



**Boston Edison**

Pilgrim Nuclear Power Station  
Rocky Hill Road  
Plymouth, Massachusetts 02360

April 8, 1997  
BECo Ltr. 2.97.039

**E. T. Boulette, PhD**  
Senior Vice President — Nuclear

US Nuclear Regulatory Commission  
Attn.: Document Control Desk  
Washington, DC 20555

Docket No. 50-293  
License No. DPR-35

The enclosed Licensee Event Report (LER) 97-005-00, entitled "Limiting Condition for Instrumentation which Provides Surveillance Information - Turbine Building Effluent Monitoring", is submitted in accordance with 10CFR50.73. A supplement to this LER will be submitted by May 15, 1997. This LER also serves as the special report required by section 3.2.F of the PNPS technical specifications.

*E. T. Boulette*  
for E. T. Boulette, PhD

ET3/RAH/avf/9700500

cc: Mr. Hubert J. Miller  
Regional Administrator, Region I  
U. S Nuclear Regulatory Commission  
475 Allendale Road  
King of Prussia, PA 19406

Sr. Nuclear Resident Inspector - Pilgrim Station

Standard BECo LER Distribution

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## LICENSEE EVENT REPORT (LER)

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digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS 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)

PILGRIM NUCLEAR POWER STATION

DOCKET NUMBER (2)

05000-293

PAGE(3)

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TITLE (4)

Limiting Condition for Instrumentation which Provides Surveillance Information - Turbine Building Effluent Monitoring

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
03	08	97	97	005	00	04	08	97	N/A	05000
OPERATING MODE (9)		N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR: (Check one or more) (11)							
POWER LEVEL (10)		00	20.2201 (b)		20.2203(a)(2)(v)		X		50.73(a)(2)(i)(B)	50.73(a)(2)(viii)
			22.2203(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)	x OTHER
			20.2203(a)(2)(iii)		50.36(c)(1)				50.73(a)(2)(v)	Specify in Abstract below
			20.2203(a)(2)(iv)		50.36(c)(2)				50.73(a)(2)(vii)	or in NRC Form 366A

## LICENSEE CONTACT FOR THIS LER (12)

NAME

Robert A. Haladyna

TELEPHONE NUMBER (Include Area Code)

(508) 830-7904

## 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)

X YES

(If yes, complete EXPECTED SUBMISSION DATE)

NO

EXPECTED  
SUBMISSION  
DATE(15)MONTH DAY YEAR  
05 15 97

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

Section 3.2.F of the Pilgrim Nuclear Power Station (PNPS) technical specifications establishes the Limiting Condition for Operation (LCO) for instrumentation that provides surveillance information. Table 3.2.F requires, as a minimum, one (1) operable instrument channel for the turbine building vent. It also identifies RI-1001-610 and RR-1001-608 as the required surveillance instrumentation for the turbine building vent. Note seven (7) for Table 3.2.F contains the governing action statement; it reads as follows:

(7) With less than the minimum number of operable instrument channels, restore the inoperable channels to operable status within 7 days or prepare and submit a special report to the Commission within 14 days of the event outlining the action taken, the cause of the inoperability and the plans and schedule for restoring the channels to operable status.

Contrary to the requirements of Section 3.2.F of the PNPS technical specifications, the turbine building effluent monitoring instrumentation was inoperable for a period of time in excess of seven (7) days and special report was not submitted to the Commission within 14 days of the time the instrument was made inoperable. The plant was shutdown for refueling when the monitoring instrumentation was made inoperable. The condition posed no threat to public health and safety because the potential for an uncontrolled release of radioactive material through the turbine building vent did not exist. This report constitutes the special report required by section 3.2.F of the PNPS technical specifications.

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		97	005	00	

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

**Description of the Event**

It was determined that the limiting conditions for operation established in technical specification 3.2.F were not satisfied. Specifically, technical specification 3.2.F requires, as a minimum, one (1) operable instrument channel for the turbine building vent. It also identifies RI-1001-610 and RR-1001-608 as the required surveillance instruments. The instruments were made inoperable when RT-1001-610 was made inoperable at the start of the refueling outage (on February 15, 1997). The problem was identified on March 9, 1997, and documented in problem report 97.9184. This LER was prepared and submitted in response to the event. The cause of the event will be determined and a supplemental LER will be submitted by May 15, 1997. The instrumentation will be restored to operable status prior to startup.

The reactor mode switch was in the shutdown position when the problem occurred. The reactor was in the refueling mode when the problem was identified. Reactor pressure was approximately zero psig when the surveillance instrumentation was made inoperable. The reactor was at atmospheric pressure when the problem was identified.

**Cause**

A root cause analysis will be conducted and a supplemental report will be submitted by May 15, 1997.

**Corrective Actions**

Corrective actions will be identified following determination of cause and will be described in the supplemental report.

**Safety Consequences**

The condition posed no threat to the health or safety of the public. The error was administrative in nature, and the unit was shut down during the period of time the instrumentation was inoperable; therefore, the potential for an uncontrolled release of radioactive material through the turbine building vent did not exist in this condition.

**Similarity to Previous Events**

A summary of LERs submitted in accordance with 10CFR50.73(a)(2)(i)(B) is presented below:

LER 85-024-00 reported that on June 2, 1985, the weekly surveillance test of the 250v station batteries required by technical specification 4.9.A.2 was missed. The cause was a procedural deficiency. The problem was identified as a result of an NRC inspection.

LER 90-012 -00 reported that on July 12, 1990, investigations revealed that two out of twenty-six radioactive sources were not leak checked within the once-per-six month interval required by technical specification 4.2.b. The sources were not leak checked as a result of a procedural error. The problem was identified as a part of a quality assurance audit.

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

LER 91-002-02 reported that on February 11, 1991, it was determined that one of the five (5) salt service water pumps had not been tested as specified in technical specification 4.5.B.1.b. The cause was an error (inappropriate instructions) in the procedure that is used when a system or component is inoperable. The error was identified as a result of a routine review of the salt service water pump data.

LER 92-012-00 reported that on September 16, 1992, it appeared that the neutron monitoring system recirculation flow converters may not have been calibrated once per cycle as specified by technical specification 4.2.c. The cause was a utility non-licensed Instrumentation and Control Division Supervisor personnel error. The problem was identified as a result of a problem report investigation.

LER 95-007-00 reported that on August 4, 1995, during an audit of the core spray system, it was determined that the technical specification required simulated automatic actuation (SAA) for the automatic depressurization system had not been performed prior to plant restart following refueling outage 10. The missed surveillance occurred because the Master Surveillance Tracking Program (MSTP) did not identify the requirement to perform the surveillance prior to startup from each refueling.

LER 95-009-00 reported that on August 21, 1995, during an audit of the core spray system, it was discovered that surveillance procedure 8.5.1.3, "Core Spray Motor Operated Valve Quarterly Operability Test" had not been performed for the "B" loop motor operated valves prior to the MSTP dead date. The "B" core spray loop was declared operable without performing the technical specification required quarterly valve operability testing, thus the action statement of technical specification 3.5.A.2 had not been met.

LER 95-010-00 reported that PNPS was not operated in accordance with technical specification 3/4.5.B on certain dates in 1991 and 1992. Specifically, the 72 hour limiting condition for operation for the salt service water system was not satisfied. The cause was the failure to correctly translate the basis of the technical specification into the associated test procedure.

LER 96-007-00 reported that on May 19, 1996, engineers discovered a non-compliance with the limiting condition for operation for technical specification 3.9.B.5. Testing in accordance with technical specification 4.9.A.2.c was not completed within the required surveillance interval. The error was identified during a quality assurance audit.

LER 96-010-00 reported that on October 3, 1996, it was determined that neutralizing sump liquid discharges were made without performing the analyses specified by technical specification 4.8.A.1(liquid effluent concentration) and Table 4.8-1(radioactive liquid waste sampling and analysis program).

LER 97-002-00 reported that isotopic analysis of a representative sample of the condenser off-gas system was not taken in accordance with section 3/4.8.G of the technical specifications. The error was identified as a result of a review of the technical specification data base.

## Energy Industry Identification System Codes

Radiation Monitoring System

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