

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oyster Creek, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 1 9	PAGE (3) 1 OF 0 4
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TITLE (4)  
Inadvertent Actuation of "B" Isolation Condenser

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)
0 8	2 8	8 8	8 8	0 1 8		0 0	9 2	6 8 3	N/A		0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9)  N

POWER LEVEL (10) 1 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"/> 22.408(a)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(a)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(a)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 306A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(viii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Barry R. Gregg	TELEPHONE NUMBER
	AREA CODE: 6 1 0 1 9    9 1 7 1 1 - 1 4 1 8 1 8 1 9

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)

YES (If yes, complete EXPECTED SUBMISSION DATE)     NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 words, i.e., approximately fifteen single-space typewritten lines) (16)

On August 28, 1988 at approximately 1240 hours, the "B" Isolation Condenser System was actuated during a valve operability surveillance test. The actuation occurred when the Control Room Operator performing the test inadvertently opened the incorrect valve. He immediately realized his error and took corrective action by closing the valve and also closing an additional upstream valve. The valve was partially open for a period of less than seven seconds and resulted in an increase in reactor power of approximately one percent and an increase in reactor water level of approximately one inch. The reactor returned to normal with the valve closure. The root cause of the occurrence was personnel error due to lack of operator attention to the task at hand. The safety significance is minimal because of the limited nature of the transient which occurred. The Control Room Operator was counseled and this report will be required reading for Operations personnel.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

DATE OF OCCURRENCE

The event occurred on August 28, 1988 at 1243 hours.

IDENTIFICATION OF OCCURRENCE

An inadvertent initiation of the "B" Isolation Condenser occurred during a valve operability test due to a personnel error in the valve operating sequence. This is considered reportable in accordance with 10CFR50.73 (a)(2)(iv).

CONDITIONS PRIOR TO OCCURRENCE

The reactor was operating in the run mode with a thermal output of 1922 MWth and a generator load of approximately 631 MWe. A valve operability surveillance test was being performed on "B" Isolation Condenser.

DESCRIPTION OF OCCURRENCE

At approximately 1200 hours on August 28, 1988 a valve operability surveillance test, Procedure 609.4.001, was commenced for the "B" Isolation Condenser. The Isolation Condenser had been out of service for repairs to the motor operator on the DC Steam Inlet Valve (V-14-33). See Figure 1 for a sketch of the Isolation Condenser System.

At approximately 1240 hours the procedure had been implemented to a point where both Steam Inlet Valves (V-14-32 and V-14-33) and the DC Condensate Return Valve (V-14-35) were open and the AC Condensate Return Valve (V-14-37) was closed. The next procedure step was to close V-14-35. Instead of closing V-14-35, the Control Room Operator inadvertently placed the control switch for V-14-37 to the "AUTO" position. This position provides a signal to return the valve to its "normal" open position. He immediately realized his error and placed the control switches for both V-14-37 and V-14-35 to "CLOSE". While both valves were closing, a reactor water level increase of approximately one inch was observed. The power level also increased approximately one percent, followed by a decrease of two percent and then a return to normal. Later review of records indicated that a period of seven (7) seconds elapsed between the valve receiving the open signal until it returned to closed. After the Group Shift Supervisor ascertained what had occurred, he attempted to contact the Manager, Plant Operations via pager. The Control Room Operator completed the surveillance procedure and returned the "B" Isolation Condenser to its normal lineup at approximately 1300 hours.

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

After completion of the surveillance test, the shell side temperature of the "B" Isolation Condenser was observed to be increasing. This indicated leakage past V-14-35. Valve V-14-37 was closed to prevent any additional increase in shell temperature.

When the Manager, Plant Operations responded to the page (approximately 1350 hours), he was informed of the valve operating error and the subsequent changes in reactor water level and power. Due to the minor effects on plant parameters and the opinion that this valving error did not meet 10CFR50.72 reporting requirements, no further reports were deemed necessary. The Group Shift Supervisor was instructed to counsel the Control Room Operator and document the occurrence for further review the following day, Monday, 8/29/88. The matter of the shell side temperature increase was also discussed and the Group Shift Supervisor was told to cycle V-14-35 in an attempt to successfully reseal the valve.

During the remainder of the shift and continuing into the 3-11 Shift, various attempts to stop leakage past V-14-35 were unsuccessful. The Group Shift Supervisor on the 3-11 shift again contacted the Manager, Plant Operations regarding the leakage problem. It was decided to contact Plant Engineering. While discussing V-14-35 with Plant Engineering, the valving error on the previous shift was mentioned. The question of reportability was again raised. It was decided to make a four-hour NRC notification, based on a "Manual Actuation of an Engineered Safety Feature". This was about 1800 hours.

APPARENT CAUSE OF OCCURRENCE

The apparent cause of the occurrence was personnel error due to lack of operator attention to the task at hand. The next sequential step of the procedure clearly called for closure of V-14-35. The operator involved reported that the incident was not a result of fatigue or a poor procedure. He had just reviewed the appropriate steps. He also stated that he had performed the same surveillance during the previous five (5) days. Although a different surveillance was in progress, it had been temporarily stopped to allow completion of the B Isolation Condenser valve operability surveillance test, and was not felt to be a contributing cause to this event.

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The isolation Condenser System is a standby, high pressure system for removal of fission product heat from the reactor vessel following a reactor trip coincident with an isolation of the reactor from the Main Condenser. The system controls the reactor pressure rise, and limits the loss of reactor coolant through the relief valves. The system is operable and ready for service at all times during power operation of the reactor. The partial actuation of this safety system is considered to have minimal safety significance. This conclusion is based on the minimal changes in reactor power and water level which accompanied the event. In general, the primary concern with this system's actuation with the reactor at power is the subsequent reactor power and level transient. During this particular occurrence, the power changes observed were approximately one percent and the level increased slightly over one inch.

CORRECTIVE ACTION

Immediate corrective action consisted of closing valves V-14-37 and V-14-35 to secure operation of the system. After it was determined that the plant returned to normal, the surveillance was completed and the "B" Isolation Condenser returned to its normal line-up. The operator was counseled shortly after the event.

Future Corrective Actions Include:

1. This report will be made required reading for all operators and their supervisors in order to re-emphasize the need for attention to detail.
2. A review of NRC reporting criteria will be conducted by the Operations Department.

SIMILAR EVENTS

None

(0578A)

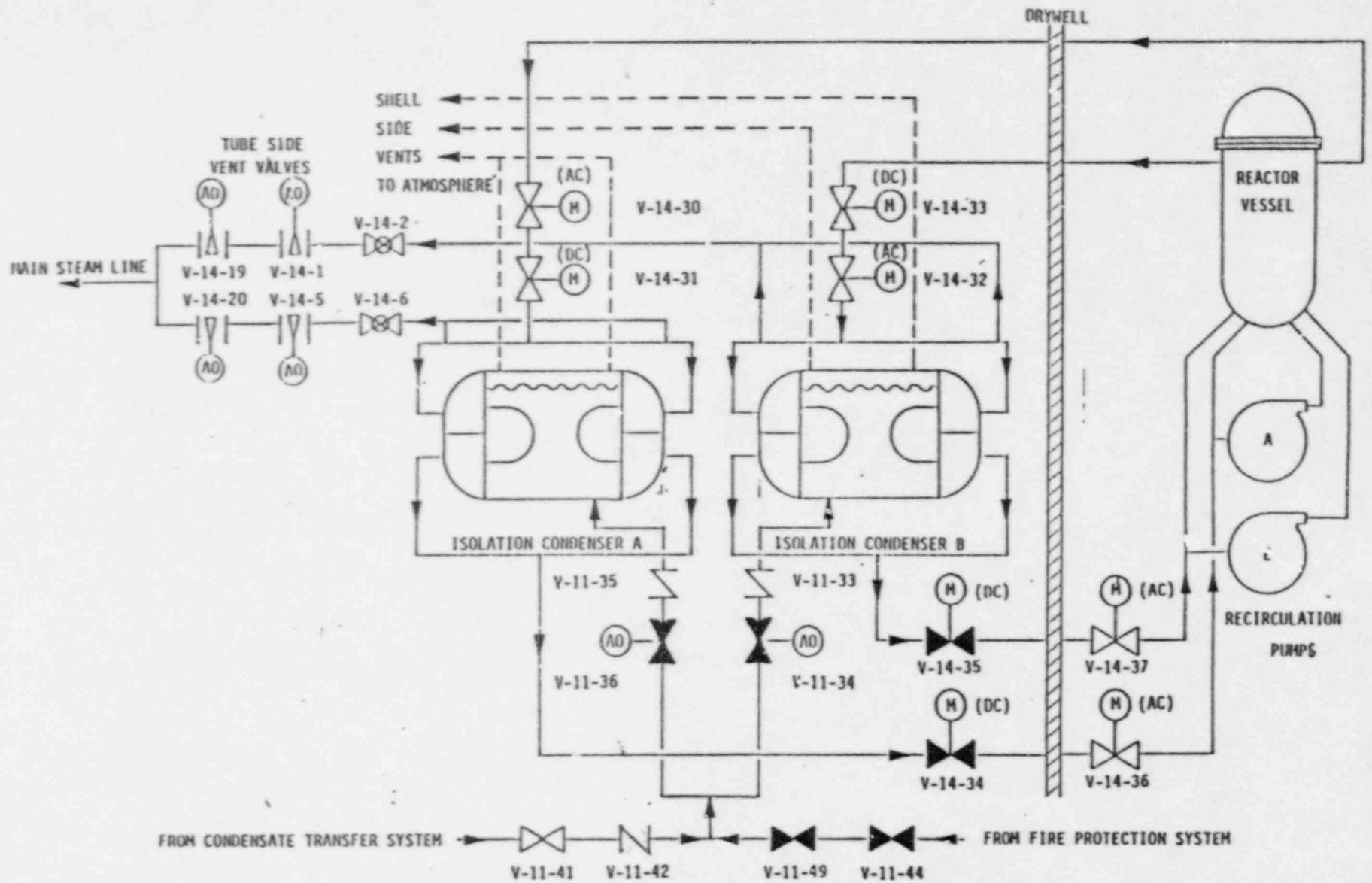


Figure 1: ISOLATION CONDENSER SYSTEM DIAGRAM.



**GPU Nuclear Corporation**  
Post Office Box 388  
Route 9 South  
Forked River, New Jersey 08731-0388  
609 971-4000  
Writer's Direct Dial Number:  
September 26, 1988

Director of Nuclear Reactor Regulation  
U.S. Nuclear Regulatory Commission  
Mail Station P1-137  
Washington, DC 20555

Dear Sir:

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

This letter forwards one (1) copy of Licensee Event Report (LER)  
No. 88-018.

Very truly yours,

  
E. E. Fitzpatrick  
Vice President & Director  
Oyster Creek

EEF:BD:smz(0705A)  
Enclosures

cc: Mr. William T. Russell, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
475 Allendale Road  
King of Prussia, PA 19406

Mr. Alexander W. Dromerick  
U.S. Nuclear Regulatory Commission  
Washington, DC 20555

NRC Resident Inspector  
Oyster Creek Nuclear Generating Station  
Forked River, NJ 08731

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