



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

Salem Generating Station

April 28, 1983

Mr. J. Allan  
Acting Regional Administrator  
USNRC  
Region 1  
631 Park Avenue  
King of Prussia, Pennsylvania 19406

Dear Mr. Allan

LICENSE NO. DPR-75  
DOCKET NO. 50-311  
REPORTABLE OCCURRENCE 83-012/03L

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 83-012/03L. This report is required within  
thirty (30) days of the occurrence.

Sincerely yours,

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

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CC: Distribution

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Report Number: 83-012/03L  
Report Date: 04-27-83  
Occurrence Date: 04-06-83  
Facility: Salem Generating Station Unit 2  
Public Service Electric & Gas Company  
Hancock's Bridge, New Jersey 08038

IDENTIFICATION OF OCCURRENCE:

Plant Systems - Low Pressure CO2 Systems - Improper Valve Lineup.

This report was initiated by Incident Report 83-062.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 6 - RX Power 0 % - Unit Load 0 MWe.

DESCRIPTION OF OCCURRENCE:

At 1730 hours, April 6, 1983, during routine shift rounds, an Equipment Operator discovered the 10 Ton Cardox System pilot valve in the closed position. The valve is normally locked open to insure pilot gas is available for actuation of the individual system master and master selector valves. All low pressure CO2 systems were declared inoperable, and Technical Specification 3.7.10.3a was entered. At 1756 hours, April 6, 1983, the pilot valve was opened and locked in position, restoring the low pressure CO2 systems to an operable status.

APPARENT CAUSE OF OCCURRENCE:

Investigation of the occurrence revealed that a check of the position of the pilot valve was not included in routine surveillance testing. On March 8, 1983, the selector valve for the Diesel Fuel Oil Transfer Pump Rooms had been opened twice for testing of system alarm and automatic damper actuation features. No problems were noted at that time, although subsequent testing revealed that, due to residual pilot line pressure, a master or master selector valve could be opened four times following isolation of the pilot valve.

A search of the Tagging Request and Inquiry System revealed no tagging requests issued for the system since November 2, 1982. System recharging had been performed on March 4, 1983; the investigation revealed that no procedure was in effect for the evolution. As indicated by subsequent testing, selector valve operation on March 8 could have been completed with the pilot valve being closed during the recharging operation on March 4. The valve may therefore have been inadvertently manipulated at the time of the recharging, although no other evidence supporting this conclusion was identified.

ANALYSIS OF OCCURRENCE:

The operability of the fire suppression systems ensure that adequate fire suppression capability is available to confine and extinguish fires occurring in any portion of the facility where safety related equipment is located. The collective capability of the fire suppression systems is adequate to minimize the potential damage to safety related equipment and is a major element in the facility fire protection program.

The fire protection program is a design feature which insures that redundant engineered safety features are not rendered inoperable by a fire. Since a coincidental low probability fire must occur before adverse performance results, however, degradation of the program does not of itself imply adverse performance during accident conditions

As demonstrated, a CO2 system could have operated upon receipt of a valid actuation signal following isolation of the pilot line. Due to maintenance associated with a refueling outage, the Diesel Generator Area automatic actuation feature was disabled, and a continuous fire watch was already in effect in the area (see LER 83-008/99X-0). As the result of the inoperability of various fire barriers, roving watches were patrolling all other affected spaces.

Finally, protection was restored in a timely fashion, in compliance with the action statement. The occurrence therefore involved no risk to the health and safety of the public. Due to the possible inoperability of required fire suppression systems, the event involved operation in a degraded mode permitted by a limiting condition for operation. The occurrence is therefore reportable in accordance with Technical Specification 6.9.1.9b.

CORRECTIVE ACTION:

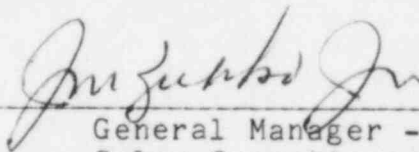
As noted, the pilot valve was opened at 1756 hours, April 6, 1983, and Action Statement 3.7.10.3a was terminated. To ensure the valve is maintained locked open, a check of the valve status was incorporated into the monthly surveillance test. A procedure for recharging the Cardox system will be written to ensure only the required valves are operated during the evolution.

FAILURE DATA:

Not Applicable

Prepared By R. Frahm

SORC Meeting No. 83-056

  
General Manager -  
Salem Operations