

# LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 N J S G S 2 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5  
7 8 9 14 15 25 26 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CON'T  
01 REPORT SOURCE L 6 0 5 0 0 0 3 1 1 7 0 7 2 7 8 3 8 0 8 2 2 8 3 9  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)  
02 On July 27, 1983, during routine startup following a refueling, the Control Room  
03 Operator observed that Tave had decreased slightly below the Technical Specification  
04 limit for critical operation. Accordingly, Action Statement 3.1.1.4 was entered.  
05 The temperature was immediately returned to within specification; no other  
06 operational transients were involved. The event constituted operation in a degraded  
07 mode in accordance with Technical Specification 6.9.1.9b.

08

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE  
C B 11 A 12 B 13 X X X X X X 14 Z 15 Z 16  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 LER RO REPORT NUMBER 8 3 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)  
10 The decrease in Tave resulted during the manual addition of feedwater to the steam  
11 generators; the operator failed to adequately monitor the temperature and  
12 inadvertently allowed it to decrease below the specification limit. The operator  
13 involved was reinstructed.

14

15 FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION  
C 28 0 0 4 29 NA A 31 Operator Observation  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

16 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE  
Z 33 Z 34 NA NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION  
0 0 0 37 2 38 NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

18 PERSONNEL INJURIES NUMBER DESCRIPTION  
0 0 0 40 NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

19 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION  
Z 42 NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 PUBLICITY ISSUED DESCRIPTION  
N 44 NA  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NAME OF PREPARER R. Frahm PHONE (609) 935-6000 Ext. 4309

NRC USE ONLY

22



**PSEG**

Public Service Electric and Gas Company P.O. Box E Hancocks Bridge, New Jersey 08038

Salem Generating Station

August 22, 1983

Dr. Thomas E. Murley  
Regional Administrator  
USNRC  
Region 1  
631 Park Avenue  
King of Prussia, Pennsylvania 19406

Dear Dr. Murley:

LICENSE NO. DPR-75  
DOCKET NO. 50-311  
REPORTABLE OCCURRENCE 83-040/03L

Pursuant to the requirements of Salem Generating Station  
Unit No. 2, Technical Specifications, Section 6.9.1.9.b,  
we are submitting Licensee Event Report for Reportable  
Occurrence 83-040/03L. This report is required within  
thirty (30) days of the occurrence.

Sincerely yours,

J. M. Zupko, Jr.  
General Manager -  
Salem Operations

RF:k11 *JGJ*

CC: Distribution

Report Number: 83-040/03L  
Report Date: 08-22-83  
Occurrence Date: 07-27-83  
Facility: Salem Generating Station Unit 2  
Public Service Electric & Gas Company  
Hancock's Bridge, New Jersey 08038

IDENTIFICATION OF OCCURRENCE:

Reactivity Control Systems - Reactor Coolant System Average Temperature below the Minimum Temperature for Criticality.

This report was initiated by Incident Report 83-127.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 2 - Rx Power 4 % - Unit Load 0 MWe.

DESCRIPTION OF OCCURRENCE:

At 0322 hours, July 27, 1983, during routine startup following a refueling, the Control Room Operator observed that the Reactor Coolant System temperature (Tave) had decreased slightly below the Technical Specification limit for critical operation (541°F). Due to the decrease, Technical Specification Action Statement 3.1.1.4 was entered.

The temperature was restored to within specification at 0326 hours; the minimum temperature reached during the event was 539°F. No transients or other unusual operational events occurred during the period.

APPARENT CAUSE OF OCCURRENCE:

An operator was controlling the steam generator levels manually at the time of the occurrence; addition of feedwater to the generators results in a corresponding decrease in Tave. The operator failed to adequately monitor the temperature and inadvertently allowed it to decrease below the specification limit.

ANALYSIS OF OCCURRENCE:

The specification limit on minimum temperature for criticality ensures that the moderator temperature coefficient is within its analyzed temperature range, protective instrumentation is within its normal operating range, the P-12 interlock is above its setpoint, the pressurizer is capable of being in an operable status, and the reactor pressure vessel is above its minimum RT<sub>NDT</sub> temperature.

Action Statement 3.1.1.4 requires:

With a Reactor Coolant System operating loop Tave less than 541°F, restore Tave to within its limit within 15 minutes or be in hot standby within the next 15 minutes.

ANALYSIS OF OCCURRENCE: (cont'd)

As noted, no transients were involved in the event and the temperature was restored to within specification in a timely fashion. The incident therefore involved no undue risk to the health or safety of the public. Due to operation in a degraded mode permitted by a limiting condition for operation, the occurrence is reportable in accordance with Technical Specification 6.9.1.9b.

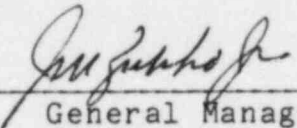
CORRECTIVE ACTION:

As mentioned, Tave was immediately restored to within specification, and at 0326 hours, July 27, 1983, Action Statement 3.1.1.4 was terminated. The operator involved was reinstructed concerning the details of manual control of steam generator levels and the need to continuously monitor Tave to insure it remains above the minimum temperature for criticality.

FAILURE DATA:

Not Applicable

Prepared By R. Frahm

  
\_\_\_\_\_  
General Manager -  
Salem Operations

SORC Meeting No. 83-107