

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9802230113	DOC.DATE: 98/02/12	NOTARIZED: NO	DOCKET #
FACIL: 50-269	Oconee Nuclear Station, Unit 1, Duke Power Co.		05000269
50-270	Oconee Nuclear Station, Unit 2, Duke Power Co.		05000270
50-287	Oconee Nuclear Station, Unit 3, Duke Power Co.		05000287
AUTH.NAME		AUTHOR AFFILIATION	
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MCCOLLUM, W.R.		Duke Power Co.	
RECIP.NAME		RECIPIENT AFFILIATION	

SUBJECT: LER 98-001-00: on 980120, failure to add new Keowee in-service test to scheduling process noted. Caused by change mgt, change related documents not developed or not received. Performed surveillance tests & exited LCOs. W/980212 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 10
 TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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W. R. McCollum, Jr.
Vice President

February 12, 1998

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 269/98-01, Revision 0
Problem Investigation Process No.: K-098-0276

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 269/98-01, concerning a missed Inservice Test surveillance required by Technical Specification 4.0.4.

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,

W. R. McCollum, Jr.

Attachment

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PDR ADOCK 05000269
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LEAD



Document Control Desk

Date: February 12, 1998

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LICENSEE EVENT REPORT (LER)

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.

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Oconee Nuclear Station, Unit 1

DOCKET NUMBER (2)
05000 269

PAGE (3)
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TITLE (4)
Failure to Add New Keowee In-Service Test to Scheduling Process Results in Missed Surveillance

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)
01	20	98	98	01	00	02	12	98	Unit 2	05000 270
									Unit 3	05000 278

OPERATING MODE (9) **N**

POWER LEVEL (10) **0**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)

<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
<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"/> Abstract below and
<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"/> in Text, NRC Form
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	<input type="checkbox"/> 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME
J.E. Burchfield, Regulatory Compliance Manager

TELEPHONE NUMBER
AREA CODE (864) 885-3292

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)

YES (f yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

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

On January 20, 1998, Oconee Unit 1 was at cold shutdown and Units 2 and 3 were at 100% full power. Keowee Hydro Unit 2 was out of service for scheduled maintenance, causing Oconee Units 2 and 3 to be in a 72-hour Limiting Condition of Operation (LCO). An engineer was preparing a monthly report and realized that quarterly test data was not available for the Keowee Turbine Guide Bearing Oil Systems. At 1012 hours, both Keowee units were declared inoperable after it was determined that the test interval was exceeded on January 18, 1998. The missed tests were new requirements that had not been added to the scheduling program. Oconee Units 2 and 3 entered a 24 hour LCO. After performing the tests, Keowee Unit 1 was returned to service at 1433 hours. This allowed Oconee Units 2 and 3 to exit the 24-hour LCO. Keowee Unit 2 remained out of service for previously scheduled maintenance. Oconee Units 2 and 3 reverted to a 72 hour LCO until completion of the scheduled maintenance and associated retests. The root cause was Change Management, Change-related documents not developed.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

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

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EVALUATION:**BACKGROUND**

At Oconee Nuclear Station, Keowee Hydro (KH) Station [EIIS:EK] serves the emergency power function typically performed by diesel generators [EIIS:DG] at other nuclear stations. KH consists of two hydroelectric turbine/generator units and associated support equipment and auxiliaries. One support sub-system is the Turbine Guide Bearing Oil System [EIIS:TD, LA]. This system includes one AC powered oil pump and one DC powered oil pump per KH unit. Each pump is equipped with a discharge check valve which must open to pass flow while its pump is running and must close to prevent recirculation when the other pump is running.

When Keowee is unavailable, a 100 KV transmission line can be dedicated to provide power from one of the Lee Steam Station combustion turbines (CT).

Technical Specification (TS) 3.7 requires both KH units and both power paths from KH to be operable. One path may be removed from service for 72 hours if the other path is verified to be operable within one hour and every eight hours thereafter. Both KH units may be inoperable for up to 72 hours for planned reasons if the Standby Buses are first energized from CT-5 transformer using the dedicated line from the Lee CT's. This last limiting condition for operation is reduced to 24 hours if both KH units are inoperable for unplanned reasons and the Standby Bus is energized from a dedicated Lee CT within 1 hour.

Nuclear Station Directive 203, Operability, states that pumps/valves which do not meet the overall requirement of the Inservice Test program shall be declared inoperable. Systems shall be considered operable if they meet the overall requirements of TS.

DESCRIPTION OF EVENT

In February 1993, an "Emergency Power Project" identified Keowee subsystems and individual components for inclusion in the ASME Section XI Inservice Test (IST) program. This also included evaluation of the modifications required to acquire test data. Several systems, including the Turbine Guide Bearing Oil (GBO) system, were identified for inclusion into the IST

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program, but required modifications. The GBO specifically needed modification to provide adequate flow indication, pressure taps, and manual valves to facilitate testing of the pumps and pump discharge check valves (1,2 GBO-1,3) on a quarterly basis. Problem Investigation Process (PIP) 0-094-1162 was written to track the actions needed to include Keowee equipment in the IST, including modifications, procedure development and initial testing. By November, 1995, the modifications on other systems had been installed and the IST program was updated. The GBO modifications were not completed until March 13, 1997, due to later parts delivery and scheduling conflicts. The post-modification Temporary Tests (TT) verified adequate flow existed.

The initial GBO IST testing was conducted in late April, 1997, using TT procedures, and PIP 0-094-1162 corrective actions were signed off as complete. The initial tests were considered acceptable, in that the measured flow was adequate for system operation, but it was recognized that the procedures needed enhancement.

On August 6, 1997, the second quarterly test was performed on Keowee Unit 1 using a revised TT procedure. The revised TT diagnosed a minor problem with the GBO pump and a work order was written for its repair. The decision was made that the revised test method was adequate, and personnel were assigned to convert the TT into a Periodic Test (PT) procedure. On August 28, 1997, a corrective action was created in PIP K-097-2422 to verify that the new PT, when completed, included certain provisions. However, the PIP computer program sets a default due date six months from the date the corrective action is created. Therefore, the default date for completion of a PT was February 28, 1998, well after the latest acceptable date for completion of the next quarterly test. The due date for the new PT was not reset to require completion of the new procedure in time for it to be used on the next quarterly test.

The GBO pumps were inspected, adjusted, and tested using the TT on September 3 and 4, 1997.

At this time Mechanical Systems Engineer A, who is accountable for Keowee mechanical systems, and Planner A, the Keowee Operations person assigned to act as planner for maintenance and testing activities performed by Keowee personnel, discussed the need to generate a work control action form and/or

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a model work order to add this test to the Work Management System. However, neither of them actually took action to generate a work control action form or model work order.

On January 19, 1998, Engineer A was reviewing documentation related to an Engineering Support tracking and trending process when he realized that he did not have any test data for GBO tests subsequent to September 4, 1997. At approximately 1730 hours, he placed a phone call to Planner A in an attempt to obtain any additional data. Planner A had already left for the day, so Engineer A left a phonemail message.

On the morning of January 20, 1998, Oconee Unit 1 was at cold shutdown and Units 2 and 3 were at 100% full power. At 0612 hours, Keowee Unit 2 was taken out of service for scheduled maintenance unrelated to this event. The overhead power path was declared inoperable and Oconee Units 2 and 3 entered a 72-hour Limiting Condition of Operation (LCO).

Upon listening to his phonemail, Planner A returned the call approximately 0730 hours. After Planner A reviewed his records, the two reached the conclusion that the test interval had been exceeded on January 17, 1998 for Keowee Unit 1 and on January 18, 1998 for Keowee Unit 2. Engineer A notified his supervision and Planner A notified Oconee Operations personnel. At 0900 hours, PIP K-098-0276 was created to document the problem. An operability evaluation was initiated and, at 1012 hours, the Operations Shift Manager declared both Keowee units out of service due to the missed surveillance. Oconee Units 2 and 3 were at 100% full power and entered a 24 hour LCO. Oconee Unit 1 was at cold shutdown and was unaffected. In accordance with Technical Specifications, a Lee Gas Turbine energized the Standby Bus at 1044 hours.

After performing testing of the Turbine Guide Bearing Oil System, Keowee Unit 1 was operationally tested and returned to service at 1433 hours. This allowed Oconee Units 2 and 3 to exit the 24-hour LCO and the Lee Gas Turbine was disconnected from the Standby Bus. Keowee Unit 2 and the overhead path remained out of service for the previously scheduled maintenance. Oconee Units 2 and 3 reverted to the 72 hour LCO.

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At 2214 hours, after testing of the Turbine Guide Bearing Oil System and completion of the scheduled maintenance and associated retests, Keowee Unit 2 was returned to service and the 72 hour LCO was exited.

CONCLUSION

The root cause of this is Change Management, Change-related documents not developed or not revised. By administrative procedure, new Periodic Tests and Preventative Maintenance activities are added to the Work Management System (WMS) by initiating Work Control "PM Action Forms". Once the activities are added to WMS, they are automatically scheduled by the computer program. Although these forms may be initiated by any knowledgeable individual, they must be reviewed and approved by the assigned component or systems engineer. According to interviews with various personnel, including those involved in this event, the normal practice is for the Engineer to initiate the form. In this event, Mechanical Systems Engineer A and Keowee Planner A discussed the fact that appropriate forms needed to be initiated to have the surveillances on 1GBO-1,3 and 2GBO-1,3 added to the computerized scheduling process. It appears to be the common perception of both individuals that, following this conversation, Engineer A was the person expected to initiate the appropriate forms. Engineer A did not add this task to any tracking program or "to-do" list and simply forgot to perform the task within an appropriate time period. Therefore, it is concluded that Engineer A failed to properly initiate these forms.

Contributing to this event were:

A) poor work practices in that no form of self-checking was applied to ensure the expected response (i.e. to follow up to ensure that the action item forms were properly entered), and

B) the progress/status of tasks were not adequately tracked. Review of several PIPs, which cover a time period from 1993 to present, indicated an intention to track implementation of Keowee systems into Inservice Test (IST) programs. However, the actual corrective actions did not track completion of a permanent PT and/or actions necessary to assure that the periodic test requirement was actually incorporated into the WMS

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scheduling process. Neither Engineer A, Planner A, nor their management and supervision provided adequate oversight of the process to assure that all required steps were tracked to satisfactory completion.

A similar event occurred in 1996 and was reported as LER 269/96-08. In that event a group of relief valves were not properly scheduled for testing per IST due to a mis-communication as to the required implementation date for components being added for a new ten year interval. Another event, reported as LER 269/97-09, involved missed surveillances where technicians mis-interpreted wording on work orders and therefore did not perform the full intended scope of the work orders. Although these events involved missed surveillances, the root causes were different, therefore this event is not recurring.

There were no injuries, radioactive releases, overexposures, or NPRDS reportable equipment failures associated with this event.

CORRECTIVE ACTION:

Immediate:

1. Upon discovery of the missed surveillances, valves 1GBO-1 and 3, and 2GBO-1 and 3 were declared technically inoperable. The associated Keowee Units were also declared technically inoperable, appropriate LCOs entered and compensatory actions taken.

Subsequent:

1. The surveillance tests were successfully performed and the LCOs were exited.
2. PM action item forms were completed and model work orders were generated.
3. A review was performed to identify any other components not properly added to to the Inservice Test (IST) program. As a result of this review, the AC and DC Guide Bearing Oil pumps were added.

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4. Mechanical Systems Engineer A was counseled in accordance with company policies.

Planned:

1. As a result of this event, a review of the process for adding, scheduling, and conducting surveillances will be conducted. Based on the results of this review, appropriate process improvements will be implemented.

Planned corrective action 1 is considered to be an NRC Commitment Item. It is the only NRC Commitment items contained in this LER.

SAFETY ANALYSIS:

This event was a case of missed quarterly check valve surveillance tests. In this case, the maximum allowed interval between tests is 135 days and this interval was exceeded by three days for Keowee Unit 1 and two days for Keowee Unit 2. Upon discovery of the missed test, it was performed. The test demonstrated that the valves were fully operable. Therefore, there was no adverse impact on the health and safety of the public resulting from this event.

The following addresses the hypothetical and unlikely event that one of these valves had failed and had been undetected due to the missed surveillance:

The function of the Keowee Guide Bearing Oil system is to provide lubrication to the Keowee turbine/generator during operation. It must perform this support function in order for the associated Keowee unit to operate properly as the emergency power supply to Oconee Nuclear Site.

Even though four valves were not tested on schedule due to a single error, the effect is not a common failure mode. The failure to perform the test does not physically cause a failure of the check valves. Furthermore, the failure of one valve on one Keowee Unit would not affect the other Keowee Unit. The Oconee electrical system is configured such that each Keowee

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power path can be aligned to both main feeder busses on each Oconee Unit and will supply emergency power to all trains of safety related systems. (This is unlike most nuclear units where loss of one emergency diesel will result in the loss of one train of emergency systems.) Therefore, even if one of these valves failed in such a manner that adequate lubrication was not available to the affected Keowee unit, the redundant Keowee Unit would have still been able to supply power for all trains performing emergency functions.

The probability of simultaneous independent failure of two of these valves to affect both Keowee Units is small, especially since the test interval was exceeded for only three days.

As stated above, the valves were tested and found to be fully operable. Therefore, there was no impact on the health and safety of the public due to this event.