NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
0 1	LICENSEE CODE (2)	N J S G S 1
	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
	LICENSE TYPE (4)	4 1 1 1 1
	CAT (5)	
CON'T 0 1	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	0 5 0 0 0 2 7 2
	EVENT DATE (8)	0 5 2 5 8 3
	REPORT DATE (9)	0 6 1 5 8 3

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On May 25, 1983, during routine power operation, an operator inadvertently opened the
0 3 supply breaker to No. 1C Vital Instrument Inverter. An automatic transfer to the
0 4 alternate power supply occurred with no loss of equipment or indication. With the
0 5 inverter de-energized, No. 1C Vital Instrument Bus and its associated bus train was
0 6 inoperable, and Action Statement 3.8.2.1 applied. The event constituted operation in
0 7 a degraded mode in accordance with Technical Specification 6.9.1.9b.
0 8

0 9	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
	E B	A	A	G E N E R A	F	Z

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 2 4	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
H	X	Z	Z	0 0 0 0	Y	N	A	X 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The operator was implementing a tagging request for the No. 2C Vital Instrument Inverter
1 1 and erroneously entered Unit 1, de-energizing the wrong inverter. The inverter was
1 2 immediately restored to service and the action statement was terminated. The operator
1 3 involved was reprimanded; a recently completed study of tagging operations considers
1 4 dual plant operation and is under evaluation.

Line	Field	Value
1 5	FACILITY STATUS (28)	E
	% POWER (29)	0 8 9
	OTHER STATUS (30)	N/A
	METHOD OF DISCOVERY (31)	A
	DISCOVERY DESCRIPTION (32)	Operational Event
1 6	ACTIVITY RELEASED (33)	Z
	CONTENT OF RELEASE (34)	Z
	AMOUNT OF ACTIVITY (35)	N/A
	LOCATION OF RELEASE (36)	N/A
1 7	PERSONNEL EXPOSURES NUMBER (37)	0 0 0
	TYPE (38)	Z
	DESCRIPTION (39)	N/A
1 8	PERSONNEL INJURIES NUMBER (40)	0 0 0
	DESCRIPTION (41)	N/A
1 9	LOSS OF OR DAMAGE TO FACILITY TYPE (42)	Z
	DESCRIPTION (43)	N/A
2 0	PUBLICITY ISSUED (44)	N
	DESCRIPTION (45)	N/A
	NRC USE ONLY	

8307050036 830615
PDR ADOCK 05000272
S PDR

NAME OF PREPARER R. Frahm

PHONE (609) 935-6000 4309

GPO 917-926

PSE&G

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

Salem Generating Station

June 22, 1983

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

Dear Mr. Allan

LICENSE NO. DPR-70
DOCKET NO. 50-272
REPORTABLE OCCURRENCE 83-024/03L

Pursuant to the requirements of Salem Generating Station Unit No. 1, Technical Specifications, Section 6.9.1.9.b, we are submitting Licensee Event Report for Reportable Occurrence 83-024/03L. This report is required within thirty (30) days of the occurrence.

Sincerely yours,

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

RF:ks

CC: Distribution

Report Number: 83-024/03L

Report Date: 06-15-83

Occurrence Date: 05-25-83

Facility: Salem Generating Station Unit 1
Public Service Electric & Gas Company
Hancock's Bridge, New Jersey 08038

IDENTIFICATION OF OCCURRENCE:

A.C. Electrical Power Sources - No. 1C A.C. Bus Train - Inoperable.

This report was initiated by Incident Report 83-101.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 - Rx Power 89 % - Unit Load 950 MWe.

DESCRIPTION OF OCCURRENCE:

At 1422 hours, May 25, 1983, during routine power operation, an operator inadvertently opened the supply breaker to No. 1C Vital Instrument Inverter. The operator was implementing a Tagging Request to de-energize the No. 2C Vital Instrument Inverter and erroneously performed the evolution on the Unit 1 device. An automatic transfer to the alternate power supply occurred satisfactorily and there was no loss of equipment or indication. With the inverter out of service, the No. 1C Vital Instrument Bus and its associated A.C bus train were inoperable, and Technical Specification Action Statement 3.8.2.1 applied. The operator immediately realized his mistake, notified the Control Room, and restored the inverter to service.

APPARENT CAUSE OF OCCURRENCE:

In an interview following the incident, the operator involved stated that he had erroneously entered Salem Unit 1 Relay Room and had mistakenly operated the breaker on No. 1C Vital Inverter. The operator overlooked the accepted operating practice of verifying proper equipment by identification prior to operation of the equipment. Although errors due to inadvertent operation of similar equipment in the opposite unit had been observed in the past, they were low frequency in nature. The incident was therefore assumed to involve an isolated personnel error.

ANALYSIS OF OCCURRENCE:

The operability of A.C. and D.C. power sources and associated distribution systems during operation ensures that sufficient power will be available to supply the safety related equipment required for the safe shutdown of the facility and the mitigation and control of accident conditions within the facility. The action requirements specified for levels of degradation of the power sources provide restriction upon continued facility operation commensurate with the level of degradation. The operability of the power sources are

ANALYSIS OF OCCURRENCE: (cont'd)

consistent with the assumptions of the accident analyses and are based upon maintaining at least one of each of the onsite A.C. and D.C. power sources and associated distribution systems operable coincident with an assumed loss of offsite power and single failure of the other onsite A.C. source.

As noted, redundant A.C. power sources were operable throughout the occurrence, and therefore the incident involved no risk to the health or safety of the public. Due to the loss of redundancy involved, the incident constituted operation in a degraded mode in accordance with Technical Specification 6.9.1.9b.

CORRECTIVE ACTION:

As noted, the operator immediately restored the No. 1C Vital Inverter to operation. The related A.C. source was declared operable, and at 1427 hours, May 25, 1983, Action Statement 3.8.2.1 was terminated. The operator involved in the incident was reprimanded. Finally, a study of Salem tagging operations was recently completed and considers the potential for operator confusion resulting from dual unit operation. Results of the study are presently being evaluated by the station; recommendations will be implemented as appropriate.

FAILURE DATA:

Not Applicable

Prepared By R. Frahm

General Manager -
Salem Operations

SORC Meeting No. 83-079