Maroni for John Summers

J. C. Summers
General Manager -
Salem Operations

SORC Mtg. 95-028
MJPJ:vs

C Distribution
LER File

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Salem Generating Station - Unit 1	05000 272	1 OF 4

TITLE (4) Failure to Restore Automatic Control of Pressurizer Power Operated Relief Valve (PORV) 1PR2 or Close Associated Block Valve 1PR7 Within One Hour

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
02	24	95	95	-- 002 --	00	03	27	95		05000
									FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)					
POWER LEVEL (10)	0%	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
		20.405(a)(1)(iii)	X	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)
Michael J. Pastva, LER Coordinator	609 339-5165

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 15 single-spaced typewritten lines) (16)

At 2058 hours on 2/24/95, a dedicated 3rd Nuclear Control Operator (NCO) placed control of pressurizer power relief valve 1PR2 in manual to support removal/inspection and channel calibration of a pressurizer pressure controller. Effective the same time, 1PR2 was declared inoperable, in accordance with Technical Specifications (TSs). Subsequently, at 2158 hours (same day) the Operations shift did not close the associated block valve, 1PR7, and the 1 hour timeframe of the TS required action was not met. Event discovery was made at 1910 hours on 2/25/95, by the offgoing Operations crew. Immediately following discovery, 1PR7 was closed to terminate the event. The event is attributed to personnel error (inattention to detail) by the involved Operations shift. Contributors: after selecting 1PR2 to manual control the 3rd NCO delayed closing 1PR7; the desk NCO and 3rd NCO became engaged with other work; and open 1PR7 was not recognized during the following shift turnover. Positive discipline has been taken regarding this event. The Operations Engineer met with the involved personnel and stressed the need for attention to detail and Management expectations regarding station operation and TS compliance. Nuclear Shift Supervisors have reviewed this event and lessons learned with their respective shifts. This event will be covered in licensed operator requalification training.

REQUIRED NUMBER OF DIGITS/CHARACTERS
FOR EACH BLOCK

BLOCK NUMBER	NUMBER OF DIGITS/CHARACTERS	TITLE
1	UP TO 46	FACILITY NAME
2	8 TOTAL 3 IN ADDITION TO 05000	DOCKET NUMBER
3	VARIES	PAGE NUMBER
4	UP TO 76	TITLE
5	6 TOTAL 2 PER BLOCK	EVENT DATE
6	7 TOTAL 2 FOR YEAR 3 FOR SEQUENTIAL NUMBER 2 FOR REVISION NUMBER	LER NUMBER
7	6 TOTAL 2 PER BLOCK	REPORT DATE
8	UP TO 18 – FACILITY NAME 8 TOTAL – DOCKET NUMBER 3 IN ADDITION TO 05000	OTHER FACILITIES INVOLVED
9	1	OPERATING MODE
10	3	POWER LEVEL
11	1 CHECK BOX THAT APPLIES	REQUIREMENTS OF 10 CFR
12	UP TO 50 FOR NAME 14 FOR TELEPHONE	LICENSEE CONTACT
13	CAUSE VARIES 2 FOR SYSTEM 4 FOR COMPONENT 4 FOR MANUFACTURER NPRDS VARIES	EACH COMPONENT FAILURE
14	1 CHECK BOX THAT APPLIES	SUPPLEMENTAL REPORT EXPECTED
15	6 TOTAL 2 PER BLOCK	EXPECTED SUBMISSION DATE

Plant and System Identification:

Westinghouse - Pressurized Water Reactor

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

Identification of Occurrence:

Failure to Restore Automatic Control Of Pressurizer Power Operated Relief Valve (PORV) 1PR2 Or Close Associated Block Valve 1PR7 Within One Hour

Event Date: February 24, 1995

Report Date: March 27, 1995

This report was initiated by Incident Report No. 95-173

Conditions Prior to Occurrence:

Mode 3 Reactor Power -0-% Unit Load -0- MWe

Heatup to normal operating temperature and pressure was in progress. To assist the Unit console Nuclear Control Operator (NCO) and the desk NCO, a dedicated third NCO was controlling pressurizer pressure, in manual.

Description of Occurrence:

At 2058 hours on February 24, 1995, the third NCO placed control of PORV 1PR2 in manual to support removal/inspection and channel calibration of pressurizer pressure controller 1PC-455K, in accordance with procedure S1.IC-CC.RC-0082(Q). Effective the same time, the valve was declared inoperable, in accordance with Technical Specification (TS) 3.4.3, ACTION: a. Subsequently, at 2158 hours (same day) the Operations shift did not close the associated block valve, 1PR7, and therefore the one hour timeframe of the TS required action was not met. Discovery of this occurrence was made at 1910 hours on February 25, 1995, by the offgoing Operations crew, during shift turnover. Immediately following event discovery, 1PR7 was then closed, which terminated the occurrence.

Analysis of Occurrence:

In MODE 3 (HOT STANDBY), TS 3.4.3, ACTION: a., requires that with one PORV inoperable and capable of being manually cycled, within one hour either restore the PORV to OPERABLE status or close the associated block valve, with power maintained to the block valve; otherwise, be in HOT SHUTDOWN within the following six hours

An operable PORV was administratively rendered inoperable by placing it in manual control. Subsequently, the TS action time frame to close the associated block valve was not met and the occurrence was not discovered until approximately 22 hours and 12 minutes later.

Apparent Cause of Occurrence:

This occurrence is attributed to "Personnel Error", as classified in NUREG-1022, Appendix B due to inattention to detail by the involved Operations shift crew. When the third NCO selected control of 1PR2 to manual he announced this action to the desk NCO, who logged that the TS action had been entered. However, within the immediate timeframe of placing control of the PORV to manual, the third NCO delayed closing 1PR7. In addition, both NCOs then became engaged with other work in progress and consequently overlooked the required closing of the block valve. Subsequently, the open 1PR7 was not recognized by the involved NCOs and Nuclear Shift Supervisors (NSSs) during the following Operations shift turnover.

Prior Similar Occurrence:

Review of documentation shows this event is an isolated occurrence. In this event, the TS action statement was appropriately entered; however the required action was not completed within the one hour time frame, as the result of personnel error.

LER 311/94-006-00 reported a Unit 2 occurrence on March 3, 1994, where documented entry into ACTION: a of corresponding Unit 2 TS 3.4.5 was not performed following closure of the PORV block valves. In the 1994 occurrence, the TS action statement was not entered due to an interpretive misunderstanding of the action statement.

Prior Similar Occurrence: (cont'd)

Corrective action to the 1994 occurrence included appropriate TS revision.

Safety Significance:

This occurrence is reportable pursuant to 10CFR50.73(a)(2)(i)(B) due to failure to comply with TS. This occurrence had minimal safety significance as credit is not taken for PORV operation in the accident analyses of the Salem Updated Final Safety Analysis Report. In addition, during this occurrence the PORV remained functionally operable and capable of being opened, if required.

Corrective Action:

Positive discipline has been taken regarding the personnel error.

As a result of this occurrence, the Operations Engineer met with the involved Operations shift personnel and stressed the need for attention to detail and Management expectations regarding operation of the station and TS compliance.

Senior Nuclear Shift Supervisors have reviewed the circumstances of this occurrence and lessons learned with their respective shifts.

In addition, this occurrence will be covered in licensed operator requalification training.

Michael Morani for John Summers

J. C. Summers
General Manager -
Salem Operations

MJPJ:vs

REF: SORC Mtg. 95-028