NRC FORM 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Susquehanna Steam Electric Station - Unit 2	05000388	1 OF 3

TITLE (4)
Secondary Containment Boundary Surveillance Missed

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
										05000
3	14	98	98	-- 001 --	00	3	16	98	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
POWER LEVEL (10)	100	20.2201(b)	20.2203(a)(2)(v)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Stephen J. Ellis - Senior Engineer, Licensing	717 / 542-3537

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

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On February 13, 1998, with Unit 2 in Condition 1 (Power Operation) at 100% power, while performing a procedural review for Improved Technical Specification related activities, it was discovered that three secondary containment boundaries were omitted from the surveillance procedure. Only one of the three had not been tested in the required time interval. Technical Specification Limited Condition for Operation (LCO) 4.0.3 was entered for the missed surveillance requirement. The untested item, door 104-R, was subsequently tested and found acceptable, and the LCO cleared. The cause of the event was determined to be related to the conversion of the procedure from one word processing software to another, without adequate proofreading by the typist and insufficient checking by the preparer. This event is reportable per 10CFR50.73(a)(2)(i)(B). The subject door is normally closed and there is reasonable assurance that the door was closed throughout the time interval that the door was not surveillance tested. Based on this, the safety significance of this event is minor and the health and welfare of the public was never compromised. The following corrective actions have been taken: the appropriate procedure has been updated, and the administrative staff, preparer, and responsible supervisor have been counseled on this event, reiterating the expectation that a converted procedure needs to be identical to the original. Also, a training package for procedure preparers and reviewers will be assembled for review of this event and to reiterate the expectation that the preparer is responsible for proofing the converted procedure.

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	05000	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Susquehanna Steam Electric Station - Unit 2	388	98	-- 001 --	00	2 OF 3

TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

EVENT DESCRIPTION

On February 13, 1998, with Unit 2 in Condition 1 (Power Operation) at 100% power, while performing a review of the surveillance for verification of Unit 2 secondary containment boundaries for Improved Technical Specifications (ITS) related activities, it was discovered that three secondary containment boundaries were not included in the surveillance procedure. Two of the three items were included in another surveillance and had met their Technical Specification requirements. The third item, door 104-R, had not been surveillance tested within the required interval (31 days) per Technical Specifications 4.6.5.1.2a and 2b. Technical Specification Limited Condition for Operation (LCO) 4.0.3 was entered for both units. The three omitted items were added to the surveillance and door 104-R was verified closed. Technical Specification LCO 4.0.3 was cleared on both units.

Investigation revealed that the omission occurred during the surveillance procedure's conversion from a Word Perfect® format to a Word® format.

CAUSE OF EVENT

In this case it was determined that there were three problem areas: the conversion process itself; the converted procedure was not proofread by the typist; and the procedure preparer and reviewer (utility; non-licensed) did not catch the error during their review. The conversion process is cumbersome and labor intensive, requiring a "cut and paste" method to move information from the old document to the new document. The exact cause of the omission can not be determined, but it most likely appears to be a "cut and paste" error. Following converting the procedure, the typist proofreads the document. In this case, the converted hard copy of the procedure contained several obvious formatting errors that should have been caught in the proofreading effort. It is concluded that this procedure was not proofread by the typist. Similarly the procedure preparer and reviewer also missed the omitted items in their reviews. The most likely cause was the failure to self verify.

REPORTABILITY/ANALYSIS

As a result of this event, the conversion process was reviewed. There have been approximately two thousand procedures converted from Word Perfect® to Word® to date. A review was performed for past identified similar occurrences and none were found. Given that there is no documented past similar errors and the fact that proofing is typically detecting conversion errors, there appears to be no generic condition associated with this event, and the in place defense-in-depth is adequate. This event was determined to be reportable per 10CFR50.73(a)(2)(i)(B). As noted previously, only one item, door 104-R, had not been surveillance tested as required by the Technical Specifications. This door is a boundary between the Unit 2 secondary containment and outside of secondary containment. It is normally locked and is not used for routine access or egress. Access and egress through the door is controlled by security, the door is labeled to prohibit passage, and any access through the door would require a Technical Specification LCO to be entered on both units. Review of the LCO logs revealed no Secondary Containment LCO entries made for door 104-R. Based on this, it can be reasonably assumed that the door was closed throughout the time it was not tested, and there is no safety significance associated with this event. The health and welfare of the public was never compromised.

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TEXT *(If more space is required, use additional copies of NRC Form 366A)* (17)

In accordance with the guidance of NUREG 1022, Revision 1, the required submission date for this report was determined to be March 16, 1998.

CORRECTIVE ACTIONS

The following corrective actions have been completed:

- The appropriate surveillance procedure has been revised.
- The procedure preparer and responsible supervisor (reviewer) involved in this event were counseled regarding the importance of thoroughly proofreading converted procedures.
- This event has been reviewed with the Administrative Support Group involved in procedure conversion, with emphasis on the importance of proofreading and the expectation that the information in the converted procedure is to be identical to the original.

A training package to all managers for review with personnel involved with procedure preparation and revision will be assembled and issued. The training package will review the event and reiterate the expectation that the preparer is responsible for proofing the converted document prior to issuing.

ADDITIONAL INFORMATION

Past Similar Events: No other reported items have been found that document a clerical/administrative error that resulted in a specific operating event.

Failed Components: None