NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Clinton Power Station	0 5 0 0 0 4 6 1	1 OF 0 3

TITLE (4)

Operator Error Resulting In Technical Specification Violation

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)
1 0	1 4	8 6	8 6	- 0 0 9	- 0 0	1 1	0 4	8 6	None	0 5 0 0 0
										0 5 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)

20.402(b)	20.405(c)	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)	X 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
R. W. Morgenstern, Director-Plant Technical, Ext. 3210	AREA CODE 2 1 7 9 3 5 - 8 8 8 1
J. F. Palchak, Supervisor-Plant Support Services, Ext. 3203	

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 fifteen single-space typewritten lines) (16)

On October 14, 1986, at 0515, during a surveillance on the Automatic Depressurization System (ADS), two level transmitters were installed to simulate reactor water level. The plant was in mode 5, initial fuel loading. These transmitters also supplied signals to the containment Isolation Logic and were required to be operable during core alterations. When the simulators were installed for the surveillance, it made the isolation logic inoperable and was a violation of section 3.3.2 of the Technical Specifications (T.S.). When the T.S. violation was discovered at 0743, core alterations were suspended.

Event cause was due to the shift crew not treating the disabled channels as inoperable, an inadequate surveillance procedure and the shift crew misunderstanding the T.S.

A training critique on the event has been conducted for each shift; the associated surveillance and other similar surveillance procedures will be revised.

This event was reportable in accordance with 10CFR50.73(a)(2)(ii).

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

DESCRIPTION OF EVENT

On October 14, 1986 at approximately 0125 the on-shift crew commenced the surveillance to test the automatic actuation of the Automatic Depressurization System (ADS) Division 1. The plant was in mode 5 and initial fueling was in progress. This surveillance requires the installation of multiple transmitter simulators to achieve the required permissive signals.

At 0515 due to a procedural inadequacy, when a low water level simulator was installed, an isolation of the Instrument Air containment isolation valves occurred. A management member started a review of the Technical Specifications concerning that level instrument. He determined that one instrument could be removed from service for surveillance for 2 hours before a one-hour action statement was entered. He was unaware that the shift had the other channel in that trip system inoperative as part of the surveillance. The Shift Supervisor was informed that he was in the action statement, and core alterations were suspended at 0743. This placed the plant in a condition where the instrumentation was no longer required to be operable. The surveillance was halted and all instrumentation returned to normal. The plant was in violation of the Technical Specification for approximately 2 hours and 28 minutes.

CAUSE OF EVENT

A critique was held at 0815, October 15. During the critique, it was found that both channels of the trip system had been disabled and during that time, the station was in violation of the Technical Specifications. During that critique, the following concerns were discussed:

* The licensed operators did not understand that only one instrument could be tested at a time and that a two-hour time limit was associated with that testing.

* The shift did not treat the disabled channels as "inoperable."

* The procedure did not define the exact plant conditions as a prerequisite for performance.

ANALYSIS OF THE EVENT

This event is reportable under Title 10, Code of Federal Regulations, Part 50.73 (a)(2)ii)(B).

This incident degraded the secondary containment by rendering the isolation instrumentation for instrument and component cooling water containment isolation valves inoperable for approximately 2 hours and 28 minutes. These valves are considered bypass leakage paths and were required to be operable during core alterations.

SAFETY ASSESSMENT

The plant was loading fuel for the initial fuel load. No irradiated fuel was involved and the safety significance is considered minimal.

The containment isolation valves involved are a containment bypass leakage path and would not have isolated on a low vessel level signal. If irradiated fuel had been in the vessel, this would represent a serious safety concern.

CORRECTIVE ACTIONS

A critique of this incident, along with lessons learned, has been held by each shift. The requirements for removing an instrument were discussed. It was stressed that any inoperability, due to a failure or removal from service for surveillance, will be treated as such and properly logged in the Control Room Operators Log.

Other surveillance procedures that have the prerequisite of "shutdown" will be revised to state the exact plant condition.

The procedure will be revised to define the exact plant conditions as a prerequisite for performance.

The licensed operations personnel will be instructed that any inoperability, due to failure or removal from service for surveillance, will be treated as such and properly logged in the Control Room Operators Log. Any associated time limits will also be logged and tracked.

ADDITIONAL INFORMATION

There are no previous similar events.

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

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ILLINOIS POWER COMPANY

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

November 4, 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. 86-009-00

Dear Sir:

Please find enclosed Licensee Event Report No. 86-009-00: Operator Error Resulting In Technical Specification Violation. This report is being submitted in accordance with the requirements of 10CFR50.73.

Sincerely yours,

F. A. Spangenberg
Manager - Licensing and Safety

RLC/ckc

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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