Illinois Power Company
Clinton Power Station
P.O. Box 678
Clinton, IL 61727
Tel 217 935-5623
Fax 217 935-4632

John G. Cook
Vice President

ILLINOIS POWER

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Docket No. 50-461

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

Subject: Clinton Power Station - Unit 1
Licensee Event Report No. 95-007-00

Dear Sir:

Enclosed is Licensee Event Report No. 95-007-00: Inattention to Detail During Surveillance Testing and Process Radiation Monitor Restoration Results in Entering the Startup Mode without Required Average Power Range Monitor Testing being Completed and a Control Room Ventilation Subsystem being Inoperable. This report is being submitted in accordance with the requirements of 10CFR50.73

Sincerely yours,

J. G. Cook
Vice President

MAR/csm

Enclosure

cc: NRC Clinton Licensing Project Manager
NRC Resident Office, V-690
Regional Administrator, Region III, USNRC
Illinois Department of Nuclear Safety
INPO Records Center

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NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), 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)

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TITLE (4)
Inattention to Detail During Surveillance Testing and Process Radiation Monitor Restoration Results in Entering the Startup Mode without Required Average Power Range Monitor Testing being Completed and a Control Room Ventilation Subsystem being Inoperable

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
									None	05000
09	09	95	95	007	00	10	09	95	FACILITY NAME: None	DOCKET NUMBER: 05000

OPERATING MODE (9)	2
POWER LEVEL (10)	000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
	20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
	20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
	20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
A. K. Beecher, Project Operations Specialist	(217) 935-8881, Extension 3373
M. S. Dodds, Supervisor-Radiological Operations	(217) 935-8881, Extension 3228

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)

While in Mode 3 (HOT SHUTDOWN), a channel functional test of the average power range monitors (APRMs) was not completed as required prior to entry into Mode 2 (STARTUP). Additionally, both control room ventilation subsystems were not operable as required prior to plant entry into Mode 2. The cause of the event is attributed to a lack of attention to detail by operations and radiation protection (RP) personnel. Operators failed to return the reactor mode switch to SHUTDOWN following reactor mode switch interlock function surveillance testing. With the reactor mode switch in STARTUP/HOT STANDBY the plant entered Mode 2 (by definition) without a current APRM surveillance and with one control room ventilation (VC) subsystem inoperable. The VC subsystem was inoperable due to an incorrect high alarm setpoint being applied to one of its air intake process radiation monitors (PRMs) during restoration from a loss of power. Corrective actions for this event include revising the PRM procedure to add independent verification of channel parameters during restoration, revising intermediate and source range monitor surveillance procedures to provide additional guidance on reactor mode switch positioning, reviewing other surveillance procedures for need of additional reactor mode switch positioning guidance, revising the surveillance guidance procedure to provide better direction regarding performance of steps that do not apply for specific uses, and briefing Operations and RP personnel about this event.

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DESCRIPTION OF EVENT

On September 9, 1995, at about 0455 hours, the plant entered Mode 3 (HOT SHUTDOWN) from Mode 1 (POWER OPERATION) to start a forced outage (FO) (FO 95-04). The FO was required to repair an air leak inside the Drywell. Entering Mode 3 from Mode 1 initiates a requirement to perform channel functional testing of source range monitors (SRMs) [MON] [IG] in accordance with surveillance CPS 9031.13, "SRM Channel Functional."

At about 0610 hours, operators commenced performance of surveillance CPS 9031.13. Step 5.6 of this surveillance requires that the reactor mode switch [HS] be placed in the STARTUP/HOT STANDBY position for the duration of the surveillance. Clinton Power Station (CPS) Technical Specification 3.10.2, "Reactor Mode Switch Interlock Testing," allows the reactor mode switch to be placed in the STARTUP/HOT STANDBY position and plant operation not be considered in Mode 2 (STARTUP) when performing testing of reactor mode switch interlock functions. At about 0713 hours, operators completed surveillance CPS 9031.13 for SRM channels "A," "C," and "D" with the exception of step 8.5.1. Step 8.5.1 of the surveillance requires that the reactor mode switch be returned to the SHUTDOWN position if moved in surveillance step 5.6. Operators left the reactor mode switch in the STARTUP/HOT STANDBY position to support the performance of surveillance CPS 9031.14, "IRM Channel Functional," and noted this action in the comments section of the Surveillance Test Package Cover Sheet for surveillance CPS 9031.13. Surveillance CPS 9013.14 was to be performed in preparation for plant entry into Mode 2 scheduled to occur later on September 9, 1995.

At about 0912 hours, operators commenced performance of surveillance CPS 9031.14 to satisfy channel functional testing requirements of intermediate range monitors (IRMs) for the Reactor Protection system (RPS) [JC] neutron flux-high and inop functions. Step 5.4 of this surveillance requires that the reactor mode switch be placed in the STARTUP/HOT STANDBY position for the duration of the surveillance. Since the reactor mode switch had been left in the STARTUP/HOT STANDBY position following completion of surveillance CPS 9031.13, the operator performing step 5.4 of surveillance CPS 9031.14 was not required to reposition the reactor mode switch as directed by the procedure; however, the operator initialed this step indicating that he had repositioned the reactor mode switch from the SHUTDOWN to the STARTUP/HOT STANDBY position.

At about 1233 hours, operators completed surveillance CPS 9031.14 on IRM channels A through H inclusive. Step 8.5.1 of this procedure requires that the reactor mode switch be returned to the SHUTDOWN position if moved in step 5.4. This step was not performed because the operator performing the surveillance noted that since he did not move the reactor mode switch as directed in step 5.4, he would leave the reactor mode switch in the position that it was in when the surveillance was started. Additionally, Operations personnel incorrectly assumed that the next surveillance to be performed, surveillance CPS 9013.12, "APRM Channel Functional," also required the reactor mode switch to be in the STARTUP/HOT STANDBY position. However, Operations personnel did not review surveillance CPS 9013.12 to verify this assumption. As a result, the operator performing surveillance CPS 9013.14 noted step 8.5.1 as "N/A" (not applicable) in the surveillance package.

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Since the reactor mode switch was not returned to the SHUTDOWN position following completion of surveillance CPS 9013.14, the allowances of Technical Specification limiting condition for operation (LCO) 3.10.2 could no longer be utilized and thus, based on reactor mode switch position the plant entered Mode 2 on September 9, 1995, at about 1233 hours. At the time of plant entry into Mode 2, reactor [RCT] coolant temperature was about 494 degrees Fahrenheit and pressure was about 650 pounds per square inch. By definition, plant operating mode corresponds to any one inclusive combination of reactor mode switch position, average reactor coolant temperature, and reactor vessel head closure bolt tensioning with fuel in the reactor vessel.

At about 2045 hours, during a routine walkdown of main control room (MCR) panels [PL], the Operations shift supervisor (SS) discovered that the reactor mode switch was in the STARTUP/HOT STANDBY position without surveillance testing in progress.

At about 2105 hours, the reactor mode switch was placed in the SHUTDOWN position and the plant re-entered Mode 3.

Technical Specification 3.3.1.1, "Reactor Protection System (RPS) Instrumentation," requires, in part, that average power range monitors (APRMs) neutron flux-high, setdown and inop functions channel functional testing be current while in Mode 2. This requirement is satisfied by performance of surveillance CPS 9031.12. Technical Specification LCO 3.0.4 prohibits entry into a Mode or other specified condition unless the associated ACTIONS of the applicable Technical Specification(s) to be entered permit continued operation in the Mode or other specified condition for an unlimited period of time. Since the plant entered Mode 2 from Mode 3 on September 9, 1995, at 1233 hours without meeting the requirements of Technical Specification 3.3.1.1, the requirements of Technical Specification LCO 3.0.4 were not met.

Condition report 1-95-09-012 was initiated to track a root cause investigation and corrective action determination for this event.

The requirements of Technical Specification LCO 3.0.4 were also not met during the plant entry into Mode 2 on September 9, 1995, at 1233 hours and when Mode 2 was entered in preparation for plant startup at 2215 hours because the requirements of Technical Specification 3.7.3, "Control Room Ventilation (CRV) system," [VI] had not been met.

On September 8, 1995, at about 0201 hours, alternating current (AC) power was lost to main control room air intake process radiation monitor (PRM) 1RIX-PR009D. This resulted in an AC power fail alarm [ALM] being received on the Area Radiation/Process Radiation (AR/PR) [IL] system central control terminal (CCT). Radiation Protection (RP) and Control and Instrumentation (C&I) personnel who responded to determine the cause of the loss of AC power to PRM 1RIX-PR009D found that the circuit breaker [52] for PRM 1RIX-PR009D was in the open position. It was later determined that the circuit breaker had been inadvertently opened by Operations personnel while removing a danger tag on an adjacent circuit breaker.

At about 0405 hours, AC power was restored to PRM 1RIX-PR009D by closing its associated circuit breaker.

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At about 0448 hours, communication was established between PRM 1RIX-PR009D and the RP office AR/PR system CCT. In accordance with plant procedure CPS 7410.75, "Operation of AR/PR Monitors," step 8.10.4, prior to declaring an AR/PR monitor operable, monitor channel parameter files are verified against those recorded on CPS 7410.75D002, "AR/PR Channel Parameter Data Sheet," for the affected monitor. While performing the required channel parameter verification, RP personnel found the channel parameters for PRM 1RIX-PR009D to be at default values due to the loss of power. At about 0452 hours, RP personnel restored PRM 1RIX-PR009D channel parameters to those recorded on the associated data sheet CPS 7410.75D002.

At about 0538 hours, PRM 1RIX-PR009D was declared operable.

On September 9, 1995, at about 2343 hours, while performing a shiftly channel check on PRM 1RIX-PR009D in accordance with surveillance CPS 9911.24, "AR/PR Shiftly/Daily Surveillances," RP personnel discovered that the PRM high alarm setpoint was incorrectly set at 9.90E+02 millirem per hour (mR/hr) versus 9.90E+00 mR/hr as specified on data sheet CPS 7410.75D002. RP personnel then changed the PRM 1RIX-PR009D high alarm setpoint to the correct value of 9.90E+00 mR/hr as specified on data sheet CPS 7410.75D002, verified that the alert alarm setpoint was correct (9.90E-01 mR/hr), and notified the main control room.

Technical Specification LCO 3.3.7.1 requires in part, that one control room air intake radiation monitor per air intake per trip system be operable with a high alarm setpoint of less than or equal to 10 mR/hr while in Modes 1, 2, and 3. Since the high alarm setpoint for PRM 1RIX-PR009D was incorrectly set at 9.90E+02 mR/hr from September 8, 1995, at 0452 hours until September 9, 1995, at 2343 hours, the monitor was inoperable during this period. Technical Specification LCO 3.3.7.1, ACTION B.2 requires that with one or more required CRV system instrumentation channels inoperable, the associated CRV subsystem be declared inoperable. During the period the high alarm setpoint for PRM 1RIX-PR009D was incorrectly set at 9.90E+02 mR/hr, the associated CRV subsystem was inoperable.

Technical Specification LCO 3.7.3 requires in part, that two CRV subsystems be OPERABLE in Modes 1, 2, and 3. Since the plant entered Mode 2 from Mode 3 on September 9, 1995, at 1233 hours and again at 2215 hours without meeting the requirements of Technical Specification 3.7.3, and since continued plant operation is limited with a CRV subsystem inoperable, the requirements of Technical Specification LCO 3.0.4 were not met.

Condition report 1-95-09-013 was initiated to track a root cause investigation and corrective action determination for this issue.

No automatic or manually initiated safety system responses were necessary to place the plant in a safe and stable condition. No other equipment or components were inoperable at the start of this event to the extent that their inoperable condition contributed to this event.

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CAUSE OF EVENT

The cause of the event is attributed to a lack of attention to detail by Operations and RP personnel. During simultaneous efforts to complete a plant shutdown and perform pre-startup checks and surveillances, inadequate communications and a lack of a questioning attitude resulted in the mispositioning of the reactor mode switch. Because of the planned short-term of the forced outage, performance of surveillance CPS 9031.13 was followed closely by performance of surveillances CPS 9031.14 and CPS 9031.12, respectively. Because surveillance CPS 9013.14 also requires the reactor mode switch to be in the STARTUP/HOT STANDBY position during the performance of the test, as does surveillance CPS 9031.13, the restoration step of surveillance CPS 9031.13, which directs that the reactor mode switch be returned to the SHUTDOWN position, was noted as not being performed. This action was done to eliminate one scram signal insertion which would occur when moving the reactor mode switch from the STARTUP/HOT STANDBY to the SHUTDOWN position. This action was not subsequently discussed during shift turnover activities which occurred prior to performance of surveillance CPS 9031.14 and with Operations personnel who performed surveillance CPS 9031.14.

When Operations personnel commenced performance of surveillance CPS 9031.14, the reactor mode switch was found in the STARTUP/HOT STANDBY position. Operations personnel did not question why the reactor mode switch was already in the STARTUP/HOT STANDBY position. Instead, step 5.4 in surveillance CPS 9031.14 which requires that the reactor mode switch be moved to the STARTUP/HOT STANDBY position was incorrectly initialed, as if the operators had positioned the switch. At the completion of surveillance CPS 9031.14, operators noted that step 8.5.1 required the reactor mode switch be returned to the SHUTDOWN position if moved in step 5.4. Operators concluded that since the reactor mode switch was not moved in step 5.4 and because they thought the next surveillance to be performed (surveillance CPS 9031.12) also required the reactor mode switch to be in the STARTUP/HOT STANDBY position, step 8.5.1 did not apply and marked the step as "N/A" in the surveillance package. Operators did not review surveillance CPS 9031.12 to verify whether or not it contained a requirement regarding reactor mode switch position and did not obtain authorization from the shift supervisor/assistant shift supervisor (SS/ASST.SS) to make step 8.5.1 "N/A" as required by plant procedure CPS 1011.02, "Implementation and Control of Surveillances."

The investigation of this event concluded that inadequate communications and inadequate supervision contributed to the cause of this event. The licensed reactor operator who performed surveillance CPS 9031.14 was not a normal member of the Operations crew on shift at the time of this event. This operator was brought into the main control room to assist in the performance of pre-startup activities. As such, this individual did not participate in the day shift pre-shift briefing, and therefore, was unaware of the previous performance of surveillance CPS 9031.13 and the position of the reactor mode switch. Although a briefing to discuss the performance of surveillance CPS 9031.14 was held just prior to its start, that briefing did not emphasize that reactor mode switch movements were involved. Following completion of surveillance CPS 9031.14, Operations personnel did not communicate their decision to leave the reactor mode switch in the STARTUP/HOT STANDBY position to the

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Operations line assistant shift supervisor (LASS), a senior reactor operator. Also, during the course of the day, neither the midnight shift to day shift nor the day shift to swing shift LASS turnovers include a discussion of reactor mode switch position. The LASS also did not provide the level of attention appropriate to activities involving reactor mode switch manipulations.

Also contributing to the cause of this event was the expected short duration of the forced outage. Because of the short duration, pre-startup activities were being started while post-shutdown actions were being completed. This overlap resulted in Operations personnel participating in or supervising multiple surveillances and tests. As a result, performance of surveillance CPS 9031.14 did not receive the appropriate level of attention.

With regard to the incorrect high alarm setpoint being applied to main control room air intake PRM 1RIX-PR009D, RP personnel failed to perform self checking after editing PRM 1RIX-PR009D channel parameters files when restoring the PRM to operability. Additionally, no independent verification of PRM 1RIX-PR009D channel parameter files was performed to verify that the correct values were edited. Contributing to this event was an inadequate procedure. Plant procedure CPS 7410.75 did not require that an independent verification of channel parameter files be performed when returning a PRM to an operable status. Also, a note contained in plant procedure CPS 7410.75 was vague as to the applicability of the requirement to initiate a CPS 7410.75D002, "AR/PR Channel Parameter Data Sheet," for editing of PRM channel parameters when they are found to be at default values. Per plant procedure CPS 7410.75, completion of data sheet CPS 7410.75D002 requires a verification of edited channel parameters by a second individual.

CORPECTIVE ACTION

Upon discovery that the reactor mode switch was incorrectly in the STARTUP/HOT STANDBY position, the switch was returned to the SHUTDOWN position.

An Operations Night Order was issued to provide guidance regarding the proper use of "N/As" and "Notes" when performing surveillances.

Operations personnel involved in this event will develop and present a briefing to Operations shift crews describing the event, including causes and corrective action. The importance of self checking, maintaining good communications, and a questioning attitude will be reinforced in the briefing.

Surveillance procedures CPS 9031.13 and CPS 9031.14 will be revised to provide additional guidance concerning the correct positioning of the reactor mode switch in the surveillance procedure restoration section. Other surveillance procedures will be reviewed to determine if additional guidance is required to provide positive control of reactor mode switch position during and following surveillance testing.

Plant procedure CPS 1011.02 will be revised to provide more specific direction regarding the approved method for the use of "N/As" and "Notes" for surveillance procedure steps and sections that do not apply for specific uses.

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A Radiological Operations Night Order was issued to specify that independent verification is required when performing PRM channel parameters edits to restore PRMs to operability.

Data sheet CPS 7410.75D004 was revised to require independent verification of PRM channel parameter files when returning PRMs to operability.

Plant procedure 7410.75 will be revised to clarify that the initiation of a new CPS 7410.75D002, "AR/PR Channel Parameter Data Sheet," is required when editing PRM channel parameters to return PRMs to an operable status if editing of parameters was not directed by a surveillance procedure.

A copy of condition report 1-95-09-013, which describes this event (concerning the main control room air intake PRM high alarm setpoint), including its root cause and corrective action, and this LER will be provided to Radiological Operations personnel as required reading.

ANALYSIS OF EVENT

This event is reportable under the provisions of 10CFR50.73(a)(2)(i)(B) because of the failure to demonstrate that the APRM neutron flux-high, setdown and inop functions were operable prior to the plant entry into Mode 2 and because one of the required two control room ventilation subsystems was not operable prior to the plant entry into Mode 2 as required by the Technical Specifications. Mode 2 was thus not entered in compliance with Technical Specification LCO 3.0.4.

Assessment of the safety consequences and implications of this event concluded that this event was not nuclear safety significant. The operability of the APRM neutron flux-high, setdown and inop functions were not demonstrated prior to plant entry into Mode 2 on September 9, 1995, at about 1233 hours. However, the completion of surveillance CPS 9031.12, "APRM Channel Functional," on September 9, 1995, at about 1920 hours, demonstrated that the APRM neutron flux-high, setdown function was capable of performing its function of generating a trip signal to prevent fuel damage resulting from abnormal operating transients during plant operation at low power (i.e., Mode 2). This surveillance also demonstrated that the APRM inop function was capable of performing its function of providing a trip signal to the RPS if an APRM channel becomes inoperable.

Both control room ventilation system subsystems were not operable prior to entry into Mode 2 on September 9, 1995, at about 1233 and again at 2215 hours as required by Technical Specifications. One subsystem was operable, the other subsystem was considered inoperable because one of two associated main control room air intake PRMs contained a high alarm setpoint which was outside the allowable value specified by Technical Specifications. With a high alarm setpoint outside that required, the associated main control room air intake PRM is not available to ensure that no single instrument failure can preclude CRV system high radiation mode initiation. However, because of the CRV initiation logic, the inoperable subsystem was still capable of automatic initiation without the occurrence of an additional failure and capable of manual initiation. In addition, operation with one control room ventilation subsystem inoperable is allowed for seven-days by Technical Specifications. Seven-days is based on the low probability of a design basis accident

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occurring during the associated seven-day inoperability period, and that the remaining control room ventilation subsystem can provide the required capability of providing a radiologically controlled environment from which the plant can be safely operated following a design basis accident. The unaffected control room ventilation subsystem was capable of performing its required function at all times during the inoperability period of the affected control room ventilation subsystem. The inoperable control room ventilation subsystem was returned to an operable status within the seven-day inoperability period allowed by Technical Specifications.

ADDITIONAL INFORMATION

No equipment or components failed as a result of this event.

A review of recent previous LERs identified that LER 92-008-00 discussed a mis-positioning of the reactor mode switch during surveillance testing resulting in actuation of containment isolation valves and the Reactor Protection System. However, that LER occurred as a result of a lack of attention to detail while moving the reactor mode switch, not in the failure to reposition the reactor mode switch following the completion of surveillance testing. Clinton Power Station has not reported similar events in recent history with regard to editing incorrect PRM channel parameters.

For further information regarding this event, contact A. K. Beecher, Project Operations Specialist at (217) 935-8881, extension 3373, (as it applies to the positioning of the reactor mode switch) or M. S. Dodds, Supervisor-Radiological Operations at (217) 935-8881, extension 3228 (as it applies to the editing of PRM channel parameter files).