

LICENSEE EVENT REPORT

*CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	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	57	CAT	58
LICENSEE CODE		LICENSE NUMBER										LICENSE TYPE																		

CON'T

REPORT SOURCE 0 1 7 8

DOCKET NUMBER 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80

EVENT DATE 0 5 0 0 0 3 1 1 7 0 4 2 5 8 3 8 0 5 1 8 8 3 9

REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On April 25, 1983, during routine shutdown operations, it was discovered that a blank had been installed on the pressurizer relief line, isolating the Reactor Coolant System (RCS) ventpath. Investigation subsequently revealed that the ventpath had been isolated on the previous day. Prompt notification was performed on May 10, 1983. No RCS pressure transients occurred during the period the vent was isolated. The event is reportable in accordance with Technical Specification 6.9.1.8b.

(83-005, 81-059, 81-043, 81-005)

SYSTEM CODE C J 11		CAUSE CODE A 12		CAUSE SUBCODE X 13		COMPONENT CODE P I P E X X 14				COMP. SUBCODE A 15		VALVE SUBCODE Z 16					
EVENT YEAR 8 3 21 22		SEQUENTIAL REPORT NO. 0 1 7 24 26		OCCURRENCE CODE 0 1 28 29		REPORT TYPE T 30		REVISION NO. 0 32									
ACTION TAKEN H 33		FUTURE ACTION F 34		EFFECT ON PLANT Z 35		SHUTDOWN METHOD Z 36		HOURS 0 0 0 0 37 40		ATTACHMENT SUBMITTED Y 41		NPRD-4 FORM 58 N 42		PRIME COMP. SUPPLIER N 43		COMPONENT MANUFACTURER W 1 2 0 44 47	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Further investigations revealed that a misunderstanding between the Shift Supervisor

1 1 and a Boiler Repair Supervisor resulted in the installation of the blank without the

1 2 knowledge of the operating shift. Personnel involved were counseled concerning the

1 3 incident.

1 4

8 9 FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)

1 5 G (28) 0 0 0 (29) NA A (31) Operational Event

7 8 9 10 12 13 44 45 46 80

ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

1 6 Z (33) Z (34) NA NA

7 8 9 10 12 44 45

PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION	
1	7	0	0	0	37	Z	38 NA

PERSONNEL INJURIES	
NUMBER	DESCRIPTION
1 8	40 NA

1		2		3		4		5		6		7		8		9		10		11		12	
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PUBLICITY
 ISSUED DESCRIPTION (45)
 2 0 N (44) NA
 8306020406 830518
 PDR ADDCK 05000311
 S PDR
 NRC USE ONLY

NAME OF PREPARER

R. Frahm

PHONE: (609) 935-6000 Ext. 3078



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

Salem Generating Station

May 19, 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 83-017/01T

Pursuant to the requirements of Salem Generating Station Unit No. 2, Technical Specifications, Section 6.9.1.8.b, we are submitting Licensee Event Report for Reportable Occurrence 83-017/01T. This is a 14 day follow-up report to the prompt notification of the NRC Resident Inspector on May 9, 1983.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "J. M. Zupko, Jr.", is written above the typed name.

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

RF:ks *JG*

CC: Distribution

Report Number: 83-017/01T
Report Date: 05-18-83
Occurrence Date: 04-25-83
Facility: Salem Generating Station Unit 2
Public Service Electric & Gas Company
Hancock's Bridge, New Jersey 08038

IDENTIFICATION OF OCCURRENCE:

Reactor Coolant System - Loss of Vent Path.

This report was initiated by Incident Report 83-075.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 5 - Rx Power 0 % - Unit Load 0 MWe.

DESCRIPTION OF OCCURRENCE:

At 0645 hours, April 25, 1983, during routine shutdown operations, the Senior Shift Supervisor was notified that the Reactor Coolant System (RCS) vent path may have been isolated on April 23, 1983, by installation of a blank flange on the the pressurizer relief line (Safety Valve 2PR5 was removed from the line providing a path to atmosphere). An operator was dispatched to investigate the status of the vent path; at 0842 hours the operator discovered that a blank had in fact been installed, eliminating the required vent. With both Pressurizer Overpressure Protection System (POPS) valves isolated and inoperable due to the removal of the valve internal parts for repair, Action Statement 3.4.10.3b was entered.

Tags on Block Valves 2PR6 and 2PR7 were cleared, and at 1358 hours, April 25, 1983, the valves were opened, establishing a vent path through the POPS valves. An investigation into the event was commenced; due to conflicting initial information, it was not immediately clear how or when the vent path was lost. On May 9, 1983, analysis of information obtained from the investigation revealed that the vent path had been lost at approximately 0600 hours, April 24, 1983, upon installation of the relief line blank. Prompt notification of the Resident NRC Inspector was performed, with written confirmation transmitted May 10, 1983. Subsequent investigation revealed no RCS pressure transients occurred during the period that no vent path existed. The occurrence therefore resulted in no adverse impact on the RCS Pressure Boundary.

APPARENT CAUSE OF OCCURRENCE:

The work order to install the flange had been approved by the Shift Supervisor on April 22, 1983. It was the understanding of the supervisor that approval of the work order was required to commence work on the fabrication of the flange, that only fabrication was to be performed, and that the Operations shift would be notified prior to commencing installation.

APPARENT CAUSE OF OCCURRENCE: (cont'd)

The Boiler Repair Supervisor involved, however, understood approval of the work order to be for all work described. On April 24, 1983, following fabrication of the blank, the supervisor had a repairman install it in the relief line, thereby eliminating the vent path.

A contributing factor involved was the extended period of inoperability of the POPS due to leakage problems (see LER 83-005/03L); the unavailability of both POPS valves necessitates reliance on only one method of overpressurization protection. The incident otherwise was associated with isolated problems in the conduct of shutdown operations.

ANALYSIS OF OCCURRENCE:

The operability of two POPS valves or an RCS vent opening of greater than 3.14 square inches ensures that the RCS will be protected from pressure transients which could exceed the limits of 10 CFR 50 Appendix G when one or more RCS cold legs are less than or equal to 312°F. Either POPS has adequate relieving capability to protect the RCS from overpressurization resulting from events postulated to occur, including starting an idle reactor coolant pump or a safety injection pump with a solid RCS.

Action Statement 3.4.10.3b requires:

With both POPs inoperable, depressurize and vent the RCS through a 3.14 square inch vent(s) within 8 hours.

As noted, the vent path was not available for a period in excess of the 8 hours specified the action statement. No pressure transient or adverse impact on the RCS Pressure Boundary occurred, however. No abnormal degradation of the fuel cladding occurred, and the incident therefore involved no risk to the health or safety of the general public.

Due to the operation of the unit when a system subject to a limiting condition for operation is less conservative than the least conservative aspect of the limiting condition for operation, the event is reportable in accordance with Technical Specification 6.9.1.8b.

CORRECTIVE ACTION:

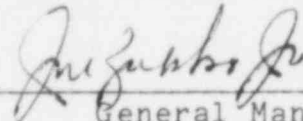
As noted, the required vent was re-established. and at 1358 hours. April 25, 1983, Action Statement 3.4.10.3b was terminated. The Shift Supervisor involved was counseled concerning the potential for adverse impact on the plant configuration inherent in the practice of approving work orders with verbal limitations on the scope of the work. A Night Order Book entry was made directing shift supervision not to approve work orders until the plant is in a condition in which work may safely proceed. Maintenance supervision will be counseled concerning the incident and the importance of keeping the operating shift informed of maintenance as it affects plant status.

Design Change Request 2EC1599 was issued to modify the POPS valves to increase their reliability; the work was completed during the current refueling. Finally, due to the numerous problems with the system, installation of valves of a different design or modification of Power Operated Relief Valves 2PR1 and 2PR2 to perform the function are being investigated by the Engineering Department.

FAILURE DATA:

Marotta Scientific Controls
Relief Valve
Model MV-225C

Prepared By R. Frahm



General Manager -
Salem Operations

SORC Meeting No. 83-069