



Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038-0236

Nuclear Business Unit

FEB 14 1997

LR-N97120

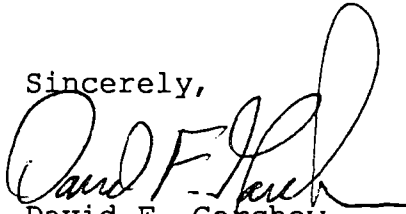
U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

LER 272/97-001-00
SALEM GENERATING STATION - UNIT 1
FACILITY OPERATING LICENSE NO. DPR-70
DOCKET NO. 50-272

Gentlemen:

This Licensee Event Report entitled "Inadequate IST Surveillance of the Boron Injection Inlet Valves" is being submitted pursuant to the requirements of the Code of Federal Regulations 10CFR50.73 (a) (2) (i) (B).

Sincerely,



David F. Garchow
General Manager
Salem Operations

Attachment

DVH

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The power is in your hands.

LICENSEE EVENT REPORT (LER)

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

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.

FACILITY NAME (1) SALEM GENERATING STATION UNIT 1	DOCKET NUMBER (2) 05000272	PAGE (3) 1 OF 3
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TITLE (4)
INADEQUATE IST SURVEILLANCE OF THE BORON INJECTION INLET VALVES

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
01	17	97	97	- 001	- 00	02	14	97	Salem Unit 2	05000311
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
POWER LEVEL (10)	000	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 388A				
		20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)					

LICENSEE CONTACT FOR THIS LER (12)

NAME Dennis V. Hassler, LER Coordinator	TELEPHONE NUMBER (Include Area Code) 609-339-1989
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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)				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 January 18, 1997 a review determined that the Inservice Test surveillance on motor operated valves SJ4 and SJ5, Safety Injection Charging Pumps to Boron Injection Tank, was not properly performed in the past. Emergency Operating Procedure (EOP) SGTR-1 requires the operators to close these valves to terminate safety injection during the steam generator tube rupture event. This method implements UFSAR Section 15.4.4 to terminate safety injection. The closure of these valves is an active safety function of the design basis of the plant. Because it is an active safety function, testing of these valves to close is required by Technical Specification 4.0.5 and must be included in the IST program. A subsequent review of the EOPs determined that there were 12 additional valves that were not being tested in the IST program in the direction contained in the EOPs.

The cause of the event was inadequate communication between the EOP group and the IST reviewers in determining valves manipulated in the EOPs that were required to be included in the IST Program. Corrective actions include procedure revisions and completing surveillances.

This event is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B), any condition prohibited by the plant's Technical Specifications.

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TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
SALEM GENERATING STATION UNIT 1	05000272				2 OF 3
		97	001	00	

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

PLANT AND SYSTEM IDENTIFICATION

Westinghouse - Pressurized Water Reactor

Safety Injection {BP/-} *
Containment Spray {BE/-}
Component Cooling {KB/-}
Main Steam {SB/-}

* Energy Industry Identification System (EIIS) codes and component function identifier codes appear as {SS/CC}

CONDITIONS PRIOR TO OCCURRENCE

At the time of the occurrence Salem Unit 1 was defueled and Salem Unit 2 was in Mode 5.

DESCRIPTION OF OCCURRENCE

On January 18, 1997 a review as a result of a recent NRC inspection determined that the Inservice Test (IST) surveillance on motor operated valves SJ4 {BP/V} and SJ5, Safety Injection Charging Pumps to Boron Injection Tank {BP/TK}, was not properly performed in the past. Emergency Operating Procedure (EOP) SGTR-1 requires the operators to close these valves to terminate safety injection during the steam generator tube rupture event. This method implements UFSAR Section 15.4.4 to terminate safety injection. The closure of these valves is an active safety function of the design basis of the plant. Because it is an active safety function, testing of these valves to close is required by Technical Specification 4.0.5 and must be included in the IST program.

Subsequent review of the SJ4 and SJ5 issue determined that there were 12 additional Unit 2 valves that were not being tested in the IST program in the direction contained in the EOPs. These 12 valves are 21CC16 {KB/V}, 22CC16, 2SJ12 {BP/V}, 2SJ13, 21SJ54, 22SJ54, 23SJ54, 24SJ54, 21CS36 {BE/V}, 22CS36, 21MS45 {SB/V} and 23MS45. The corresponding Unit 1 valves are likewise affected.

CAUSE OF OCCURRENCE

The cause of the event was inadequate communication between the EOP group and the IST reviewers in determining what valves were manipulated in the EOPs and were therefore required to be included in the IST Program.

LICENSEE EVENT REPORT (LER)
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

PRIOR SIMILAR OCCURRENCES

In the past two years there have been three LERs, 272/95-018-00, 272/95-005-09, and 311/97-001-00, that addressed IST issues. The corrective actions in LER 272/95-018-01 was to complete an assessment of the IST program to ensure that programmatic and procedure deficiencies were identified and corrected. This assessment did not adequately review the UFSAR and EOPs to identify the issues contained above. The corrective actions in LERs 272/96-005-09 and 311/97-001-00 were specific to the issues in those LERs.

SAFETY CONSEQUENCES AND IMPLICATIONS

There were no safety consequences associated with the occurrences in this LER. Evaluation of other testing performed on the identified valves provides confidence that the valves would have operated if needed. This is based on the following.

The 21CC16, 22CC16, 2SJ4, 2SJ5, 2SJ12, and 2SJ13 valves are in the GL 89-10 program and are stroke timed quarterly in the open direction.

The 21CS36 and 22CS36 valves are in the GL 89-10 program and open stroked during cold shutdown. After the open stroke test, the valve is returned to the closed position.

The 21SJ54, 22SJ54, 23SJ54, 24SJ54 valves are in the GL 89-10 Program and are operated when transitioning in and out of cold shutdown.

The 21MS45 and 23MS45 valves are manual valves and do not have any scheduled stroke tests. These valves are closed which provides assurance that they were capable of being closed in the past.

The health and safety of the public was not affected.

CORRECTIVE ACTIONS

1. The Salem EOPs were reviewed for similar problems and the results are noted above.
2. The Operations Department Emergency/Abnormal Operating Procedure Program procedure, SC.OP-AP.ZZ-0113, will be revised to include IST notification of proposed changes. This will be completed by May 5, 1997.
3. As a result of the issues in this LER and other recently identified IST issues, a plan has been developed and will be completed to ensure that the Unit 2 IST Program is satisfactory prior to Unit 2 entering Mode 4.
4. The Salem Generating Station IST Manual will be revised to include the addition of the stroke test to the required valve tests for these valves. This will be completed by March 31, 1997.
5. The revised surveillance test for the identified valves will be performed prior to entering the applicable mode when the valve is required to be operable for Units 1 and 2.