

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Salem Generating Station - Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 2 7 2 1				PAGE (3) 1 OF 0 4	
TITLE (4) Missed Tech. Spec. Surveillance 4.0.5 - V & P Due To Inadequate Administrative Control															
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)		
0 2	1 9	8 9	8 9	0 1 3	0 0	0 3	2 2	8 9					0 5 0 0 0		
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)													
1		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)	
POWER LEVEL (10)		20.405(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)	
1 0 0		20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
		20.405(a)(1)(iii)				X 50.73(a)(2)(i)				50.73(a)(2)(vii)(A)					
		20.405(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(vii)(B)					
		20.405(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)					
LICENSEE CONTACT FOR THIS LER (12)															
NAME M. J. Pollack - LER Coordinator										TELEPHONE NUMBER 6 0 9 3 3 9 - 4 0 2 2					
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)															
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPD		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPD					
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)

On 2/21/89, it was discovered that the Technical Specification Surveillance 4.0.5-V & P for the Service Water Valve and 1A Diesel Generator (D/G) Prelube Oil Pump vibration check was not performed within the required time frame. The surveillance was due on 2/19/89. The late surveillances were discovered both by Maintenance-Planning and the station Technical Specification Coordinator via a computer "flag" from the Managed Maintenance Information System (MMIS). The MMIS is a computerized work tracking and historical file system. The root cause of this event has been attributed to inadequate administrative control. Operations Department personnel did not fully utilize the available reports to ensure surveillance work activities were completed as scheduled. Operations Department management has assigned an individual to monitor the scheduled surveillance program and report concerns directly to Operations management. The individuals responsibilities include review of computer generated reports to ensure surveillances are performed. The MMIS computer programming has been modified to identify if work orders are re-printed. The work activity sign off sheet will be issued from the Work Control Center instead of from Planning. However, Planning will still provide the work package containing the details/procedures required to complete the work activity. This event will be reviewed by Operations and Maintenance management with the personnel within their respective departments. This event will be reviewed by the Nuclear Training Center for incorporation of information in applicable training programs.

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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:

Missed Technical Specification Surveillance 4.0.5-V & P Due To Inadequate Administrative Control

Event Date: 2/19/89

Discovery Date: 2/21/89

Report Date: 3/22/89

This report was initiated by Incident Report No. 89-103.

CONDITIONS PRIOR TO OCCURRENCE:

Mode 1 Reactor Power 100% - Unit Load 1146 MWe

DESCRIPTION OF OCCURRENCE:

On February 21, 1989 at 0900 hours, it was discovered that the Technical Specification Surveillance 4.0.5-V & P for the Service Water Valve and 1A Diesel Generator (D/G) Prelube Oil Pump {LA} vibration check was not performed within the required time frame. The surveillance was due on February 19, 1989.

The late surveillances were discovered both by Maintenance-Planning and the Technical Specification Coordinator via a computer "flag" from the Managed Maintenance Information System (MMIS). The MMIS is a computerized work tracking and historical file system.

Technical Specification Surveillance 4.0.5 states:

"Surveillance Requirements for inservice inspection and testing of ASME Code Class 1, 2 and 3 components shall be applicable as follow: "

The valve and pump in question are required to be surveilled every 92 days.

APPARENT CAUSE OF OCCURRENCE:

The root cause of this event has been attributed to inadequate administrative control. Operations Department personnel did not fully utilize the available reports to ensure surveillance work activities are completed as scheduled.

Planning had originally scheduled the work on January 27, 1989.

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APPARENT CAUSE OF OCCURRENCE: (cont'd)

However, it was re-scheduled to coincide with the 1A D/G {EK} operability surveillance scheduled to be performed on February 17, 1989. The updated work activity form could not be found, although, it was believed to have been printed. Since Operations personnel did not find a work activity form to perform the 1A D/G Prelube Pump and SW Valve surveillance in the file drawer, it was not performed when the 1A D/G operability surveillance was performed on February 17.

The original work activity form, for the completion of the surveillance, was printed as indicated by computer records, however, it has not been found.

The Planning Department issues two reports to Operations addressing scheduled work. One report, called the "Surveillance Overdue Report", addresses surveillances overdue within two weeks as of the date of issue of the report. The other report, called the "Four Day Look Ahead Report", addresses work scheduled (including preventive maintenance and surveillances) to be performed over the four day period from the report's date of issue. Although these reports were provided to Operations Department personnel, they were not fully utilized to ensure completion of assigned work. Surveillances were worked only if the respective Work Order was found in the appropriate file folder. Had Operations Department personnel made use of the above reports, the need to perform the surveillance would have been addressed prior to the surveillance being missed.

Due to missed surveillances in 1988, attributed to the MMIS system implementation, Operations continued to rely on the accuracy of the file drawers. Operations personnel relied on the working files to contain the scheduled work activities, including surveillances. Operations used the Four Day Look Ahead Report to identify equipment/system inoperability. The report was not used to ensure scheduled surveillance work activity forms were available nor to ensure that surveillances were not missed.

ANALYSIS OF OCCURRENCE:

The 1A D/G SW valve and Prelube Pump surveillance ensures the continued reliable operation of this equipment. Failure of this equipment would result in inoperability of the 1A D/G.

To safely shut the plant down during normal and accident conditions, a minimum of two D/Gs are required.

The surveillance was completed on February 21, 1989 satisfactorily. The subject equipment proved it would function as designed. Therefore, the 1A D/G would have functioned as designed during the time period when the surveillance was exceeded. This event did not affect the health or safety of the public, however, it is reportable in accordance with 10CFR 50.73(a)(2)(i)(B) since a required surveillance was not performed within its required time frame.

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CORRECTIVE ACTION:

Operations Department management has assigned an individual to monitor the scheduled surveillance program and report concerns directly to Operations management. The individuals responsibilities include review of computer generated reports to ensure surveillances are performed. This surveillance monitoring will continue until Operations Department management and supervision are sufficiently familiar with the use of the MMIS computer system and its associated reports.

The MMIS computer programming has been modified to identify if work orders are re-printed.

The work activity sign off sheet will be issued from the Work Control Center instead of from Planning. However, Planning will continue to provide the work package containing the details/procedures required to complete the work activity. Work Control Center personnel report to Operations Department management.

This event will be reviewed by Operations and Maintenance management with the personnel within their respective departments.

This event will be reviewed by the Nuclear Training Center for incorporation of information in applicable training programs.

LK Mills/pc
General Manager -
Salem Operations

MJP:pc

SORC Mtg. 89-023



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

Salem Generating Station

March 22, 1989

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 89-013-00

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

Sincerely yours,

LK Miller/pw

L. K. Miller
General Manager -
Salem Operations

MJP:pc

Distribution

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