



GPU Nuclear Corporation
Post Office Box 388
Route 9 South
Forked River, New Jersey 08731-0388
609 971-4000
Writer's Direct Dial Number:

C321-95-2161
June 13, 1995

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

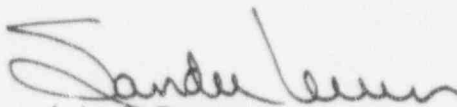
Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report

This letter forwards one (1) copy of Licensee Event Report No. 95-002.

If you should have any questions, please contact Mr. Terry Sensue, OC Licensing Engineer at 609-971-4680.

Sincerely,


for Jean J. Barton
Vice President and Director
Oyster Creek

JJB/TS:jc
Enclosure

cc: Administrator, Region 1
Senior NRC Resident Inspector
Oyster Creek NRC Project Manager

950619 0332 950613
PDR ADUCK 05000219
S PDR

TEP
111

NRC FORM 366A (5-92)						LICENSEE EVENT REPORT (LER)						U.S. NUCLEAR REGULATORY COMMISSION APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95									
FACILITY NAME (1) <div style="text-align: center; font-weight: bold;">Oyster Creek, Unit 1</div>												DOCKET NUMBER (2) <div style="text-align: center;">05000219</div>				PAGE (3) <div style="text-align: center;">1 OF 4</div>					
TITLE (4) <div style="text-align: center;">UNSUPERVISED CORE ALTERATION DUE TO PERSONNEL ERRORS IN DECISION MAKING</div>																					
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 NAME				DOCKET NUMBER								
11	06	94	95	002	0	06	13	95	FACILITY NAME				DOCKET NUMBER								
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)																		
POWER LEVEL (10)			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								
			20.405(a)(1)(iii) X			50.73(a)(2)(i)			50.73(a)(2)(viii)(A)				Specify in Abstract below and in Text, NRC Form 366A								
			20.405(a)(1)(iv)			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: ROBERT A. HENRIKSEN, PLANT OPERATIONS ENGINEER												TELEPHONE NUMBER (include Area Code) 609-971-4872									
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		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS					
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)									
YES (If yes, complete EXPECTED SUBMISSION DATE):												X		NO		MONTH		DAY		YEAR	
ABSTRACT (16): <p>On November 6, 1994, with 19 fuel bundles loaded in the core, refueling was interrupted to correct a faulty fuel handling Grapple Engaged indication. After repairs were completed, at approximately 1257 hours, fuel bundle LYL-510 was raised about 6 inches from its fully seated location in the core as part of ensuring the problem had been corrected. A Senior Reactor Operator was not present to supervise the fuel movement as required by Technical Specifications. The incident was not reported until six months later since personnel did not recognize that the activity was inconsistent with Technical Specifications.</p> <p>The cause of the event was due to personnel error in decision making which led to an unsupervised core alteration. The safety significance is minimal. The fuel bundle location and orientation was not altered. Corrective actions will include reviewing the roles and responsibilities for personnel involved with refueling operations and subsequently revising procedures, plans, and testing requirements related to refueling operations. Appropriate personnel will be trained on these changes.</p>																					

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Oyster Creek, Unit 1	05000219	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 4
		95	002	0	

DATE OF OCCURRENCE

This event occurred on November 6, 1994.

IDENTIFICATION OF OCCURRENCE

Fuel bundle LYL-510 was lifted about 6 inches from its seated position in the core and returned to its seated position in the core without direct supervision by a Senior Reactor Operator (SRO). This event is reportable in accordance with 10 CFR 50.73(a)(2)(i).

CONDITIONS PRIOR TO OCCURRENCE

Reactor refueling was in progress and a total of 19 fuel bundles were located in the core. LYL-510 was the third fuel bundle to be placed in an island around Source Range Monitor (SRM) 22. The other 16 fuel bundles were located in an island around SRM 21 located two control cells away. The Grapple Engaged indication (CFI-ZI) circuit on the main hoist (CFI-HOI), used to show that the grapple is closed, had been repaired immediately prior to this event.

DESCRIPTION OF OCCURRENCE

On November 6, at 1048 hours, the Grapple Engaged light on the main hoist on the refueling bridge (CFI-FMB) intermittently blinked off and on while loading a fuel bundle into the core. Shortly thereafter, the grapple failed in that the bridge operator was unable to engage a fuel bundle in the fuel pool. Refueling was stopped at 1051 hours and maintenance personnel were called to troubleshoot and repair the problem. During troubleshooting activities, the Senior Reactor Operator (SRO) that had been supervising core alterations, left the bridge and the refueling floor. Maintenance personnel identified the cause to be a loose amphenol connector (CFI-CON) and proceeded to correct the problem. Based on discussion among the Core Engineering Manager (CEM), the Licensed Control Room Operator (CRO) assigned to operate the bridge, and the Maintenance Foreman (MF), a post maintenance test (PMT) was determined and successfully completed. Personnel involved then wanted to observe the grapple under its most demanding conditions, that is with the mast fully extended and grapple under load, to ensure all possible causes of the grapple engagement light problem had been corrected. The CRO and the CEM decided that this could be done by lifting the last bundle that was placed in the core.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATIONU.S. NUCLEAR REGULATORY COMMISSION
APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Oyster Creek, Unit 1	05000219	95	002	0	3 OF 4

DESCRIPTION OF OCCURRENCE - Cont'd

At approximately 1257 hours the CRO raised fuel bundle LYL-510 about 6 inches from its fully seated position in the core, observed indications needed to satisfy that the problem had been corrected, and returned the fuel bundle to its fully seated position. The SRO assigned to supervise refueling was not present while the bundle was lifted and resealed. Technical Specification 6.2.2.2(e) requires that all core alterations be directly supervised by either a licensed SRO or an SRO Limited to Fuel Handling who has no other concurrent duties. In addition, the definition of 'core alteration' in the Technical Specifications includes any manual movement of fuel in the reactor core. The location, seating and orientation of the bundle was subsequently verified by an SRO to be correct. Shortly after the event, the incident was discussed with the on-duty Group Shift Supervisor (GSS) who subsequently discussed it with the Manager, Plant Operations. It was not recognized at that time that the activity was inconsistent with Technical Specification requirements. On May 8, 1995, in an unrelated discussion, some of the circumstances surrounding this event were related to senior plant management and a subsequent assessment concluded on May 15, 1995 that a Tech Spec violation had occurred.

APPARENT CAUSE OF OCCURRENCE

The cause of this event is due to personnel errors in decision making which led to an unsupervised core alteration. The CEM and bridge CRO did not recognize that lifting a bundle in the core constituted a core alteration. The SRO responsible for supervising refueling activities did not adequately communicate with the MF or the bridge CRO and did not maintain adequate control over the movement of fuel.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

Control over fuel bundle location and orientation in the reactor core is required to prevent inadvertent criticality, to maintain control over individual bundle power, and to maintain control over power distribution. The lifting and resetting of the last bundle loaded into the core had no effect on these factors since the location and orientation were not changed. In addition, a licensed operator was stationed in the Control Room to monitor for inadvertent criticality as required by procedure. Since the bundle was only lifted and resealed a distance of about six inches, a negligible change in core reactivity would result.

The core configuration at the time consisted of a 16 fuel assembly "island" around SRM 21 and a 3 fuel assembly "island" being constructed around SRM 22. Fuel Assembly LYL-510, the assembly involved in this event, was in the 3 bundle island located at least two control cells away from the 16 bundle island. In effect, the 3 bundle island could be viewed as a separate "core" from a reactivity standpoint. Based on the amount of loaded assemblies in this island, criticality could not have been achieved. Therefore, the safety significance of this event is considered minimal.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Oyster Creek, Unit 1	05000219	95	002	0	4 OF 4

CORRECTIVE ACTIONS

Upon notification that the fuel bundle LYL-510 was lifted and reseated, an SRO verified it to be correctly located, seated, and oriented in the reactor core.

Plant Management, upon determining that a core alteration may have been performed without SRO supervision, requested an Independent Assessment Team be assembled to evaluate the incident and develop corrective actions. These corrective actions are summarized as follows:

1. The Error-Free Refueling Plan and related refueling procedures will be reviewed and revised. Specific items to be addressed as a minimum will be: a) detailed definition of a fuel move and a core alteration and (b) detailed responsibilities consistent with the organization in place (e.g. refueling crew reporting relationship to GSS, etc.).
2. The roles and responsibilities for personnel involved with refueling operations and related maintenance activities will be reviewed and revised such that the authority, interfaces, and boundaries are clearly defined. This will include clarifying refueling procedures and the Error Free Refuel Plan which provides administrative control over refueling activities.
3. The Technical Specification aspects of this event and any resultant procedure changes will be included in the refueling training lessons for the operating crews and support staff. Training will be developed and presented to maintenance and planning personnel on the Error Free Refuel Plan, related refueling procedures, Tech Spec requirements and implications regarding potential maintenance activities (refueling interlocks, etc.).

These actions are scheduled to be completed prior to the next (16R) refueling outage.

SIMILAR EVENTS

None