

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9711140164 DOC.DATE: 97/11/10 NOTARIZED: NO
FACIL:50-269 Oconee Nuclear Station, Unit 1, Duke Power Co.
AUTH.NAME AUTHOR AFFILIATION
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MCCOLLUM,W.R. Duke Power Co.
RECIP.NAME RECIPIENT AFFILIATION

DOCKET #
05000269

SUBJECT: LER 97-009-00:on 971010,discovered that LPI flow instrument
TS surveillance interval had exceeded.Caused by deficient
work practice.Performed TS surveillance for LPI flow
instrument calibr on 971010.W/971110 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 8
TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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W. R. McCollum, Jr.
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November 10, 1997

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

Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
Licensee Event Report 269/97-09
Problem Investigation Process No.: 7-097-3465

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 269/97-09, concerning a missed Technical Specification Surveillance.

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

Very truly yours,

WR McCollum for

W. R. McCollum, Jr.

Attachment

IE221/

9711140164 971110
PDR ADOCK 05000269
S PDR



Document Control Desk

November 10, 1997

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cc: Mr. Luis A. Reyes
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Mr. M. A. Scott
NRC Resident Inspector
Oconee Nuclear Station

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), 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.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)

Oconee Nuclear Station, Unit One

DOCKET NUMBER (2)

05000 269

PAGE (3)

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TITLE (4) Low Pressure Injection Flow Instrument Technical Specification Surveillance Interval Exceeded Due To Deficient Work Practices

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(S)
10	10	97	97	- 09	- 00	11	10	97	Oconee, Unit Three	05000 287
										05000

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)									
POWER LEVEL (10)	000	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
		<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
		<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
		<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
		<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
		<input type="checkbox"/> 20.405(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	TELEPHONE NUMBER	
	AREA CODE	
R. T. Bond, Safety Review Manager	(864)	885-3043

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 (f yes, complete EXPECTED SUBMISSION DATE)				X			
				NO			

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

On October 10, 1997, Unit 1 was in a refueling outage, Unit 2 was at 100% full power, and Unit 3 was at hot shutdown condition and preparing for startup. The Instrument and Control (I&C) section completed a review of Technical Specification (TS) instrument surveillances for Low Pressure Injection (LPI) flow transmitters. On October 10, 1997, it was discovered that when the surveillance was last performed in 1995, the Unit 1 and 3 LPI flow transmitters were omitted. The surveillance was immediately performed on Unit 3 since it was in a startup mode and Unit 1 was calibrated the next day. There were no deficiencies noted for the calibration of Unit 1 or 3 LPI flow transmitters. The root cause is Deficient Work Practices; Document Use Practices, Documents not followed correctly because the I&C personnel misinterpreted the work order task description. Corrective actions include calibrating the LPI flow transmitters, counseling personnel, and reviewing other Instrument procedures that satisfy TS surveillance criteria to determine if this event is an isolated case.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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BACKGROUND

The Low Pressure Injection (LPI) system at Oconee is an Emergency Safeguards system designed to maintain core cooling for large break Loss Of Coolant Accidents. There are two Safety Related instruments measuring and recording flow for the LPI system (LPIFT005P and LPIFT004P). There are also two non-safety grade electric transmitters for flow measurement (LPIFT004A and LPIFT005A) and a Differential Pressure Indicator (PG-1042).

Technical Specification (TS) Table 4.1-1 (Instrument Surveillance Requirements) item 29 requires the calibration of High and Low Pressure Injection Systems Flow Channels at a Refueling frequency. TS 4.0.2 maximum allowable interval between surveillances is 22 months, 15 days.

EVENT DESCRIPTION

On October 7, 1997, a request was made by the NRC to verify the Low Pressure Injection System (LPI) required testing. On October 8, 1997, a search of Technical Specification (TS) required testing was performed to verify the tests were completed as required. On October 9, 1997, a possible deficiency was identified with the LPI flow calibration required by TS Table 4.1-1 item 29. The procedure containing this calibration was performed for Unit 1 on June 24, 1996 and for Unit 3 on July 30, 1996. The only portion of the procedure that was performed was the calibration of a differential pressure indicator. On July 21, 1997, the complete procedure was performed as required for Unit 2. A search of the Work Management System was performed to determine if the Unit 1 and 3 LPI flow calibrations were performed on separate work orders. There was no other documentation found associated with the LPI flow instruments calibration.

The complete calibration procedure was performed October 10, 1997, for Unit 3 and October 11, 1997, for Unit 1 with no discrepancies noted for the flow transmitters.

An investigation to determine the cause of the failure to perform TS required calibrations was initiated. Copies of the work orders and procedures associated with the TS required calibrations were reviewed. The surveillances performed in 1995 were performed correctly. The

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calibration of the differential pressure indicator was added in the description of the work order in 1996 per an NRC commitment. Different Instrument and Control (I&C) Technicians and Supervisor performed the work in 1995. Interviews were conducted with the personnel who were involved with the procedure in 1996. I&C Technicians performing the procedure indicated that they understood the work order to be for calibrating the differential pressure indicator only. The I&C Technician who led the work activity thinks he may have questioned the performance of the entire procedure but is not positive. The I&C supervisor indicated that he also misinterpreted the work order. The I&C supervisor believes the added description was misinterpreted as being the only calibration required at that time. The personnel involved were qualified to perform the task as stated in the work order.

The work planning supervisor indicated that the work order is correct and step 1 is clearly identified for performing the LPI flow transmitter procedure.

The work order task description for the surveillance performed in 1995 states:

PERFORM LPI FLOW INSTRUMENT CALIBRATION
REQUIRED BY TECH SPEC 4.1-1
PERFORM ANNUALLY.

Step 1 LPI FLOW INSTR. CALIB.

A. PROCEDURE IS PMT FUNCTIONAL TEST. DOCUMENT SUCCESSFUL COMPLETION OF IP/0-0/A0203/001C AS PMT ON R121.

The work order task description for the surveillance performed in 1996 states:

PERFORM LPI FLOW INSTRUMENT CALIBRATION
REQUIRED BY TECH SPEC 4.1-1.
CALIB. OF PG-1042 NRC COMMITMENT ITEM PER PIP 94-1811
PERFORM EVERY EIGHTEEN MONTHS

Step 1 U1 LPI FLOW INST. CAL.

A. DOCUMENT SUCCESSFUL COMPLETION OF REQUIRED SECTIONS OF IP/0-0/A/0203/001C AS PMT ON R121.
B. FT-04A AND FT-05A WILL BE CALIBRATED EVERY THREE YEARS UNDER A SEPARATE WORK ORDER

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CONCLUSIONS

The root cause is Deficient Work Practices; Document Use Practices, Documents not followed correctly.

The Low Pressure Injection (LPI) flow transmitters were not calibrated within the Technical Specification (TS) required time frame. The transmitters were scheduled for calibration in June and July 1996 for Unit 1 and 3 respectively. The Instrument and Control (I&C) supervisor indicated the work order was not interpreted properly. I&C technicians think they questioned the supervisor but the supervisor does not recall a discussion. In any case, an error occurred in only performing the differential pressure instrument calibration. The previous calibrations for the LPI flow transmitters were performed by different I&C technicians and supervision. The Unit 2 calibration was performed correctly in July 1997 by the same personnel involved in the Unit 1 and 3 calibration of 1996.

Since the errors in 1996, there have been significant communications concerning methods of obtaining event free human performance. One of the communications that continues to be stressed is Qualify, Validate, Verify (QV&V). These communications stress the questioning attitude that all personnel must have in every task that is performed. This may have contributed to correctly performing the procedure for LPI flow calibration in 1997.

A review of the work history indicated one Technical Specification surveillance was missed in 1993 (LER 270/93-04). This was associated with the failure to schedule testing of an Emergency Feedwater Pump initiation circuitry. The root cause was attributed to a Management Deficiency. In the current event, the calibration was scheduled but the technicians and supervisor did not perform the procedure as specified. Therefore, this event is not considered recurring.

This event did not involve a component failure or malfunction, therefore it is not NPRDS reportable. Also, there were no personnel injuries, radiation exposures, or releases of radioactive materials associated with this event.

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CORRECTIVE ACTIONS

Immediate

1. The Unit 3 Technical Specification (TS) surveillance for Low Pressure Injection flow instrument calibration was performed satisfactorily on October 10, 1997.

Subsequent

1. The Unit 1 TS surveillance for Low Pressure Injection flow instrument calibration was performed satisfactorily on October 11, 1997.

2. The error contained in this report was discussed with the personnel involved.

Planned

1. Perform a review of other TS surveillances which are satisfied by Instrument procedures to determine if this event was an isolated case.

Planned corrective action number 1 is considered the only NRC commitment in this report.

SAFETY ANALYSIS

The Low Pressure Injection (LPI) system provides emergency coolant injection which is necessary following a Loss Of Coolant Accident (LOCA). Operators monitor LPI flow from outputs supplied by two safety related flow transmitters.

The flow transmitter calibrations for Units 1 and 3 were successfully performed in 1995. The transmitters were scheduled but not calibrated in 1996 due to misinterpretation of the work order. The maximum allowed

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frequency between calibrations were exceeded in December 1996. The error was discovered in October 1997; the transmitters were calibrated and were found to be satisfactory. Therefore, even though the Technical Specification frequency for calibration was exceeded, the transmitters would have performed satisfactorily during a LOCA.

The health and safety of the public was not affected by this event.