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March 24, 2006

LTR: BYRON 2006-0037
File: 2.01.0700

United States Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

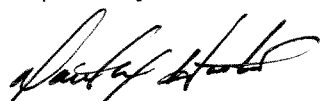
Subject: Licensee Event Report (LER) 454-2006-001-00, "Technical Specification Required Action Completion Time Exceeded for Inoperable Containment Isolation Valves Due to Untimely Operability Determination"

Byron Station, Unit 1
Facility Operating License No. NPF-37
NRC Docket No. STN 50-454

Enclosed is an LER for the January 24, 2006 event of exceeding the Technical Specification required action completion time for Unit 1 inoperable containment isolation valves due to an untimely operability determination. This condition is reportable to the NRC in accordance with 10 CFR 50.73 (a) (2) (i) (B).

Should you have any questions concerning this matter, please contact Mr. William Grundmann, Regulatory Assurance Manager, at (815) 234-5441, extension 2800.

Respectfully,



David M. Hoots
Site Vice President
Byron Nuclear Generating Station

Attachment LER 454-2006-001-00

cc: Regional Administrator, Region III, NRC
NRC Senior Resident Inspector- Byron Station

NRC FORM 366 (6-2004)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB: NO. 3150-0104		EXPIRES: 06/30/2007			
<h2 style="margin: 0;">LICENSEE EVENT REPORT (LER)</h2> <p style="margin: 5px 0;">(See reverse for required number of digits/characters for each block)</p>				Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.					
1. FACILITY NAME Byron Station				2. DOCKET NUMBER 0500454		3. PAGE <div style="text-align: right; font-weight: bold;">1 of 3</div>			
4. TITLE Technical Specification Required Action Completion Time Exceeded for Inoperable Containment Isolation Valves Due to Untimely Operability Determination									
5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	
01	24	2006	2006	001	00	03	24	2006	
			8. OTHER FACILITIES INVOLVED						
			FACILITY NAME			DOCKET NUMBER			
			FACILITY NAME			DOCKET NUMBER			
9. OPERATING MODE <div style="text-align: center; font-size: 2em;">1</div>		11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: <i>(Check all that apply)</i>							
10. POWER LEVEL <div style="text-align: center; font-size: 2em;">100</div>		<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> 20.2201(b)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(3)(i)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(i)(C)</div> <div style="width: 50%;"><input checked="" type="checkbox"/> 50.73(a)(2)(vii)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2201(d)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(3)(ii)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(ii)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(viii)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(1)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(4)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(ii)(B)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(viii)(B)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(2)(i)</div> <div style="width: 50%;"><input type="checkbox"/> 50.36(c)(1)(i)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(iii)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(ix)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(2)(ii)</div> <div style="width: 50%;"><input type="checkbox"/> 50.36(c)(1)(ii)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(iv)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(x)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(2)(iii)</div> <div style="width: 50%;"><input type="checkbox"/> 50.36(c)(2)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(v)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 73.71(a)(4)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(2)(iv)</div> <div style="width: 50%;"><input type="checkbox"/> 50.46(a)(3)(ii)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(v)(B)</div> <div style="width: 50%;"><input type="checkbox"/> 73.71(a)(5)</div> <div style="width: 50%;"><input type="checkbox"/> 20.2203(a)(2)(v)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(i)(A)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(v)(C)</div> <div style="width: 50%;"><input type="checkbox"/> OTHER</div> <div style="width: 50%;"><input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)</div> <div style="width: 50%;"><input type="checkbox"/> 50.73(a)(2)(v)(D)</div> </div>							
12. LICENSEE CONTACT FOR THIS LER									
FACILITY NAME						TELEPHONE NUMBER (Include Area Code)			
Byron Station, William Grundmann, Regulatory Assurance Manager						(815) 406-2800			
13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT									
CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
N/A	N/A	N/A	N/A	N/A					
14. SUPPLEMENTAL REPORT EXPECTED						15. EXPECTED SUBMISSION DATE			
<input type="checkbox"/> YES <i>(If yes, complete 15. EXPECTED SUBMISSION DATE)</i>						<input checked="" type="checkbox"/> NO			
MONTH						DAY			
YEAR									

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

On January 23, 2006, a Chemistry technician recognized an abnormal condition while attempting to obtain a Pressurizer liquid sample. He noted that he was able to obtain sample flow at the sample panel with both containment isolation valves and the sample panel isolation valve closed. The technician and his supervisor didn't have sufficient knowledge to recognize the potential impact on containment integrity with this condition and did not promptly notify Shift Operations. The supervisor did document the condition in a Corrective Actions Program Issue Report (IR) the next day on January 24, 2006 but failed to notify Shift Operations of the IR, which would have generated a prompt operability determination. On January 25, 2006 during subsequent IR screening activities, Shift Operations became aware of the condition and initiated a prompt operability evaluation. The containment isolation valves were declared inoperable at 1250 hours on January 25, 2006 and appropriate Technical Specifications entered and followed. This event is reportable in accordance with 10 CFR 50.73 (a) (2) (i) (B), as an event or condition prohibited by Technical Specifications. Even though all Technical Specification actions were accomplished within the completion times there was firm evidence to indicate the inoperable condition existed on the day before. The operability evaluation and subsequent inoperability declaration should have occurred on January 24, 2006. The cause of this event was inadequate understanding within the Chemistry department concerning the threshold of when to report equipment issues to Shift Operations. Corrective actions include reinforcing the correct expectation to Chemistry personnel. During this delay in declaring the containment isolation valves inoperable the penetration flow path was always isolated.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
Byron Station	0500454	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	Page 2 of 3
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(If more space is required, use additional copies of NRC Form 366A)(17)

A. Plant Condition Prior to Event:

Event Date/Time: January 24, 2006 / 0930 hours CST

Unit 1 - Mode 1 – Power Operations, Reactor Power 100%

Reactor Coolant System [AB]: Normal operating temperature and pressure.

B. Description of Event:

On January 23, 2006, at approximately 0900 hours, a Chemistry Technician (CT) (non-licensed) was performing daily reactor coolant [AB] sampling activities. During this sampling activity he noted an abnormal condition with the pressurizer liquid space sample line in that he was able to obtain sample flow at the panel with the Pressurizer Liquid Sample Isolation Valve (1PS9350B) closed, the Pressurizer Liquid Inboard Containment Isolation Valve (1PS9355A) closed and the Pressurizer Liquid Outboard Containment Isolation Valve (1PS9355B) closed. The CT did not notify Shift operations and did not notify his Chemistry Supervisor (CS) (non-licensed) of this abnormal condition until approximately 1230 hours. A Corrective Action Program (CAP) Issue Report (IR) was not generated to document the abnormal condition.

Not realizing the potential significance of the abnormal condition from a containment integrity perspective, the CS decided to perform a preliminary investigation/troubleshooting effort to gain more information before documenting the issue in an IR. After this preliminary effort, the CS wrote the IR the next morning on January 24, 2006, at 0930 hours. The CS did not promptly notify Shift Operations to screen the IR for operability. Consequently, the IR was not identified as needing an operability determination until subsequent IR screening activities on the morning of January 25, 2006. The Shift Manager then engaged the appropriate plant staff to assess the abnormal condition and provide additional information to make an operability determination of the containment isolation valves involved.

The additional information provided to the Shift Manager could not support a reasonable expectation that the 1PS9355A and 1PS9355B containment isolation valves could perform their design function. Consequently, the valves were declared inoperable at 1250 hours on January 25, 2006 and Technical Specification 3.6.3, "Containment Isolation Valves," Required Actions A and B were entered. These actions require that the containment penetration be isolated within one hour by a closed and deactivated automatic or remote manual valve, closed manual valve, or blind flange. This was accomplished by 1350 hours. This event is reportable to the NRC in accordance with 10 CFR 50.73 (a) (2) (i) (B), as an event or condition prohibited by Technical Specifications. Even though all Technical Specification actions were accomplished within the required completion times there was firm evidence to indicate the inoperable condition existed on the day before when the IR was generated. The operability evaluation and subsequent inoperability declaration should have occurred on January 24, 2006.

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

C. Cause of the Event

The cause of this event was inadequate understanding within the Chemistry department concerning the threshold of when to report equipment issues to Shift Operations. Not recognizing the containment integrity aspects of this abnormal condition, the CT and CS involved did not believe the condition was significant enough to warrant prompt Shift Operations notification. In addition, the CS and CT involved failed to document the abnormal condition in the CAP in a timely manner.

D. Safety Analysis

This event had minimal safety consequences. The penetration flow path was always isolated during this delay period consistent with the Technical Specification required action except for one of the valves utilized to isolate the flow path was an automatic valve, which was closed but not deactivated. This valve was not intentionally nor inadvertently opened.

E. Corrective Actions

Expectations for prompt supervisor notification and IR initiation concerning equipment issues have been reinforced with Chemistry Department personnel.

Expectations for the prompt notification of Shift operations concerning equipment issues have been reinforced with Chemistry Department personnel.

Appropriate management actions have been performed with the CT and CS involved for their failure to follow CAP requirements.

The causes of the containment isolation valves' failure are unknown and will be further investigated and repaired in the fall 2006 refuel outage.

F. Previous Occurrences

There have been no previous LER occurrences of this nature at Byron in the previous 2 years.