

CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 9812010053 DOC. DATE: 98/11/23 NOTARIZED: NO DOCKET #
 FACIL: 50-269 Oconee Nuclear Station, Unit 1, Duke Power Co. 05000269
 AUTH. NAME AUTHOR AFFILIATION
 BURCHFIELD, J.E. Duke Power Co.
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 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 98-013-01: on 981002, noted that LCO exceeded on LPSW sys. (
 Caused by inadequate design interface. Repairs were made to /
 LPSW PAM flow instrumentation & addl guidance was provided /
 in Units 1, 2 & 3 surveillance procedures. J

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

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W. R. McCollum, Jr.
Vice President

November 23, 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 269/1998-13, Revision 01
Problem Investigation Process No.: 0-098-4653

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 269/1998-13, Revision 1, concerning a condition prohibited by Technical Specifications. This is a supplemental report which describes the circumstances and causes of the event.

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
S PDR

Document Control Desk

Date: November 23, 1998

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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 (MNB 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) 1 OF 8
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TITLE (4) Limiting Condition For Operation Exceeded On The Low Pressure Service Water System Due To Inadequate Design Interface

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	02	1998	1998	13	01	11	23	1998	Unit Two	05000 270	
									Unit Three	05000 287	

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) 100%	20.402(b)			20.405(c)			50.73(a)(2)(iv)			73.71(b)	
	20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)			73.71(c)	
	20.405(a)(1)(ii)			50.36(c)(2)			50.73(a)(2)(vii)			OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
	20.405(a)(1)(iii)			X 50.73(a)(2)(i)(B)			50.73(a)(2)(viii)(A)				
	20.405(a)(1)(iv)			50.73(a)(2)(ii)			50.73(a)(2)(viii)(B)				
	20.405(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(x)				

LICENSEE CONTACT FOR THIS LER (12)								TELEPHONE NUMBER			
NAME J.E. Burchfield, Regulatory Compliance Manager								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	
B	BI	FR	L130	N	X	BI	FI	D327	Y	
X	BI	CNV	R335	Y						

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 September 9, 1998, Oconee Units 1 and 2 were at 100% full power and Unit 3 was at 88% full power coasting down to a refueling outage. At about 0800 hours, the Unit 1 train "A" Low Pressure Service Water (LPSW) flow to the Low Pressure Injection (LPI) Decay Heat Cooler chart recorder failed high. Corrective maintenance on the two pen recorder began on October 2, 1998. While investigating the train "A" recorder failure, the train "B" safety-related Post-Accident Monitoring (PAM) LPSW flow meter failed high. It was determined at 1210 hours, that both trains "A" and "B" of PAM LPSW flow indication for the respective LPI Coolers were inoperable and a 72-hour Limiting Condition for Operation (LCO) of Technical Specification 3.3.7 was entered per Selected Licensee Commitment 16.9.12. Both PAM LPSW instrument trains were restored to operability at 2251 hours, on October 3, 1998, and the LCO was exited. A records review conclusively indicated that, although not obvious to operators, train "A" PAM LPSW LPI cooler flow instrumentation had been inoperable since September 9, 1998. Therefore, the TS LCO time limit was exceeded. The root cause is inadequate design; as the uniqueness of the design was not apparent. Corrective actions include replacing the recorder, repairing the instruments, modifying the instrumentation, revising operations procedures and training. The health and safety of the public was not compromised by this event.

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EVALUATION:

Background:

The Low Pressure Injection (LPI) [EIIS:BP] system is an Engineered Safeguard (ES) [EIIS:JE] system designed to maintain core cooling for large break Loss of Coolant Accidents (LOCA).

There are two trains of LPI on each unit. Only one train of LPI is required to mitigate a design basis accident.

The Low Pressure Service Water (LPSW) [EIIS:BI] system provides cooling for components in the Turbine Building, Auxiliary Building (AB) and the Reactor Buildings (RB). Units 1 and 2 have a shared system with three pumps supplying both units. ES equipment located in the RB and AB (such as the LPI Coolers) is cooled by the LPSW system. The LPSW system is a support system for LPI and is required to be operable per Technical Specification (TS) 3.3.7.

During normal operation, LPSW flow is isolated to the LPI Coolers. If a LOCA occurs, Operators manually initiate flow to the LPI Coolers while establishing long term cooling in the Reactor Building Sump recirculation mode. Flow is controlled by operators throttling valves from the control room. Operators use the flow instrumentation to maintain sufficient LPSW pump NPSH and adequate LPSW flow to the safety related loads.

Each train of LPSW flow to the LPI coolers includes one channel of Post Accident Monitoring flow instrumentation to meet Regulatory Guide 1.97. Each train consists of a power supply, transmitter, square root extractor, signal isolator, and Dixon flow indicator. A single, two pen, safety related chart recorder [EIIS:FR] is utilized to indicate and record flow for both trains.

The Dixon meter type indicator is considered to be the flow instrument required for LPSW train operability. The design of the circuit in the Dixon meter produces a blinking Light Emitting Diode (LED) such that the LED may blink if the input voltage signal changes. As a result, a properly

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functioning instrument flow loop can result in a bar graph LED that might briefly start and stop blinking due to normal calibration drift or noise. Also, the Dixson meter is designed so that the lowest bar graph will blink if the input falls to a value less than zero. When either of these conditions are present the Dixson flow meter LED blinking is actuated. Therefore, this limitation in the Dixson flow meter design precludes Operators from using the blinking LED as an indication of a potentially failed instrument.

Selected Licensee Commitment 16.9.12 J.1 specifies that if safety related LPSW instrumentation for Train "A" and/or Train "B" LPI Cooler flow is inoperable, the required action is to enter a 72 hour Limiting Condition for Operation on the applicable unit(s) per TS 3.3.7, LPSW System.

Description of Event

On September 9, 1998, Units 1 and 2 were at 100% full power and Unit 3 was at approximately 88% full power and coasting down for a refueling outage. A work request had been initiated to investigate and repair the control room chart recorder for Unit 1 Low Pressure Injection (LPI) Cooler flow. The red pen for the "1A" Low Pressure Service Water (LPSW) flow recorder had failed high. The work request priority assigned by the Operations Shift Work Manager specified the work to be performed within one month. Operations was unaware that the chart recorder could affect the Regulatory Guide 1.97 flow instrumentation.

On October 2, 1998, Instrument and Control (I&C) personnel began work on the control room chart recorder. They encountered failed Dixson meters on both the "A" and "B" trains of LPSW flow to the LPI Coolers while performing investigative trouble shooting for the chart recorder. The trouble shooting was stopped and appropriate Operations personnel were informed of the lack of proper Safety Related LPSW flow indication.

At 1210 hours, Operations entered a 72 hour Limiting Condition for Operation (LCO) per Selected Licensee Commitment (SLC) 16.9.12 due to a loss of LPSW flow indication to the Unit 1 LPI coolers.

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On October 3, 1998, I&C trouble shooting of the Regulatory Guide 1.97 circuitry revealed that the square root extractor which feeds the signal to the LPSW "1A" Train of the chart recorder, Operator Aid Computer (OAC), and Dixson meter had failed. The cause of the failure could not be determined. The square root extractor for the "1B" train failed during the trouble shooting that occurred on October 2, 1998. The chart recorder, OAC, and LPSW flow indicators were not damaged by the square root extractor failure. The chart recorder and instrumentation circuit parts, damaged during the trouble-shooting effort and previous failure, were replaced. Both trains of LPSW flow to the LPI Coolers tested satisfactorily. Operations exited the LCO at 2251 hours.

On October 6, 1998, Engineering completed a review of the failure and determined that a single failure could cause a simultaneous failure of both Safety Related Post Accident Monitoring LPSW flow indications to the Decay Heat Coolers. The chart recorder servo motor case could contact exposed terminals which would short out the instrumentation in both trains of the LPSW flow indication. This failure could occur when the chart recorder paper or ink is being reloaded. It would be most likely to occur when inspecting for a problem in the recorder. However, there is no indication that anyone manipulated the chart recorder at the time of the failure on September 9, 1998.

A review of data for the Unit 1 LPSW to Decay Heat Cooler flow indications showed that the "1A" chart recorder pen pegged high on September 9, 1998, and the "1A" signal to the OAC failed at the same time. Engineering concluded that the "1A" square root extractor failed on September 9, 1998. Therefore, the "1A" LPSW flow indication was inoperable and a 72 hour LCO per SLC 16.9.12 was applicable on September 9, 1998. However, previous training information regarding these instruments did not present the operators with a reasonable opportunity to identify the LCO condition. The safety related flow instrument indicated no flow, as anticipated.

A review of performance testing revealed that Unit 1 LPSW pumps had been tested on September 15, 1998. However, the test conditions did not supply sufficient flow to indicate in the instrumentation for the LPSW to the LPI Cooler. Therefore, there was no opportunity to detect the failed instrument.

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Conclusion

The root cause of this event is determined to be an inadequate interface design, the uniqueness of the design was not made apparent. If a Dixon meter fails in a low condition, the failure is not obvious to Operators due to the inherent design of the meter.

Train "1A" of Low Pressure Service Water (LPSW) Post Accident Monitoring (PAM) flow instrumentation failed on September 9, 1998 due to an unknown cause. Operators did not determine the "1A" Dixon meter indication failed on this date. Therefore, a Selected Licensee Commitment (SLC) 16.9.12, 72 hour Technical Specification (TS) Limiting Condition for Operation (LCO) was not entered as required.

When the Instrumentation and Control personnel were working on the chart recorder on October 2, 1998, the train "1B" of LPSW PAM flow instrumentation was rendered inoperable. As required by SLC 16.9.12, a 72 hour TS LCO was entered on October 2, 1998.

The root cause of the single failure vulnerability is an inadequate design configuration. The failure mechanism associated with the chart recorder resulted in the loss of the "1B" train of LPSW PAM flow instrumentation during trouble shooting. This failure contributed to the identification of the single failure vulnerability.

A review of Operating Experience within the last two years revealed that there have not been any LERs with a root cause of inadequate interface design. Also, a review of Problem Investigation Process (PIP) reports revealed that on July 7, 1998, the "1A" LPI train was out of service for train maintenance and the "1B" LPSW flow to "1B" Low Pressure Injection cooler was valved out of service for an impulse line flush for flow transmitter calibration. It was initially not understood that this condition resulted in entering a LCO. However, five minutes after removing the "1B" from service it was returned to service. Even though this PIP was associated with the same components, it did not involve an inadequate interface design. A search of the Operating Experience Data Base did not reveal any similar events. Therefore, the event described in this LER is non-recurring.

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There were no radiological overexposures, radioactive releases or personnel injuries associated with this event.

CORRECTIVE ACTION:

Immediate

1. A 72 hour Limiting Condition for Operation per Selected Licensee Commitment 16.9.12 was entered until the required instrumentation was restored to be operable.

Subsequent

1. A Root Cause Investigation Process was initiated.
2. Repairs were made to the Unit 1 Low Pressure Service Water (LPSW) Post Accident Monitoring (PAM) flow instrumentation.
3. The LPSW PAM instrumentation on Unit 2 and 3 were verified to be operating properly.
4. Additional guidance was provided in the Units 1, 2, and 3 surveillance procedures for identifying indications of Dixson meter instrumentation inoperability. The guidance specifies what actions to take for the specified conditions.
5. The Emergency Operations Procedure was revised to address appropriate actions when both trains of LPSW flow instrumentation are inoperable.
6. The other chart recorders of this type were analyzed for the potential single failure mechanism.

Planned

1. Determine the modifications that are required to prevent a single failure from affecting both Safety Related LPSW PAM flow indications and implement as appropriate.

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

SAFETY ANALYSIS:

Train "1A" of Low Pressure Service Water (LPSW) Post Accident Monitoring (PAM) flow instrumentation was not available from September 9, 1998 to October 3, 1998. Train "1B" of LPSW PAM instrumentation was available until October 2, 1998, when the chart recorder trouble shooting was performed. Technicians properly identified the condition and notified Operations personnel who appropriately entered a 72 hour Limiting Condition for Operation.

The safety related LPSW PAM flow instrumentation is required to provide an indication of Low Pressure Injection Cooler shell side flow in the control room when throttling is required following a design basis accident. If the flow is not throttled and an LPSW pump is lost, LPSW pump NPSH and LPSW flow to other safety related loads may be inadequate. If a single failure of a LPSW pump is not assumed, sufficient LPSW pump NPSH and LPSW flow to the safety related loads exist without throttling.

Only one of the two trains of Low Pressure Injection is required to mitigate a design basis accident. If a design basis accident had occurred while the "1A" LPSW PAM flow instrumentation was out of service from September 9 to October 2, 1998, the second LPSW train was available and would have provided the required cooling. However, with the "1A" train LPSW PAM flow instrumentation out of service, the most limiting postulated single failure could render the "1B" train LPSW PAM flow instrumentation and the "1B" LPSW pump inoperable. In this low probability scenario, it is likely that other non-Regulatory Guide 1.97 flow instruments would be available to Operators for throttling flow during an accident. The flow control to each LPSW train is accomplished via a pneumatically operated valve in each train with an associated electronic flow indicator/controller. Each valve is supplied with Instrument Air and is backed up by non-load shed Auxiliary Instrument Air. The electronic flow indicator/controller receives its flow signals from a different instrument loop than the Regulatory Guide 1.97 instrument loop. Operators normally control LPSW flow based on the flow indicated by the electronic flow

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indicator/controller. The electronic flow indicator/controllers are located in the Control Room side-by-side with the Dixson flow meters.

Therefore, the postulated scenario where no flow indication is present and an LPSW pump fails during a Loss Of Coolant Accident and Loss Of Offsite Power is considered highly unlikely.

During the time period the PAM LPSW flow instrumentation was inoperable, no event occurred which required long term core cooling.

For the above reasons, it is concluded that the health and safety of the public was not affected by this event.