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SUBJECT: LER 90-001-00: on 891215, failure to implement Tech Spec
 change due to mgt deficiency, inadequate policy/directive.
W/8 ltr.

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 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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DUKE POWER

January 26, 1990

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

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
LER 269/90-01

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report (LER) 269/90-01 concerning failure to implement Technical Specification change due to management deficiency, inadequate policy/directive.

This report is being submitted in accordance with 10 CFR 50.73 (a)(2)(i). This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

H. B. Barron
Station Manager

RSM/ftr

Attachment

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LICENSEE EVENT REPORT (LER)

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TITLE (4) **Failure to Implement Technical Specification Change Due to Management Deficiency, Inadequate Policy/Directive**

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)
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OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)						73.71(b)
POWER LEVEL (10) 1 0 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.408(a)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)			<input type="checkbox"/> 73.71(e)
	<input type="checkbox"/> 20.408(a)(1)(i)	<input type="checkbox"/> 50.38(a)(1)	<input type="checkbox"/> 50.73(a)(2)(v)			<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 356A)	
	<input type="checkbox"/> 20.408(a)(1)(ii)	<input type="checkbox"/> 50.38(a)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)				
	<input type="checkbox"/> 20.408(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)				
	<input type="checkbox"/> 20.408(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)				
<input type="checkbox"/> 20.408(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)					

LICENSEE CONTACT FOR THIS LER (12)

NAME H. R. Lowery, Chairman Oconee Safety Reivew Group	TELEPHONE NUMBER 8 0 3 8 8 5 - 3 0 3 4
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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) <input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH DAY YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

ABSTRACT

On December 15, 1989, while Oconee Units 1 and 2 were operating at 100% Full Power, and Unit 3 was shut down for refueling, the NRC approved an amendment to Technical Specifications (TS) to revise operating parameters affected by the Unit 3 reload. A provision of this change affected all three units to require a unit trip whenever only two Reactor Coolant Pumps were running at power. Units 1 and 2 were not in compliance on the effective date of the amendment. During review in August, the implementing section did not receive the draft TS. On December 4, 1989, they were informed of the change, but were not told that the change had to be implemented on Units 1 and 2 during Unit 3 startup. The change was implemented on Unit 3 prior to restart. On December 29, 1989, during conversation between an Instrument and Electrical Support Specialist and an engineer in license training, it was realized that the TS change had not been implemented on Units 1 and 2. This was reported to Operations, Compliance, and NRC personnel. Immediate corrective action was to issue temporary guidelines to operators. Subsequent corrective action was to implement the change on January 4, 1990. The root cause of this event was Management Deficiency, Inadequate Policy/Directive.

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

BACKGROUND

All three Oconee units are Babcock and Wilcox Nuclear Steam Supply Systems [EII:AB], with two steam generators [EII:HX] and four reactor coolant pumps [EII:P], two per steam generator. Technical Specification (TS) 2.3 had provided that two pump operation was permissible if each steam generator had one operating pump and power was equal to or less than 55% Full Power. The Nuclear Engineering Section of Duke Power Design Engineering Department performed appropriate calculations as part of each core reload design to verify that no safety limits would be violated by operation in this mode.

The Reactor Protective System (RPS) [EII:JC] is a safety related system which generates signals to trip the reactor when necessary due to operating conditions. In order to prevent spurious trips due to single failure of system inputs, the RPS uses two out of four logic. Therefore, there are four redundant channels for each RPS parameter. The trips associated with two pump operation are produced by the pump power monitor circuits. The pump power monitor logic detects two pump operation, then trips if both pumps are in the same steam generator loop or if reactor power is above a given setpoint (previously 55% Full Power).

Station Directive (SD) 4.5.2 provides guidance for review and implementation of TS amendments. It assigns responsibility for station coordination of the review and approval of TS changes to the Compliance Section. Compliance is to "determine which station groups or sections need to review the proposed revisions" and, for surveillance requirements, "review associated documentation from the affected station groups or sections to assure that new or revised requirements will be met by station procedures." According to SD 4.5.2, "...more conservative or restrictive...requirements may be implemented...prior to NRC approval..."; otherwise "affected groups or sections should be prepared to implement the ... requirements when NRC approval is given." Any grace period "...should be identified during the review..." for inclusion in the submittal to the NRC.

EVENT DESCRIPTION

As part of the preparation of the Oconee Unit 3 Cycle 12 Reload Report, the personnel of the Nuclear Engineering Section (NES) of Design Engineering suggested a cost savings idea to delete the portion of the fuel cycle analysis related to power operation with only two Reactor Coolant Pumps in service. This mode of operation had seldom, if ever, occurred in the 16 year history of Oconee. While evaluating the feasibility of such a change, NES personnel contacted Instrument and

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

Electrical (I&E) Support Specialist "A" (Specialist "A"), who stated that the physical implementation would require only the revision of the 55% Full Power setpoint in each channel of the pump power monitor circuits of the Reactor Protective System (RPS). At the time of this conversation, the change had not yet been submitted to management as a proposal.

On August 2, 1989, NES submitted a draft Technical Specification (TS) revision to Nuclear Production Licensing. Included was wording which would make the limitation on two pump operation effective on all three units, even though the current Unit 1 and 2 core designs had been analyzed for two pump operation. This was done in order to keep the affected TS identical on all three units. It should be noted that TS changes for core reloads normally do not include provisions affecting other units. In fact, Licensing personnel stated that they cannot recall any previous reload TS change that did affect the TS of another unit. This revision was subsequently sent to the station for review and approval prior to submittal to the NRC for their approval. Included as part of the submittal was a copy of the Unit 3 Cycle 12 Reload Report.

In accordance with Station Directive (SD) 4.5.2, Shift Supervisor A (SS "A"), a licensed Senior Reactor Operator assigned to the Compliance Section, was responsible for identifying all affected groups or sections in the station and sending copies of the proposed TS to them for review. On August 21, 1989, SS "A" sent copies to several sections but did not include the Instrument and Electrical Support section. Attached to the copy sent to Performance Section Reactor Engineer "A" (Engineer "A") was a hand written memo from SS "A" which stated that "TS 2.3 will have to apply to Unit 1&2 when it becomes effective on unit #3, therefore the pump monitor trip will have to be reset to 0.0% for all units."

SD 4.5.2 specifies that the reviewer should determine during the review and comment phase if a "grace period" is required between TS approval and the effective date to allow for implementation. If a grace period is needed, it should be requested in the submittal to the NRC. The Duke Power submittal to the NRC specified that the changes to Unit 1 and 2 would be "implemented upon Unit 3 Cycle 12 startup." However, there was no specific wording to indicate if this was intended to be a request for a grace period or delayed effective date for Units 1 and 2.

On August 30, 1989, station management approved the proposed TS with minor changes unrelated to this event. The proposed TS was sent to the NRC on September 25, 1989.

On December 4, 1989, Engineer "A" realized that I&E Support had been omitted from all correspondence related to the Unit 3 reload TS change. Therefore, he checked with Specialist "A" to assure that the procedure

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TEXT (If more space is required, use additional NRC Form 308A's) (17)

changes required to implement the TS change on Unit 3 were in progress. Specialist "A" was surprised by this, since he had not been informed that any changes were necessary. I&E Support Nuclear Production Engineer "B" (Engineer "B"), who normally performs the review of proposed TS changes for the I&E Support unit, was contacted and confirmed that the section had not received a copy of either the review copy or the final copy as submitted to the NRC.

Specialist "A" went to Engineer "A's" office and together they duplicated part of the draft TS from Engineer "A's" files. This draft copy included the cover letter, the draft TS, and the Reload Report. The files also contained the memo from SS "A". Specialist "A" states that the package he obtained contained the Reload Report and applicable portions of the revised TS 2.3, but did not contain the cover letter or the memo from SS "A" to Engineer "A."

Specialist "A" states that he requested that a copy of the proposed TS from SS "A," who informed him that one was not available. SS "A" does not recall a request for a copy of the proposed TS but does recall being asked to notify Specialist "A" when the TS received NRC approval. Neither SS "A" nor Engineer "A" communicated, during these conversations, that the changes were expected to be implemented on Unit 1 and 2 during Unit 3 startup.

Specialist "A" made revisions to the affected Unit 3 procedures based on the conversations of December 4 and the package received from Engineer "A," primarily the Reload Report. These changes were reviewed by Engineer "B." During this process, neither Specialist "A" nor Engineer "B" recognized that the wording of TS 2.3 and Figure 2.3-2 of the draft TS applied to all three Oconee units. Specialist "A" states that he and Engineer "B" discussed future implementation on Units 1 and 2, but they were unaware of any requirement to do so prior to or during Unit 3 startup. The Unit 3 procedure changes were approved by management December 11, 1989 and implemented on all four channels of the Unit 3 Reactor Protective System between December 13 and 15, 1989.

On December 15, 1989, the NRC approved the TS revision. The associated amendments to the Oconee licenses were made effective on the date of issuance, which was December 15, 1989. The Oconee Compliance Manager was notified by telephone of the approval, and he sent notification to other members of station management via a computer mail network. At this time both Units 1 and 2 were at 100% Full Power and, since the new provisions of TS 2.3 had not been implemented, both units were in noncompliance. On December 18, Unit 3 went critical for Zero Power Physics Testing, and, on December 20, the General Office received the signed copy of the new TS.

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TEXT (If more space is required, use additional NRC Form 308A's) (17)

SS "A" received copies of the approved TS at the station on either December 21 or 22, and advanced copies were distributed to appropriate groups and sections for inclusion in working copies of TS. At the same time, SS "A" delivered a copy of the TS to the supervisor of Engineer "B". The supervisor placed it in Engineer "B's" "In Basket" where it remained until December 29. Also, due to delays associated with the Christmas holidays, the control room copies were not posted until December 27.

On the night shift of December 27, Operations Shift Supervisor "A" (OSS "A") reviewed the contents of the new TS revisions. It was recognized that the changes affected Units 1 and 2, so OSS "A" contacted the I&E Shift Supervisor (I&ESS "A") on duty. OSS "A" stated that he emphasized that the concern was the status of Unit 1 and 2. I&ESS "A" knew nothing of the new TS or its implementation status (normally I&E Shift personnel would not be assigned to perform such work unless it was urgently required during a back shift). He did promise to find out and called Engineer "B" at home. I&ESS "A" asked Engineer "B" about the status of the implementation of the TS revision, but he stated later that he may not have adequately communicated that the concern was for Units 1 and 2 rather than Unit 3. Engineer "B" states that he understood the question to apply only to Unit 3 and responded that the change had been fully implemented. I&ESS "A" relayed the answer to OSS "A". OSS "A" then informed the control room personnel.

One of the personnel present in the control room at the time was an engineer in license training (Engineer "C"). On December 29, 1989, at approximately 1000 hours, Engineer "C" and Specialist "A" were having a casual conversation and the topic of the procedure changes to implement this particular change on Units 1 and 2 came up. Specialist "A" stated that the procedure changes had not been initiated yet, and Engineer "C" stated that Operations understood that they had already been implemented. They notified the Operations Shift Supervisor on duty and the Compliance Section.

Compliance personnel notified General Office Licensing personnel and the NRC. An agreement was reached that implementation on Unit 1 and 2 would be completed by January 8, 1990. This date would allow for preparation, review, and implementation of the necessary procedures without undue haste. Compliance issued temporary operating guidance calling for orderly shutdown of either Unit 1 or 2 in the event of either two pump operation, or operation at 55 % Full Power or less. Actual implementation of the required setpoint changes was completed on both Units 1 and 2 prior to 1515 hours, January 4, 1990, thus bringing the station into full compliance with the new TS.

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TEXT (If more space is required, use additional NRC Form 306A-1) (17)

CONCLUSIONS

The root cause of this event is Management Deficiency, Inadequate Policy/Directive. A review of Station Directive (SD) 4.5.2 and other directives indicates that there is less than adequate emphasis on the implementation phase when a TS is reviewed. Additionally, the TS revision program does not provide adequate policy/directive concerning the control and coordination of activities to identify, schedule and verify implementation of revisions to TS.

During the review phase, SD 4.5.2 leaves identification and notification of affected groups or sections entirely to the judgement of the assigned Compliance person, in this case SS "A". The directive gives no guidance as to which sections of TS affect which groups or sections, gives no guidance to consider implementing groups in addition to operating groups, nor does it provide for any independent or supervisory review of the list of identified groups. When SS "A" identified the affected groups which should review the comment draft of the Technical Specification revision, SS "A" did not identify the Instrument & Electrical (I&E) Support unit as being affected by the proposed TS change and give them the opportunity to review the proposed TS. SS "A" stated that he knew by training and experience that I&E should have been provided with a copy, but that they were omitted by oversight. This prevented proper front end review of the change and identification of the required procedure changes by I&E Support. However, if SD 4.5.2 had provided specific guidance to consider implementation and implementing groups, it is probable that I&E would have been included in the review.

This event demonstrates that policies/directives do not adequately explain the requirements on the timing of implementation with respect to effective dates. In addition, the use of grace periods is not adequately understood. Revised TS are effective on the date stated in the license amendment, even if the Licensee does not receive copies for several days thereafter. The NRC resident inspectors were consulted as to any guidance or policy within the NRC establishing an unofficial grace period to allow implementation upon notification of approval if the effective date is the approval date. They indicated that the NRC does not have any such guidance. It should be noted that many people within the station staff thought or assumed that a "reasonable" period of time was allowed for implementation and that the station was in compliance as long as a "good faith effort" was being made to implement provisions of a TS change. In short, personnel assumed that they did not have to request a formal grace period unless a "significant" delay was involved. Such an assumption is implicit in the wording of SD 4.5.2, paragraph 4.3.

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TEXT (if more space is required, use additional NRC Form 306A's) (17)

There is a significant problem in that we seldom know ahead of time the date that the NRC will grant approval. Therefore, more conservative provisions should be implemented either prior to or promptly after submittal, and any grace period requested should be sufficient to permit reasonable flexibility in scheduling. The Duke Power submittal to the NRC specified that the changes to Unit 1 and 2 would be "implemented upon Unit 3 Cycle 12 startup." This wording is not clear if a delayed effective date was being requested or not. This led the NRC to make the TS change effective on the approval date, which had no specific relationship to Unit 3 startup. Because there is currently less than adequate coordination or scheduling of implementation activities, no one in Duke Power Nuclear Production Department Licensing or station Compliance identified the impact of the difference. The result was that, even if appropriate personnel had planned to implement the changes on Units 1 and 2 prior to Unit 3 criticality, Oconee would have been in violation. This wording would have been avoided if appropriate policy/directive adequately clarified implementation requirements with respect to effective dates and adequately required identification, scheduling and tracking of implementation.

SD 4.5.2 contains no provisions to verify completion of implementation activities. In this case, Operations Shift Supervisor "A" took it upon himself to question whether or not I&E had implemented the change. This responsibility may be implied by the overall duties of the Shift Supervisor, but it is not a specific requirement. It seems appropriate that some administrative policy should designate responsibility for assuring that all groups and sections at the station have made any changes to procedures, policies, systems or components necessary to implement a Technical Specification change.

SD 4.5.2 does not specify how rapidly TS changes should be distributed other than "as soon as practical after NRC approval." Operations Management Procedure 1.5 specifies the distribution of advanced TS copies in the Operations Group, including the control room, but does not provide any guidance on the timeliness of distribution. It does not seem appropriate that TS revisions are not posted to critical copies, such as control room copies, on the effective date. In this case, the control room copies were not updated for 12 days after issuance. Admittedly, this was aggravated by the impact of Christmas holidays, but no administrative controls exist to prevent distribution from being excessively delayed by absence or work load of one or two specific individuals.

A contributing cause was Inappropriate Action, Deficient Communication on the part of SS "A". After Engineer "A" alerted the I&E Support unit, SS "A" and Engineer "A" both failed to communicate that the change would be

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applicable to Units 1 and 2 during Unit 3 startup. Primary responsibility for this failure should lie with SS "A" because he failed to communicate the requirement to I&E Support personnel even though he had previously recognized that Units 1 and 2 were affected and required implementation at the same time as Unit 3. His duties include the responsibility for coordination of review and approval of TS changes and he is therefore expected to be the station contact for questions about the submitted TS as approved by station management. Therefore, he should have reviewed his documentation of the submittal and communicated the full requirements.

Other instances of inappropriate action, deficient communications, also contributed to this event. First, I&ESS "A" did not adequately communicate between OSS "A" and Engineer "B". This prevented earlier discovery of the non-compliance, but did not cause it. However, this could have been avoided if appropriate scheduling and tracking mechanisms were required by policy/directive.

After they were notified of the requirement to implement the TS revision on Unit 3, Specialist "A" and Engineer "B" prepared and reviewed the procedure changes for implementation on Unit 3. They did this based on their understanding of the requirements after discussion with Engineer "A" and SS "A" and a review of package obtained from Engineer "A." They understood that the procedure change being made was more conservative than the existing TS and, as a result, they did not insist upon an opportunity to review the entire proposed TS submittal. Furthermore, they did not review the applicable portion of the draft TS revision in their possession in enough detail to recognize that it applied to all three units. This instance of Inappropriate Action, Lack of Attention to Detail, is classified as a contributing cause.

Operations Shift Supervisor "A" and Engineer "C" both responded appropriately. OSS "A" attempted to verify that the new TS had been implemented on all units. Engineer "C" discovered the problem by chance, and took prompt action to report it to the appropriate personnel.

Neither Unit 1 nor Unit 2 ever operated with only two pumps during this time period. There were no radiation exposures, injuries, or releases of radioactive materials associated with this incident. Also, there were no equipment failures, and, therefore, no NPRDS reportability.

This incident is considered non-recurring. Proper implementation of the proposed administrative enhancements should substantially reduce the probability of a similar event occurring in the future.

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TEXT (if more space is required, use additional NRC Form 288A's) (17)

CORRECTIVE ACTION

Immediate

1. Upon notification of the violation, Compliance issued temporary operating guidance calling for orderly shutdown of either Unit 1 or 2 in the event of either two pump operation, or operation at 55 % Full Power or less.
2. The NRC was notified and concurred with a plan to implement the changes on Units 1 and 2 by January 8, 1990.

Subsequent

1. The required setpoint changes on Unit 1 and 2 were completed prior to 1515 hours, January 4, 1990.
2. Appropriate personnel have been counselled concerning their inappropriate actions as described in this report.

Planned

Compliance will review, evaluate, and revise Station Directive 4.5.2 and/or other appropriate policies/directives as necessary to improve coordination of the implementation of Technical Specification (TS) revisions. Areas where enhancements are recommended are:

- * identification of affected groups,
- * designation of responsibility for scheduling and verifying implementation of TS revisions,
- * timeliness of posting or other notification of personnel when TS revisions are approved.

SAFETY ANALYSIS

There was never any safety hazard associated with this specific event. The current core designs of both Unit 1 and 2 included verification that the two pump mode of operation permitted by the existing Technical Specification (TS) 2.3 did not violate any safety limits. Both cores were initially licensed to operate in this mode. Application of the new TS to the existing cores on Units 1 and 2 was purely a matter of convenience in that it kept the TS identical on all three units, thus avoiding separate,

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TEXT (if more space is required, use additional NRC Form 306A's) (17)

unit specific, specifications and operating limits. The new limits were considered conservative compared to the existing limits and, therefore, technically could have been implemented at any time prior to actual operation with the next core design.

However, the significance of this event is the demonstrated failure to implement an approved TS. If Engineer "A" had not contacted the Instrument and Electrical Support Unit, it is possible that the revision to TS 2.3 might not have been implemented on Unit 3. In that case, it would have been possible for Unit 3 to operate in an unanalyzed condition. However, this scenario would require two Reactor Coolant Pumps to be removed from service, which is extremely unlikely. Additionally, the operators are trained to recognize conditions which require a trip and manually trip the unit. Therefore, they would have complied with the new TS, even if the Reactor Protective System had not been recalibrated. Furthermore, even if it is further postulated that the operators failed to immediately trip the unit, any event leading to the removal of two Reactor Coolant Pumps from service and subsequent power reduction would receive prompt management attention, recognition of the TS limitation and rapid compliance. Therefore, even the consequences of a postulated failure to implement this TS on Unit 3 are minimal.

At no time during this event did any Oconee unit actually operate in the mode prohibited by the new TS. There were no accidents, releases of radioactive materials, or other threat to the health and safety of the public. Proper implementation of the proposed administrative enhancements should substantially reduce the probability of a similar event occurring in the future.