NRC Form 366A 19-831

#### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)					PAGE (3)		
Clinton Power Station			YEAR		SEQUENTIAL NUMBER		REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

### DESCRIPTION OF EVENT

On October 19, 1986, at approximately 0221 during the performance of the Intermediate Range Neutron Monitoring (IRM) channel functional surveillance, instead of placing he IRM switch in TEST, the Control Room Operator inadvertent placed the Source Range Monitoring (SRM) channel "C" out of OrdRATE, causing a Reactor Protection System (RPS) trip. The plant was in mode 5 performing core alterations during initial fuel load. The RPS shorting links were removed. All control rods were inserted prior to the trip.

The surveillance was stopped and the Mode Switch was taken to SHUTDOWN. The SRM channel was placed back in OPERATE and the RPS trip was reset at approximately 0240. Notification to the NRC was made as per 10CFR50.72(b)(2)(ii).

A post trip critique was held by Operations Supervision and the involved parties.

## CAUSE OF EVENT

The cause was a licensed operator failed to follow an approved procedure.

There was no procedural error or any unusual characteristics of the work location or equipment that directly contributed to the error.

# ANALYSIS OF EVENT

This was an unplanned automatic actuation of the Reactor Protection System and is reportable under 10CFR50.73(a)(2)(iv).

The RPS system had the shorting links removed which placed the circuitry in a condition where only one channel would cause a trip.

The SRM circuitry only produces a scram signal during core alterations, i.e., when the shorting links are removed. The scram places the plant in a safe condition. During other modes, the SRM Inoperative signal would produce a rod block, which is also a safe condition. The event had no safety significance.

The SRM channel was out of OPERATE for only a moment; the scram was reset in 20 minutes.

NRC Form 386A
19-831

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO 3150-0104
EXPIRES 8/31/L.

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### CORRECTIVE ACTION

The operator was counseled on the need to be more careful and observant while manipulating the controls.

### ADDITIONAL INFORMATION

There are no similar previous events.

For additional information, contact Roger Morgenstern, Director - Technical, area code (217) 935-8881, ext. 3210.

Alternate contact is J. F. Palchak, Supervisor - Plant Support Services at ext. 3203.

## ILLINOIS POWER COMPANY



CLINTON POWER STATION, P.O. BOX 678, CLINTON, ILLINOIS 61727

October 31, 1986

Docket No. 50-461

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

Subject: Clinton Power Station - Unit 1

Licensee Event Report No. 86-013-00

Dear Sir:

Please find enclosed Licensee Event Report No. 86-013-00: Operator Error Resulting In RPS Actuation. This report is being submitted in accordance with the requirements of 10CFR50.73.

Sincerely yours,

F. A. Spangenberg

Manager - Licensing and Safety

D. Z. Holtzehn for

RLC/bsa

Enclosure

cc: NRC Resident Office
NRC Region III
INPO Records Center
Illinois Department of Nuclear Safety

NRC Clinton Licensing Project Manager

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LICENSEE EVENT REPORT (LER)						U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85								
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NAME					D1			0010			TELEPHONE NUM	48 E R		
R.W. Morgenstern, Director-Plant Technical, Ext. 3210 J.F. Palchak, Supervisor-Plant Support Services, Ext. 3203				2202	AREA CODE									
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On October 19, 1986, during the performance of the Intermediate Range Neutron Monitoring (IRM) channel functional surveillance, the Control Room Operator inadvertently placed the Source Range Monitoring (SRM) channel "C" out of OPERATE, causing a Reactor Protection System (RPS) trip. The plant was in mode 5 performing core alterations during initial fuel load. The RPS shorting links were removed. All control rods were inserted prior to the trip.

The surveillance was stopped and the mode switch was taken to SHUTDOWN. The SRM channel was placed back in OPERATE and the RPS trip reset after 20 minutes. The switch was only out of OPERATE momentarily. The cause was the failure of a licensed operator to follow an approved procedure. As corrective action the operator was counseled on the need to be more alert and careful of his control manipulations. The RPS initiation notification to the NRC was made as per 10CFR50.72(b)(2)(ii) and this event is reportable as an LER in accordance with 10CFR50.73(a)(2)(iv).

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