

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Shoreham Nuclear Power Station Unit #1	DOCKET NUMBER (2) 0 5 0 0 0 1 3 2 2	PAGE (3) 1 OF 3
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TITLE (4)
RPS Actuation due to Technician Error

EVENT DATE (5)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (6)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
01	08	85	85	005	0	02	07	85	None		0 5 0 0 0 0

OPERATING MODE (9) 5	POWER LEVEL (10) 0 0 0	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)									
		<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(c)	<input checked="" type="checkbox"/> 80.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
		<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 80.36(a)(1)	<input type="checkbox"/> 80.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
		<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 80.36(a)(2)	<input type="checkbox"/> 80.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 306A)						
		<input type="checkbox"/> 20.406(a)(1)(iii)	<input type="checkbox"/> 80.73(a)(2)(i)	<input type="checkbox"/> 80.73(a)(2)(viii)(A)							
		<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 80.73(a)(2)(ii)	<input type="checkbox"/> 80.73(a)(2)(viii)(B)							
		<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 80.73(a)(2)(iii)	<input type="checkbox"/> 80.73(a)(2)(ix)							

LICENSEE CONTACT FOR THIS LER (12)			TELEPHONE NUMBER		
NAME Joseph G. Wynne, Operational Compliance Engineer			AREA CODE 5 1 6		
			9 2 9 - 8 3 0 1 0		

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	

SUPPLEMENTAL REPORT EXPECTED (14)	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES // <input checked="" type="checkbox"/> NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (18)

On January 8, 1985 at 4:29 pm an RPS actuation occurred due to an Instrument and Control technician's error. The plant was in Operational Condition 5, with the RPS shorting links removed and all control rods inserted. No fuel was being moved at the time of the actuation. The plant was in the process of transferring nuclear instrumentation from the Fuel Load Chamber (FLC) "B" to the Source Range Monitor (SRM) "B". The SRM "B" channel was bypassed. The technician inadvertently connected test equipment to the "A" SRM preamplifier. This resulted in an upscale trip on the "A" SRM channel, which caused the RPS actuation.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 5	- 0 0 5	- 0 0	2	OF	3

TEXT (If more space is required, use additional NRC Form 368A's) (17)

On January 8, 1985 at 4:29 pm an RPS actuation occurred. The plant was in mode five (Refueling) with the reactor vessel head removed. All control rods were fully inserted and 260 unirradiated fuel bundles loaded in the core. No fuel loading was being performed at the time of the RPS actuation. The initiating event was an upscale trip on the Source Range Monitor (SRM) "A" channel. All plant systems functioned as designed. No ECCS systems were challenged or required for the event. The operators carried out all required actions. Available nuclear indicators indicated stable counts and a stable infinite period.

The cause of the RPS actuation was a technician error. At the time of the actuation, the plant was transferring nuclear instrumentation from the Fuel Load Chamber (FLC) "B" to SRM "B". The work was being performed in accordance with the approved Startup Test Procedure for fuel loading. The work sequence consisted of bypassing the channel being transferred; replacing the FLC high voltage power supply with the SRM high voltage power supply; and making adjustments to the SRM instrumentation circuits to select proper operating values for the SRM.

Work proceeded normally until the technician attempted to make the SRM adjustments. The technician inadvertently connected the test equipment to the SRM "A" preamplifier instead of the SRM "B" preamplifier. This resulted in an upscale trip of the SRM "A" channel. Since the shorting links were removed, an RPS actuation occurred. The two preamplification drawers are located side by side and are clearly marked. The technician realized his error when the trip occurred and restored the SRM "A" preamplifier to normal, permitting the scram to reset.

All work on the SRMs was stopped until the Instrument and Control (I&C) Engineer reviewed the incident. A Maintenance Work Request (MWR) was issued to clarify the exact sequence of steps necessary to make the SRM adjustments (not given in the Startup Test Procedure). The technician involved was relieved of any further work on the SRMs (other than data taking) and safety-related equipment.

On January 10, 1985 the Maintenance Division Manager and I&C engineer discussed the RPS actuation with the technician and other involved I&C personnel.

Upon completion of the meeting the technician was authorized to work on safety-related systems.

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To prevent recurrence, the incident was also reviewed with the entire I&C Section on January 11, 1985. The following points were stressed, both to the individual involved and to the entire I&C section:

- 1) All work shall be clearly defined by procedures. If a procedure is only being partially completed, a MWR shall be used to clearly define which steps are to be performed, and in what order.
- 2) When performing a procedure, clear direct communications between personnel must be maintained at all times. Before removing or restoring equipment to service, verbal instructions shall be repeated to clearly identify what steps are being performed on which equipment.
- 3) It was emphasized that all critical work must be carefully preplanned so all personnel are aware of the work being performed and their role in the task.



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TEL. (516) 929-8300
PM-85-017

February 7, 1985

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

ATTN: Document Control Desk

Dear Sir:

In accordance with 10CFR50.73, enclosed is a copy of Shoreham Nuclear Power Station Unit #1's License Event Report 85-005.

Very truly yours,

W.E. Steiger for
W.E. Steiger

Plant Manager

WES/jp

cc: Dr. Thomas E. Murley
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