

John A. Bailey Vice President Nuclear Operations

January 3, 1991

NO 91-0002

U. S. Nuclear Regulatory Commission ATTN: Document Control Desk Mail Station P1-137 Washington, D. C. 20555

Subject: Docket No. 50-482: Licensee Event Report 90-018-01

Gentlemen:

The attached Licensee Event Report (LER) describes a evaluation which concluded that a Technical Specification violation did not occur, as reported in LER 90-018-00.

Very truly yours,

John A. Bailey Vice President

Nuclear Operations

John a. Bailey

JAB/aem

Attachment

cc: A. T. Howell (NRC), w/a

R. D. Martin (NRC), w/a

D. V. Pickett (NRC), w/a

M. E. Skow (NRC), w/a

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On August 3, 1990 at 0911 CDT, the Turbine Building Operator reported to the Shift Supervisor that scaffolding was discovered interfering with the operation of check valve ALV001 in the suction line to the Turbine Driven Auxiliary Feedwater Pump PAL02 from the Condensate Storage Tank. Initially it was conservatively assumed that pump PAL02 was inoperable, since the interference would not allow valve ALV001 to fully open. The scaffolding was adjusted such that movement of valve ALV001 was no longer restricted.

An initial review of this event concluded that the scaffolding was in such a position that it made pump PALO2 inoperable between July 25 and August 3. This condition violated Technical Specification 3.7.1.2; which requires, in part, that three independent auxiliary feedwater pumps be operable. This event occurred because of a failure to comply with the scaffolding procedure. The procedure requirements were reviewed with all scaffold builders. The procedure has also been reviewed for possible enhancements, but none were deemed necessary. All scaffolding in safety-related areas were inspected to ensure no similar situations existed. Two minor scaffold interferences were found which had no adverse effect on system function and were corrected.

This supplemental report describes an evaluation which concluded that the initial review of this event was overly conservative and that pump PALO2 was operable between July 25 and August 3.

NAC FORM 366A

#### U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 4/30/92

# TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-30). US NUCLEAR REGULATORY COMMISSION WASHINGTON DC 20555. AND TO THE PARENWORK REDUCTION FROJECT (3150-0104). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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### INTRODUCTION

On August 3, 1990 at 0911 CDT, the Turbine Building Operator reported to the Shift Supervisor that scaffolding was discovered interfering with the operation of the Turbine Driven Auxiliary Feedwater Pump (TDAFP), PALO2 [BA-P] suction check valve, ALV001 from the Condensate Storage Tank (CST) [KA-TK]. Initially it was conservatively concluded that pump PALO2 was inoperable, since the interference would allow valve ALV001 to only open approximately 25 percent. Because pump PALO2 was considered to have the inoperable since the scaffolding was erected on July 25, 1990, this situation constituted a violation of Technical Specification 3.7.1.2, which requires, in part, that three independent auxiliary feedwater pumps be operable. Therefore, Revision 0 of this Licensee Event Report was submitted pursuant to 10 CFR 50.73(a)(2)(i) concerning a condition prohibited by the plant's Technical Specifications. Subsequent evaluations conducted by Nuclear Plant Engineering on September 12, 1990 have concluded that pump PALO2 was operable between July 25 and August 3.

#### DESCRIPTION OF EVENT

On July 24, 1990 a scaffolding request was initiated to install scaffolding in the TDAFP room. The purpose of this scaffolding was to allow installation of conduit and emergency lighting. The scaffolding was installed on July 25, 1990 and was independently verified to insure proper installation.

At 0832 CDT on August 3, 1990 the Turbine Building Operator discovered that the scaffolding was interfering with the operation of suction check valve ALV001. This interference prevented valve ALV001 from fully opening, so the Turbine Building Operator moved the scaffolding slightly to allow free operation of ALV001 at 0837 CDT. The Turbine Building Operator informed the Shift Supervisor of the situation and the corrective actions taken to alleviate the problem at 0911 CDT, and the scaffolding was subsequently removed.

Technical Specification 3.7.1.2 requires, in part, that at least three independent steam generator auxiliary feedwater pumps and associated flow paths be operable. If one auxiliary feedwater pump is inoperable, the Technical Specification requires restoration of the required auxiliary feedwater pumps to operable status within 72 hours or be in at least Hot Standby within the next 6 hours and in Hot Shutdown within the following 6 hours. Because pump PALO2 was initially considered inoperable between July 25 and August 3, this requirement of Technical Specification 3.7.1.2 was deemed not satisfied. During this time period the unit was operating in Mode 1, Power Operation, at approximately 100 percent rated thermal power.

NEC FORM 366A

U.S. NUCLEAR REQULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 4/30/92

# TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST BOLD HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630). U.S. NUCLEAR REGULATORY COMMISSION, WASHINDTON, DC 20666. AND TO THE PAPERWORK REDUCTION PROJECT 13160-0104]. OFFICE OF MANAGEMENT AND BUDGET WASHINGTON, DC 20803.

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Further review and evaluation of the flow capability of valve ALV001, with the disk travel approximately 25 percent of its full open position, has shown that all design functions of the Auxiliary Feedwater System could have been fulfilled, including pump PAL02's designed flow rate. It was concluded that the initial review of this event was overly conservative since pump PAL02 was fully operable during the time period in question. Therefore, no condition prohibited by the plant's Technical Specifications existed.

### ROOT CAUSE AND CORRECTIVE ACTIONS

The root cause of this event was a personnel error by nonlicensed utility personnel, who failed to comply with the scaffolding procedure when installing the scaffolding. This procedure requires that scaffolding shall not restrict the movement or travel of any mechanical mechanism, (e.g., valve stem, handwheel, etc.)

In order to insure compliance with procedures, the scaffolding installation procedure requirements were reviewed again with all scaffold builders on August 6, 1990. The scaffolding procedure was reviewed and no changes were deemed necessary.

#### ADDITIONAL INFORMATION

On August 3, 1990, an inspection was conducted on all installed scaffolding in safety-related areas. During the examination of the scaffolds, two minor interferences were observed which had no adverse effect on system function. The two interferences involved two 3/4" manual valves which have no active function and remain normally closed. The scaffolds were altered to provide full open swing movement to the subject valve handles.

There have been no previous similar occurrences.