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L45-92(07-09)LP
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ILLINOIS POWER

July 9, 1992
10CFR50.73

Docket No. 50-461

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

Subject: Clinton Power Station - Unit 1
Licensee Event Report No. 92-008-00

Dear Sir:

Please find enclosed Licensee Event Report No. 92-008-00: Inattention to Detail During Surveillance Results in Mis-Positioning the Reactor Mode Switch and Actuation of Containment Isolation Valves and the Reactor Protection System. This report is being submitted in accordance with the requirements of 10CFR50.73.

Sincerely yours,

RF Phares Jr

F. A. Spangenberg, III
Manager, Licensing and Safety

RSF/mfm

Enclosure

cc: NRC Clinton Licensing Project Manager
NRC Resident Office
Regional Administrator, Region III, USNRC
Illinois Department of Nuclear Safety

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NRC FORM 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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TITLE (4) Inattention to Detail During Surveillance Results in Mis-Positioning the Reactor Mode Switch and Actuation of Containment Isolation Valves and the Reactor Protection System

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)
										None	0 5 0 0 0
0 6	2 3	9 2	9 2	— 0 0 8	—	0 0	0 7	0 9	9 2		0 5 0 0 0

OPERATING MODE (9)	3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 0 0	20.402(b)	20.405(c)	X 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)	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
J. A. Neuschwanger, Assistant Director - Plant Operations, extension 3326	AREA CODE 2 1 7 9 3 5 - 8 8 8 1

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	
X	S B	I S V	A 5 8 5	Y							

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 June 23, 1992 with the plant in HOT SHUTDOWN and all control rods fully inserted, Group 1 (Main Steam) containment isolation valves and the Reactor Protection System (RPS) automatically actuated. This event occurred during preparations to perform a routine source range monitor channel functional surveillance. As a licensed reactor operator rotated the reactor mode switch from the SHUTDOWN position to the STARTUP/HOT STANDBY position as required by the surveillance prerequisites, he inadvertently rotated the switch slightly past the STARTUP/HOT STANDBY position and partially into the RUN position engaging the RUN position contacts. As a result, Group 1 containment isolation valves closed and the RPS initiated. Following the actuations, operators verified the reactor was in a stable condition. The cause of this event is attributed to inattention to detail by the operator. Corrective actions included counseling the operator and the Operations shift crews.

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DESCRIPTION OF EVENT

On June 23, 1992 at about 1205 hours, reactor operators completed manual insertion of all control rods to shut down the reactor in preparation for a maintenance outage to repair a Reactor Recirculation [AD] pump [P]. At about 1216 hours, operators placed the reactor mode switch [HS] in the SHUTDOWN position and the plant entered Mode 3 (HOT SHUTDOWN). A forced reactor cool-down was in progress using the turbine [TRB] bypass valves [V] as necessary to control the cool-down rate.

At about 1425 hours, operators started routine surveillance test CPS 9031.13, "Source Range Monitor Channel Functional." The prerequisites of CPS 9031.13 require that the reactor mode switch be placed in the STARTUP/HOT STANDBY position. At about 1427 hours with the plant in Mode 3, reactor [RCT] temperature at about 490 degrees Fahrenheit and reactor pressure at about 620 pounds per square inch gauge (psig), the reactor operator rotated the reactor mode switch toward the STARTUP/HOT STANDBY position. While manipulating the mode switch, the operator inadvertently rotated the switch slightly past the STARTUP/HOT STANDBY position into the RUN position. The switch was not placed fully into the RUN position, but was rotated far enough to engage the RUN position contacts. The incorrect positioning of the mode switch into the RUN position caused Group 1 (Main Steam System [SB]) containment isolation valves to close due to isolation logic being satisfied with the mode switch in RUN and main steam line pressure below 849 psig. The isolation of main steam isolation valves [ISV] in combination with the mode switch in the RUN position resulted in an automatic initiation of the Reactor Protection System (RPS) [JC]. Recognizing the actuations had occurred, the operator released the switch and left it in the STARTUP/HOT STANDBY position. The surveillance was immediately suspended.

In response to this event, operators verified the plant was in a stable condition. No level or pressure transients occurred as a result of this event. The Line Assistant Shift Supervisor and the Shift Supervisor discussed the event and determined the isolation signal should be reset and the main steam isolation valves should be reopened. At about 1432 hours, the isolation signal was reset. At about 1433 hours, the mode switch was placed in the SHUTDOWN position to reset the RPS trip signal.

At about 1435 hours, operators attempted to reopen the main steam isolation valves; all valves opened except for inboard isolation valve 1B21-F022D. Maintenance Work Request (MWR) D31129 was initiated to document this deficiency and track corrective actions. (Valve 1P21-F022D was reworked, local leak rate tested with satisfactory results, and was determined to operate as designed prior to plant startup from the maintenance outage.)

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

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

CAUSE OF EVENT

The cause of this event is attributed to personnel error by a licensed operator due to inattention to detail in over-rotating the reactor mode switch. The switch was checked during resumption of surveillance 9031.13 and was determined to operate properly. The check of the switch operation ensured each position had an audible click and that a Group 1 containment isolation would not occur with the switch in the STARTUP position.

CORRECTIVE ACTION

The operator involved in this event was counselled by the Director - Plant Operations, and the Operations shift crews were counselled by the Assistant Director - Plant Operations.

ANALYSIS OF EVENT

This event is reportable under the provisions of 10CFR50.73(a)(2)(iv) due to the automatic actuation of containment isolation valves and the automatic initiation of the Reactor Protection System.

Assessment of the safety consequences and implications of this event identified that this event was not nuclear safety significant. The actuation of Group 1 isolation valves and the initiation of the Reactor Protection System which occurred during this event maintained the plant in a safe and stable condition. This event would not be safety significant in any other mode and is not applicable to any other power level since all control rods were fully inserted and the plant was already in a safe and stable condition.

ADDITIONAL INFORMATION

The main steam isolation valve, 1B21-F022D, which failed to reopen following this event is a twenty-four-inch-diameter, air-operated with spring assist, globe valve, model number 40012, manufactured by the Atwood & Morrill Company.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Several LERs have addressed previous events involving personnel errors by licensed and non-licensed operators in manipulating controls: LERs 86-013, 86-022, 87-018, 87-060, 88-004, 89-032, and 90-017. However, these events involved operating the wrong control, unknowingly operating a control or improperly coordinating multiple controls, and therefore are not considered to be similar to LER 92-008.

For further information regarding this event, contact J. A. Neuschwanger, Assistant Director - Plant Operations at (217)935-8881, extension 3326.