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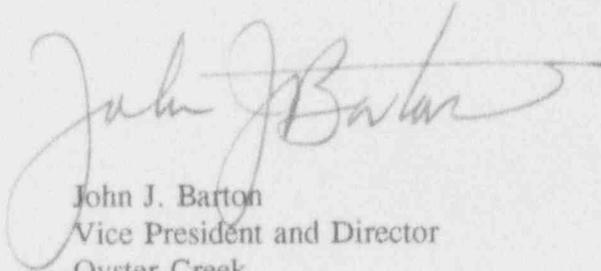
U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report 93-008

Enclosed is Licensee Event Report 93-008.

If there are any questions please contact Brenda DeMerchant, OC Licensing Engineer at 609-971-4642.

  
John J. Barton  
Vice President and Director  
Oyster Creek

300043

JJB/BDEM

Enclosure

cc: Administrator, Region I  
Senior Resident Inspector  
Oyster Creek NRC Project Manager

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)

Oyster Creek, Unit 1

DOCKET NUMBER (2)

05000219

PAGE (3)

1 OF 5

TITLE (4) Inadvertent Actuation of Core Spray System I During Surveillance Testing 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 NAME	DOCKET NUMBER
12	03	93	93	008	0	12	23	93	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
		20.402(b)		20.405(c)	<input checked="" type="checkbox"/>	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 DONALD HOLT, Materiel Assessment Engineer

TELEPHONE NUMBER (Include Area Code) 609-971-4657

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)

YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/>	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (16)

On December 3, 1993 at approximately 1115 hours, the reactor was operating at approximately 100 % power and Procedure 610.3.105, Core Spray System I Instrument Channel Calibration Test and System Operability Surveillance was in progress. I & C Technicians performing this test removed fuses from System II rendering it inoperable. When System I was tested, it inadvertently initiated. Reactor Pressure Vessel injection did not occur because the Core Spray System is designed to inject at pressures less than 350 psig. This event was caused by inattention to duty.

Core Spray System I was returned to operation. System II was returned to operation and operability was demonstrated. A critique was held and appropriate personnel actions were taken with respect to the individuals involved. Corrective actions will be incorporated into the I & C Personnel training program.

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DATE OF OCCURRENCE

This event occurred on December 3, 1993 at 1115 hours.

IDENTIFICATION OF OCCURRENCE

While performing a surveillance test on Core Spray System I, an inadvertent actuation occurred of Core Spray System I (CSS) (EEIS Code BM). Instrument & Control (I & C) Technicians had mistakenly removed the fuses for Core Spray System II Pumps instead of the fuses for Core Spray System I, which allowed Core Spray System I to actuate when the instrument calibration was performed. This event is reportable based on 10CFR50.73(a)(2)(iv).

CONDITIONS PRIOR TO OCCURRENCE

The Core Spray System I Instrument Channel Calibration Test and System Operability Surveillance, #610.3.105 was in progress to verify operability of Core Spray System I, prior to removing System II from service for maintenance. The reactor was at approximately 100% power with the mode switch in run.

DESCRIPTION OF OCCURRENCE

On Thursday, December 2, 1993, six (6) I & C Technicians were preparing to perform the scheduled Surveillance of Core Spray System II, # 610.3.205, when they were advised System II was postponed to December 4, because of maintenance on the system.

On Friday, December 3, 1993, at approximately 0800 hours, six (6) I & C Technicians were assigned to perform the same surveillance on Core Spray System I, (# 610.3.105). Four (4) of the six (6) I & C Technicians had reviewed the System II Surveillance the previous day. Five (5) of the Technicians were given controlled copies of the Core Spray System I Surveillance by their Job Supervisor and were told which Technicians would be performing the Surveillance. The sixth (6th) Technician reviewed the surveillance after one of the other Technicians completed reviewing his copy. After they had completed reviewing the Surveillance, the Lead Technician made the assignment of procedure steps to the Technicians. After they had completed reviewing the Surveillance, all Technicians initialed the prerequisite acknowledging that they had reviewed the Surveillance.

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**DESCRIPTION OF OCCURRENCE (Cont'd)**

The lead Technician and his assistant then went to the Control Room to start the Surveillance, while two of the other Technicians proceeded to the Instrument Rack to prepare to perform their steps in the Surveillance. The last two Technicians waited in the Instrument Shop until the Lead Technician called them to perform their steps in the Surveillance.

The Lead Technician was given permission from the Group Shift Supervisor to start the Surveillance and then proceeded to call the Instrument Shop to have the Instrument Technicians perform steps 6.2.3 through 6.2.6. of the procedure. During preparation for the Surveillance in the Instrument Shop, a Technician picked up a copy of Core Spray System II Surveillance that was left next to the test equipment from the day before. The Instrument Technicians then left the Instrument Shop with the copy of the Core Spray System II Surveillance instead of the correct copy of Core Spray System I Surveillance. One of the two Technicians put down his copy of the Core Spray System I Surveillance after the other Technician told him he already had a copy.

The Technicians performed the steps as requested, but on System II instead of System I, pulling the negative bus closing circuit control power fuses for System II Core Spray Pumps and Booster Pumps rendering Core Spray System II inoperable. They installed five (5) voltmeters and prevented the idle start of Emergency Diesel Generator 2 (EDG2).

During the calibration check of Reactor Vessel Low-Low Water Level Sensor (RE02A) trip point, Core Spray System I initiated. The Technicians who pulled fuses on Core Spray System II discovered they had the System II Surveillance. The I & C Technicians were then instructed to put both Core Spray Systems back to their normal line up. Core Spray System II Surveillance was then performed to prove operability of the system. Core Spray did not inject into the reactor since reactor pressure was greater than 350 psig, and the EDG started and idled as designed.

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APPARENT CAUSE OF OCCURRENCE

This event was caused by inattention to duty. The I & C Technician who picked up the wrong Surveillance stated during the critique that when he left the I & C shop, he was unsure on which Core Spray System the surveillance was to be performed, even though he had performed a review and signed the prerequisite in the System I Surveillance procedure. The other Technician stated that he did know he was going to perform the Surveillance on System I, but was so focused on performing the required steps, that he did not question if they had the proper Surveillance Procedure when he left the Instrument Shop.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The Core Spray System is designed to provide decay heat removal following a postulated Loss-of-Coolant Accident (LOCA) in order to prevent fuel clad melting. The Core Spray System delivers a low pressure spray pattern over the fuel following a LOCA, to limit peak clad temperature below 2200 degrees Fahrenheit.

Core Spray System I initiated as designed during the calibration check of Reactor Vessel Low-Low Water Level Sensor (RE02A) during the Core Spray System I Surveillance. All Technical Specification requirements for Core Spray System I were maintained. Core Spray System II was rendered inoperable when the I & C Technicians pulled the negative bus closing circuit control power fuses for System II Core Spray Pumps and Booster Pumps. Maximum Average Planner Linear Heat Generation Rate (MAPHLGR) was maintained less than 90 percent while Core Spray System II was inoperable.

During this event, all Engineered Safety Features operated as designed. Reactor Pressure Vessel injection did not occur because the Core Spray System is designed to inject at pressures less than 350 psig. Based on the proper response of the Core Spray System and diesel generator, the safety significance of this event is considered minimal. The Core Spray System contains two completely independent systems each containing two sets of pumps, either one of which can supply one hundred percent rated flow for the system.

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CORRECTIVE ACTIONS

Immediate corrective actions were taken to restore the Core Spray Systems to normal configuration and the Core Spray System II was demonstrated to be operable.

The critique of this incident will be incorporated in the Training Program for I&C personnel. Included in this training, I & C personnel will be given direction that, prior to performing a surveillance, an announcement will be made to all technicians involved in the testing (via their common communications equipment) informing all technicians what procedure they are about to perform.

Direction to the Job Supervisor will re-emphasize the need to control all copies of Surveillances.

SIMILAR EVENTS

LER 88-018                      Inadvertent Actuation of "B" Isolation Condenser  
Special Report 92-03        Inadvertent Opening of 'C' Electromatic Relief Valve