



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

Salem Generating Station

October 20, 1982

Mr. R. C. Haynes
Regional Administrator
USNRC
Region 1
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Haynes

LICENSE NO. DPR-70
DOCKET NO. 50-272
REPORTABLE OCCURRENCE 82-042/03X-1
SUPPLEMENTAL REPORT

Pursuant to the requirements of Salem Generating Station
Unit No. 1 Technical Specifications, Section 6.9.1.9.c,
we are submitting supplemental Licensee Event Report for
Reportable Occurrence 82-042/03X-1.

Sincerely yours,

H. J. Midura
General Manager -
Salem Operations

RH:ks *s.c.l.*

CC: Distribution

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The Energy People

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Report Number: 82-042/03X-1
Report Date: 10-20-82
Occurrence Date: 06-28-82
Facility: Salem Generating Station, Unit 1
Public Service Electric & Gas Company
Hancocks Bridge, New Jersey 08038

IDENTIFICATION OF OCCURRENCE:

Valves 12AF10 and 12AF86 - Improper Implementation of Administrative Controls.

This report was initiated by Incident Report 82-162.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 - Rx Power 97% - 1050 MWe.

DESCRIPTION OF OCCURRENCE:

On June 28, 1982 at 1020 hours, the NRC Resident Inspector reported to the Shift Supervisor that he had found that Valves 12AF10 and 12AF86 were not properly locked open as required by Surveillance Procedure SP(O)4.7.1.2a(4). The valves were, in fact, open, but the chains were only locked on the valve yokes and did not prevent operation of the valve handwheels. The Shift Supervisor immediately dispatched an operator to properly lock the valves. At 1030 hours, the Shift Technical Advisor verified that the valves were locked in the open position.

DESIGNATION OF APPARENT CAUSE OF OCCURRENCE:

Upon investigation, it was determined that the valves had last been operated on June 21, 1982, for a maintenance tag-out. Following completion of the maintenance, the valves were opened and locked in that position; verification of the valve positions was performed in accordance with Administrative Procedure AP-15. It is suspected that the personnel performing the valve line up and verifications checked that the valves were in the proper position and that the chains were in place and locked, but failed to notice that the chains were improperly installed.

ANALYSIS OF OCCURRENCE:

The operability of the Auxiliary Feedwater System ensures that the Reactor Coolant System can be cooled down to less than 350°F from normal operating conditions in the event of a total loss of offsite power. Valves 12AF10 and 12AF86 are isolations in No. 13 Auxiliary Feedwater Pump supply to No. 12 Steam Generator. Since the valves were open, however, there was no loss of an auxiliary feedwater flowpath. The incident therefore involved no risk to the health and safety of the general public.

This occurrence constituted inadequate implementation of procedural controls which threatened to cause a reduction of the degree of redundancy provided in an engineered safety feature, and is reportable in accordance with Technical Specification 6.9.1.9.c.

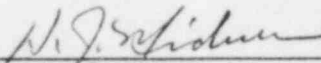
CORRECTIVE ACTION:

As noted, the valves were found to be in the open position, and were then properly locked in place. An investigation was conducted to determine the cause of the event. All personnel performing valve line ups and verifications were counseled on the proper methods of locking and chaining valves open and closed. Valve operation and tagging lesson plans have been revised to include proper methods of locking and chaining valves.

FAILURE DATA:

Not Applicable.

Prepared By R. Heller



General Manager -
Salem Operations

SORC Meeting No. 82-94B