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SUBJECT: Special rept: on 870908, discovered that standby shutsown facility (SSF) weekly instrument surveillance not performed on 870831 & 870907. Caused by personnel error. SSF instrument surveillance performed. Licensed operators to review rept.

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November 17, 1987

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D. C. 20555

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
Proposed Technical Specification 4.20.2 Violation

Gentlemen:

Duke Power Company (Duke) is providing the attached special report concerning the violation of proposed Technical Specification (T.S.) 4.20.2. The proposed Technical Specifications for the Standby Shutdown Facility (SSF) were submitted by letters dated July 26, 1985 and August 14, 1987.

This report is being submitted on a voluntary basis. This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Hal B. Tucker

PJN/143/sbn

Attachment

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DUKE POWER COMPANY
OCONEE NUCLEAR STATION

SPECIAL REPORT ON THE
VIOLATION OF PROPOSED TECHNICAL SPECIFICATION 4.20 AND TABLE 4.20-1
RESULTING FROM A PERSONNEL ERROR

Introduction:

On August 31, 1987, Units 1, 2 & 3 were operating at 80%, 80.4% and 99.92% of full power respectively.

The Standby Shutdown Facility (SSF) weekly instrument surveillance was not performed, which resulted in a violation of Proposed Technical Specification (TS) Table 4.20-1. The violation of the proposed TS was due to a personnel error by a Unit 2 Assistant Shift Supervisor in not assigning the performance of a Periodic Test (PT) for the surveillance. The Assistant Shift Supervisor also failed to report to the Unit Engineer or to the Operations Projects Section that the surveillance was not performed on its required day. A contributing personnel error occurred when another Assistant Shift Supervisor, responsible for reviewing the completed PTs for compliance, did not realize that the SSF Instrument Surveillance PT was not performed.

On September 8, during a review of the surveillance PTs completed, it was discovered that the SSF Instrument Surveillance had not been performed on Monday, September 7. Upon further investigation it was found that the PT had not been performed on August 31 and that the maximum of ten days between surveillances had elapsed. This was immediately reported.

The immediate corrective action was to perform the PT in order to comply with TS Table 4.20-1. Planned corrective actions are to counsel Assistant Shift Supervisors involved and for all licensed operators to review this report.

Description Of Incident:

On August 24, 1987, the Standby Shutdown Facility (SSF) instrument surveillance test was performed. This task was performed by successfully completing the requirements of the applicable Periodic Test Procedure. In accordance with Proposed Technical Specification 4.20 and the Periodic Test Schedule, the SSF instrument surveillance was due to be performed on August 31, 1987.

The Unit 2 Assistant Shift Supervisor "B" through oversight, did not assign the PT to anyone to complete the surveillance. Also, he did not make the Operations Support Group or the Unit Operating Engineer aware that the weekly PT was not performed on the day it was scheduled.

On August 31 or September 1, the August Periodic Test Schedule calendar, located in the Unit Supervisor's work area, was removed and replaced with the September calendar. The September calendar correctly started the month with September falling on Tuesday. It also showed the subject PT as being due on Monday of that week, however the September calendar did not show that Monday as being August 31. Assistant Shift Supervisor "B" did not recognize the fact that the PT had been missed during his review of that week's surveillance requirements on the September calendar.

On September 1, Assistant Shift Supervisor "A", the individual in the Operations Support Group responsible for scheduling PTs and verifying compliance with the schedule, picked up the completed PTs which were performed on August 31. Assistant Shift Supervisor "A" reviewed the completed PTs, marked them complete on his calendar and filed them. By oversight, Assistant Shift Supervisor "A" failed to recognize that the subject PT was not performed on its required date. Due to this oversight, he did not inform the Unit Operating Engineer of the missed surveillance and did not bring this fact to the attention of Unit 2 Assistant Shift Supervisor "B".

Assistant Shift Supervisor "A" was not scheduled to work on Wednesday, September 2, Thursday, September 3, and Friday, September 4. During these three days Assistant Operating Engineer "A" performed the duties of Assistant Shift Supervisor "A". Each morning of these three days Assistant Operating Engineer "A" picked up the completed PTs for the previous day, marked them off the calendar, and filed them.

Assistant Operating Engineer "A" was not aware that the subject PT had not been performed on Monday, August 31.

On Monday September 7, the weekly SSF Instrument Surveillance test was due to be performed again by Unit 2 day shift personnel. On this day, Assistant Shift Supervisor "B" gave the procedure for the SSF Instrument Surveillance to a control room operator and instructed him to assign it to an operator for completion. Later in that shift, Assistant Shift Supervisor "B" realized that the PT had not been returned to him completed. Upon inquiring about the PT, he was told it had not been assigned. He then reminded the control room operator that weekly PT's should be performed on the due date and must be completed before the end of the three day grace period. It was agreed that it would be performed the following day. Assistant Shift Supervisor "B" did not complete a "Procedure Process Record" to inform the Operating Support Group or the Unit 2 Operating Engineer that the PT was not performed on its due date, as required by the Operations Manual.

On September 8, Assistant Shift Supervisor "A" reviewed the PT completed on the previous day. At that time, he realized that the PT had not been performed on September 7. Upon further investigation, Assistant Shift Supervisor "A" became aware that the PT was not performed the previous week. Assistant Shift Supervisor "A" informed the Unit 2 Operating Engineer and Unit 2 Assistant Shift Supervisor "B" of the missed surveillances. The SSF Instrument Surveillance PT was successfully completed on September 8.

There was no automatic or manual initiation of safety systems as a result of this incident.

Cause Of Occurrence:

Technical Specification 4.0.2 describes the minimum surveillance frequencies and the maximum allowable interval between surveillances. The maximum allowable interval between a weekly surveillance is 10 days. Since the SSF Instrument Surveillance is a weekly requirement, and the time between August 24 and September 8 is greater than 10 days, Proposed Technical Specification 4.20 and Table 4.20-1 were violated.

The root cause of the incident was a personnel error due to the failure of Assistant Shift Supervisor "B" to assign the PT on its due date and to insure the PT was performed within its grace period. A contributing cause to the incident is a personnel error on the part of Assistant Shift Supervisor "A"in that he did not verify PT was completed on its required date and did not make the individual, that performed his duties while he was not at work, aware the PT had not been performed.

Corrective Actions:

The immediate corrective action was to perform the SSF instrument surveillance on September 8, 1987, (the same day the non-conformance was identified). Planned corrective actions are to counsel The Assistant Shift Supervisors "A" and "B" concerning the importance of the Periodic Testing Program and complying with Technical Specifications. In addition, all licensed operators will review this report.

Safety Analysis of Occurrence:

The weekly requirements for the SSF Instrument Surveillance program are described in proposed TS 4.20 and Table 4.20-1. This surveillance is to insure that the SSF instrumentation will function properly to monitor parameters of specific equipment important to the operation of the SSF. The maximum allowable time between weekly surveillances is ten days, as described in TS 4.0.2. Since the time between the SSF Instrument Surveillance, from August 24 to September 8, was in excess of 10 days, the SSF was considered to be in a limited condition of operation. This condition existed from the time it was discovered, September 8, until the SSF Instrument Surveillance was successfully performed that same day. The completed surveillance indicated that the instrumentation was operable from August 24 until September 8 and would have been able to perform its function, if required.

There was no unplanned Safety System Actuation associated with this incident. There was no release of radioactivity as a result of this incident, therefore the health and safety of the public were not affected.