

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1) Salem Generating Station - Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 2 7 2 1 OF 0 5										PAGE (3) 1			
TITLE (4) Containment Pressure Relief Operations Not IAW Tech. Spec. Requirements																							
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (9)													
MONTH DAY YEAR			YEAR SEQUENTIAL NUMBER REVISION NUMBER				MONTH DAY YEAR			FACILITY NAMES								DOCKET NUMBER(S)					
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0 2 1 3 8 5			8 5 - 0 0 2 - 0 0 0 3 1 5 8 5															0 5 0 0 0					
OPERATING MODE (8)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8: (Check one or more of the following) (11)																					
1		20.402(b)				20.406(e)				80.73(a)(2)(iv)				73.71(b)									
POWER LEVEL (10)		20.406(a)(1)(i)				80.36(a)(1)				80.73(a)(2)(v)				73.71(e)									
1 0 0		20.406(a)(1)(ii)				80.36(a)(2)				80.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)									
		20.406(a)(1)(iii)				X 80.73(a)(2)(i)				80.73(a)(2)(vii)(A)													
		20.406(a)(1)(iv)				80.73(a)(2)(ii)				80.73(a)(2)(vii)(B)													
		20.406(a)(1)(v)				80.73(a)(2)(iii)				80.73(a)(2)(x)													
LICENSEE CONTACT FOR THIS LER (12)																							
NAME										TELEPHONE NUMBER													
J. L. Rupp										AREA CODE 6 0 9 3 3 9 - 4 3 0 9													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																							
CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC		CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC					
SUPPLEMENTAL REPORT EXPECTED (14)																EXPECTED SUBMISSION DATE (15)		MONTH		DAY		YEAR	
YES (If yes, complete EXPECTED SUBMISSION DATE)																X NO							
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																							
<p>On February 14, 1985, it was discovered by the shift supervisor that two containment pressure relief operations, which were performed on February 13, 1985, were not in accordance with the Technical Specification requirements or with approved procedures. Although the Plant Vent Iodine Radiation Monitor (1R41B) was substituted for the inoperable Containment Iodine Radiation Monitor (1R12B) as authorized by the Technical Specifications, the 1R41B channel setpoints were not reduced. This technically rendered the Containment Ventilation Isolation System inoperable, due to the fact that the setpoint at which an isolation signal from 1R41B would have initiated containment ventilation isolation was not consistent with the Technical Specification requirement, or with the assumptions used in the FSAR. The event was attributed to personnel error; specifically, the failure to follow procedures as written. Both pressure relief operations were continuously monitored to ensure that the release rates were within specification; however, the event is reportable in accordance with 10CFR 50.73(a)(2)(i)(B). The event was discussed with the operating shift involved, and the responsible personnel were dealt with individually according to the disciplinary process. In addition, a discussion of this event will be included in the operator requalification program.</p>																							
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**PLANT AND SYSTEM IDENTIFICATION:**

Westinghouse - Pressurized Water Reactor

Energy Industry Identification System (EIIS) codes are identified in the text as [XX].

**IDENTIFICATION OF OCCURRENCE:**

Containment Pressure Relief Operations Not in Accordance With Technical Specification Requirements

Event Date: 02/13/85

Report Date: 03/15/85

This report was initiated by Incident Report No. 85-038

**CONDITIONS PRIOR TO OCCURRENCE:**

Mode 1 - Rx Power 100 % - Unit Load 1140 MWe

**DESCRIPTION OF OCCURRENCE:**

On February 14, 1985, it was discovered by the shift supervisor that two (2) containment pressure relief operations, which were performed on February 13, 1985, were not in accordance with the Technical Specification requirements or with approved procedures. Although the plant vent Iodine Radiation Monitor (1R41B) was substituted for the inoperable containment Iodine Radiation Monitor (1R12B) as authorized by the Technical Specifications, the 1R41B channel setpoints were not reduced. This technically rendered the Containment Ventilation Isolation System inoperable, due to the fact that the setpoint at which an isolation signal from Radiation Monitor 1R41B would have initiated containment ventilation isolation was not consistent with the Technical Specification requirement, or with the assumptions used in the FSAR. The circumstances surrounding the event are as follows:

At 0857 hours, February 13, 1985, permission was granted by the shift supervisor to perform calibration procedures on Channel 1R12B of the Radiation Monitoring System [IL], and at 1000 hours, 1R12B was removed from service. After consulting Technical Specification 3.3.3.1 Table 3.3-6 Action No. 22 and OD-12 (Technical Specifications Interpretations) Guide-7, the Nuclear Control Operators (NCO's) decided that entry into the action statement was not required.

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**DESCRIPTION OF OCCURRENCE: (cont'd)**

Action No. 22 states:

With the number of channels operable less than required by the minimum channels operable requirement, comply with the action requirements of Specification 3.9.9.

Limiting Condition For Operation (LCO) 3.9.9 states:

With the Containment Purge and Pressure/Vacuum Relief Isolation System inoperable, close each of the purge and pressure/vacuum relief penetrations providing direct access from the containment atmosphere to the outside atmosphere.

The decision not to enter the action statement was based on the operators knowledge that the Technical Specifications permitted either 1R12B or 1R41B to be operational during containment purges and pressure/vacuum reliefs, and the fact that 1R41B was in an operable status. However, the NCO's failed to note the Technical Specification requirement to reduce the setpoints for channel 1R41B. As noted in the Technical Specifications, and explained in OD-12 Guide-7, the setpoints of plant vent radiation monitoring channel R41A (particulate), R41B (iodine) or R41C (gaseous) are to be reduced whenever any of these monitors is substituted for its respective containment radiation monitoring channel; i.e., R11A (particulate), R12A (gaseous) or R12B (iodine).

As previously stated, failure to reduce the 1R41B setpoints technically rendered the Containment Ventilation Isolation System inoperable, and resulted in violation of the Technical Specification LCO 3.9.9 during two containment pressure relief operations. Those pressure reliefs were performed on February 13, 1985, between 1050 and 1122 hours, and between 1346 and 1412 hours.

**APPARENT CAUSE OF OCCURRENCE:**

A review of the Technical Specifications, the containment pressure/vacuum relief operating procedure (OP-II-16.3.1) and Operations Directive No. 12 revealed no procedural inadequacies. The procedures are very explicit on the requirements for containment pressure relief operations when utilizing the R41 channels. The root cause of this event was attributed to personnel error; specifically, the failure to follow the procedures as written. Contributing to the event was the lack of communications between shift personnel concerning the inoperability of the 1R12B monitor, and its affect on plant operations.

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**ANALYSIS OF OCCURRENCE:**

1R12B and 1R41B are provided to measure radioactive iodine in the containment, and to ensure that the release rate through the plant vent during purging is maintained below specified limits. High radioactivity level initiates closure of the containment purge supply and exhaust duct valves. Technical Specification 3.3.2 requires operation of the Containment Iodine Radiation Monitor (1R12B) with a Containment Ventilation Isolation setpoint signal of less than or equal to two times normal, and a response time of less than or equal to five (5) seconds. The Containment Ventilation Isolation System provides the means of isolating the containment atmosphere to prevent the release of radioactivity to the environment in the event of a loss-of-coolant accident. In addition, the required closure time of the valves ensures that no significant release of radioactivity to the environment can occur during such an event. With 1R12B inoperable, 1R41B is capable of monitoring the release from the containment and initiating the containment isolation signal. However, without reducing the 1R41B setpoint to at least that of 1R12B, it cannot be guaranteed that isolation of the pressure relief line would be achieved prior to exceeding the calculated release values. Throughout both pressure relief operations, 1R41B and 1R16 (Plant Vent Gross Activity Monitor) remained operational, and both channels were continuously monitored to ensure that the release rates were within specification. However, because the pressure relief operations were not in accordance with Technical Specification requirements, the event is reportable in accordance with the Code of Federal Regulations, 10CFR 50.73(a)(2)(i)(B).

**CORRECTIVE ACTION:**

The event was discussed with the operating shift involved, and the importance of communications within the shift was stressed. Operators were informed of the incident via the Operations Department newsletter. The personnel involved in this occurrence were dealt with individually according to the disciplinary process.

All Licensee Event Reports are reviewed by the Nuclear Training Department. In each case, existing training programs are evaluated for adequate coverage of the respective area. The decision is then made for the need to upgrade existing training or for the implementation of new training. Because of PSE&G's desire to reduce the number of personnel error related incidents, the Nuclear Training Department will include a discussion of each reportable occurrence (attributed to personnel error) in the next scheduled operator requalification cycle.



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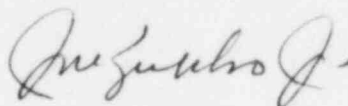
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CORRECTIVE ACTION: (cont'd)

All events are reviewed for their repetitive nature. This event and a previous event (Unit 2 LER 84-014-00) involving the radiation monitors were compared. Both events were the result of personnel error, and although the root causes of the events were different, the results were the same (performing pressure reliefs without reducing the R41 channel setpoints). In compliance with our new policy concerning personnel error related incidents, a discussion of both events will be included in the operator requalification program.



General Manager-  
Salem Operations

JLR:tns

SORC Mtg 85-047



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

Salem Generating Station

March 15, 1985

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

Dear Sir:

SALEM GENERATING STATION  
LICENSE NO. DPR-70  
DOCKET NO. 50-272  
UNIT NO. 1  
LICENSEE EVENT REPORT 85-002-00

This Licensee Event Report is being submitted pursuant to the requirements of 10CFR 50.73(a)(2)(i)(B). This report is required within thirty (30) days of discovery.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "J. M. Zupko, Jr.".

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

JR:tcs

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