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REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9111140048 DOC. DATE: 91/11/06 NOTARIZED: NO DOCKET #
 FACIL: 50-387 Susquehanna Steam Electric Station, Unit 1, Pennsylv 05000387
 AUTH. NAME AUTHOR AFFILIATION
 LLOYD, H. Pennsylvania Power & Light Co.
 STANLEY, H. G. Pennsylvania Power & Light Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 91-012-00: on 911007, discovered that manual containment boundary valves not included in required surveillance procedures. Caused by personnel error during initial preparation of procedures. Procedures changed. W/911106 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: LPDR 1 cy Transcripts. 05000387

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	NRR/DET/EMEB 7E	1	1		NRR/DLPQ/LHFB10	1	1	
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	RES/DSIR/EIB	.1	1		RGN1 FILE 01	1	1	
EXTERNAL:	EG&G BRYCE, J. H	3	3		L ST LOBBY WARD	1	1	
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Pennsylvania Power & Light Company

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November 6, 1991

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

SUSQUEHANNA STEAM ELECTRIC STATION
LICENSEE EVENT REPORT 91-012-00
FILE R41-2
PLAS - 503

Docket No. 50-387
License No. NPF-14

Attached is Licensee Event Report 91-012-00. This report is being made pursuant to 10CFR50.73(a)(2)(i)(b), in that Susquehanna Unit 1 and Unit 2 were in a condition prohibited by the Technical Specifications when required surveillance tests were not performed on certain manual containment boundary valves per Technical Specification 4.6.1.1.b. This condition has been corrected.

H.G. Stanley
Superintendent of Plant - Susquehanna

HL/mjm

cc: Mr. T. T. Martin
Regional Administrator, Region I
U.S. Nuclear Regulatory Commission
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-830), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Susquehanna Steam Electric Station - Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 8 7	PAGE (3) 1 OF 0 4
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TITLE (4)
Valves Not Surveillance Tested - Operation Prohibited by Technical Specifications

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 NAMES		DOCKET NUMBER(S)									
1	0	0	7	9	1	9	1	0	1	2	0	0	1	1	0	6	9	1	SSES - Unit 2	0 5 0 0 0 3 8 8
												0 5 0 0 0								

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)										
POWER LEVEL (10) 1 0 0	20.402(b)	20.406(e)	50.73(a)(2)(iv)	73.71(b)							
	20.406(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(e)							
	20.406(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 388A)							
	20.406(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)								
	20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(vii)(B)								
20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(a)									

LICENSEE CONTACT FOR THIS LER (12)

NAME Harrison Lloyd, Jr. - Power Production Engineer	TELEPHONE NUMBER 7 1 7 5 4 2 - 3 9 1 7
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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

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On October 7, 1991, with both Units 1 & 2 at 100%, it was discovered that certain manual containment boundary valves were not included in required surveillance procedures. This condition was discovered during a periodic review of the procedure. The subject valves are normally locked closed test connection valves and were in fact in this configuration. Several causes were determined for this event. The first was personnel error during the initial preparation of the procedure for the valves in the RHR System. Concerning the valves in the CRM System, one cause was attributed to not including all applicable disciplines in the installation and/or closeout review process of the modification. Another cause was the methods utilized by operations during the modification closeout review process. The event was determined to be reportable per 10CFR50.73(a)(2)(i)(B) as a condition prohibited by Technical Specification in that surveillances were not performed as required by Technical Specification 4.6.1.1.b. There were no safety consequences or compromises as a result of this condition since the valves remained in the required locked closed position. Necessary surveillance procedure changes have been completed and the Operations section and Systems Engineering group are reviewing their present procedural guidance for enhancements to prevent recurrence of this type of event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT. (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Unit 1 Susquehanna Steam Electric Station	DOCKET NUMBER (2) 0 5 0 0 0 3 8 7	LER NUMBER (6)			PAGE (3)		
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TEXT (If more space is required, use additional NRC Form 306A's) (17)

DESCRIPTION OF EVENT

On October 7, 1991, with both Units in Condition 1 at 100% power, it was discovered that eighteen valves in each Unit were not included in surveillance procedure; "Monthly Outside Containment Verification of Primary Containment Integrity", and thus had not had the required 31 day surveillance of verifying the valves closed performed per Technical Specification 4.6.1.1.b. This condition was discovered during the periodic two year review of the applicable procedures. Twelve of the eighteen valves are vent and drain valves on Residual Heat Removal (RHR) piping penetrations and the other six valves are vent and drain valves on the Containment Radiation Monitor (CRM) piping penetrations. Upon discovery of this condition, all of the valves were immediately verified to be in the required locked closed position which served to verify operability of the subject primary containment penetrations. Procedural changes were initiated to include these valves in the appropriate surveillance procedure.

CAUSE OF EVENT

There were several causes determined for this event.

For the RHR valves, the cause was personnel error during initial preparation of the surveillance procedures. The procedure writer erroneously assumed that three automatic valves which are located on the penetration side of the twelve valves were Containment Isolation valves. If this were the case, the twelve valves would not require testing. These automatic valves are in fact not containment isolation valves and thus the twelve RHR test valves are required to be surveilled. During subsequent reviews of the surveillance procedures, this error was not discovered until the most recent revision review process. This oversight is considered an isolated occurrence.

Concerning the CRM valves, two modifications added several test lines to satisfy penetrations leakage testing requirements. The closure process for the modification failed to identify the six new CRM test connection valves for incorporation into the surveillance procedure. There were two causes determined for failing to incorporate the CRM valves into the surveillance procedures. One cause was that the modification installation and/or closeout review team did not include all applicable disciplines. The modification was designated as CRM's therefore the CRM system engineer was responsible for modification implementation. Part of this modification added new containment boundary valves. The Containment system engineer was not aware of this modification nor was he involved with the modification installation and/or closeout review. The CRM system engineer was unaware of the containment penetration surveillance requirement per Technical Specification 4.6.1.1.b,

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

therefore this surveillance was not listed on the "Procedure Changed Sheet" during modification closeout. It is possible, if the containment system engineer had been involved, this surveillance may have been identified. The Systems Engineering review for procedure impacts, is the first lines of defense to ensure all Systems Engineering and Operation procedures are revised.

The other cause was that the Operations modification engineer was unaware of the penetration surveillance. He failed to identify this surveillance on the "Procedure Changed Sheet" during modification closeout. Operations review of the "Procedure Changed Sheet" is our second line of defense. It was determined that the appropriate operations procedure writers were unaware of this modification, therefore did not provide any input during modification closeout. It is possible, if the Operations Surveillance procedure writer had been involved during Operations modification closeout review, this surveillance may have been identified.

REPORTABILITY/ANALYSIS

This condition was determined to be reportable per 10CFR50.73(a)(2)(i)(B), as a condition prohibited by the plant's Technical Specifications in that surveillances were not performed as required by Technical Specification 4.0.3.

This condition did not create a degradation in our ability to protect the health and safety of the public and/or plant personnel since the subject valves were in the required safe position of locked closed and thus their safety function was maintained as required.

This event would not have been more significant at any other initial operating condition.

In accordance with guidance provided in NUREG 1022, Supplement 1, item 14.1; the required submission date for this report was determined to be 11/6/91.

CORRECTIVE ACTION

Procedure changes were initiated for the subject valves and the valves were verified to be in their proper locked closed position.

The Operations section is evaluating methods of handling/processing modifications within their department to ensure adequate review of procedures which may be affected by modifications.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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TEXT (If more space is required, use additional NRC Form 366A's) (117)

Systems Engineering is evaluating programmatic changes to their Technical Instruction on Installation Kickoff Meetings to assure attendance by appropriate system engineers as well as a comprehensive affected procedure review, especially for modifications involving multiple systems. In addition, Systems Engineering will review our containment boundary to ensure all valves are properly addressed in procedures.

ADDITIONAL INFORMATION

Failed Component Identification: N/A

Previous Similar Events:

Although there have been previous events involving missed surveillances, there were none caused by components missing out of existing procedures.