

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oconee Nuclear Station, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 1 6 1 9	PAGE (3) 1 OF 0 1 3
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TITLE (4)
Exceeded Surveillance Interval for Some Keowee Fire Protection Equipment

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 NAMES		DOCKET NUMBER(S)
1	1	1 2 8 4	8 4	0 0 5	0 0	1	2	1 7 8 4	Oconee Unit 2		0 5 0 0 0 2 7 0
									Oconee Unit 3		0 5 0 0 0 2 8 7

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)				
POWER LEVEL (10) 0 1 0 1 0	<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)	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)	<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)(ix)		

LICENSEE CONTACT FOR THIS LER (12)

NAME Richard F. Haynes, Licensing	TELEPHONE NUMBER AREA CODE: 7 1 0 1 4 3 1 7 3 1 - 1 7 1 1 2 1 9
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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 (If 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 November 12, 1984, with Units 1 and 3 shut down, and Unit 2 operating at 100% full power, the surveillance interval given by the Oconee Technical Specifications for some Keowee Hydroelectric Station fire protection equipment was exceeded. The Keowee Hydro units provide the primary backup source of A.C. Power for the three Oconee Units.

A review of the surveillance data for the fire protection equipment, done at approximately 1000 hours on November 15, 1984, indicated that the surveillance interval had been exceeded by two days. The current inspection interval was exceeded primarily due to a Procedural deficiency within the Preventive Maintenance (PM) System. In addition, personnel errors have been identified which contributed to the cause of the accident.

No immediate corrective action was necessary, since the current inspection had been successfully completed by the time the exceeded interval had been discovered. Responsible personnel were counselled concerning the oversight and the administrative controls by which Technical Specification surveillance items are monitored will be reviewed, and revised if necessary, in order to prevent similar occurrences in the future.

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LICENSED EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	OF	0 3

TEXT (If more space is required, use additional NRC Form 368A's) (17)

Description of Occurrence:

On September 21, 1984, a specific Standing Work Request (SWR) was issued to perform the required surveillance, for September, on the Keowee fire protection equipment. The SWR indicated a scheduled completion date of September 30th and indicated October 15th as the date on which the Technical Specification (TS) would be would be violated. The work specified by SWR was completed on September 28th and was forwarded for review. After being reviewed, the SWR was sent on for documentation that the work was completed. In the process of transmitting for documentation, the SWR was lost.

On October 10th, the preventive maintenance computer program identified the SWR for the previous surveillance as being late for completion with only five days remaining before a TS violation; this information was provided to the appropriate personnel but these personnel did not appropriately respond in accordance with procedure. Procedures further dictated that another notification should have been given three days prior to the TS violation, but was not provided.

The SWR for the previous surveillance of the Keowee fire protection equipment, therefore, remained outstanding between October 15th and November 14th. On November 14th, personnel noted that the SWR for October's surveillance of the fire protection equipment had not yet been issued. Once this was communicated to the appropriate personnel, it was discovered that the SWR for the previous surveillance had not yet been closed out. This explained why the SWR for the current surveillance had not yet been issued. A work request was immediately issued and the required surveillance was performed and completed on November 14, 1984.

On November 15th, while reviewing the SWR for the September surveillance, personnel noted that the required inspection had been performed on September 28th two days prior to the scheduled completion date of September 30th. In accordance with an Oconee Technical Specification (4.0.2), the maximum allowable interval between surveillances performed on a monthly basis is 45 days. Based on this, the required monthly surveillance, for October, of the fire protection equipment for Keowee Hydroelectric Station should have been completed by November 12, 1984. As noted earlier, the required surveillance for October was completed on November 14, 1984.

Cause of Occurrence:

The principal cause of this incident is attributable to the failure of the preventive maintenance program to identify the incomplete status of the SWR for the previous surveillance. Contributing causes include the loss of the SWR for the previous surveillance, and the personnel errors for the cases in which actions required by procedures were not performed. A review of records indicates that this incident does not represent a recurring problem.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Analysis of Occurrence:

The applicable technical specifications, which were violated as a result of this incident, were established to ensure that the Keowee fire protection equipment is maintained in an operable status at all times. Although the forty-five day surveillance interval specified in TS was exceeded, the current inspection indicated that all the fire protection equipment at Keowee was in an operable status during the two-day period following the surveillance expiration date. On this basis, it is concluded that the health and safety of the public were not affected by this incident.

Corrective Action:

Once the problem was discovered, efforts were directed to performing the required surveillance as rapidly as possible. Responsible personnel were counselled in connection with their errors which contributed to the late inspection. The discovery that the TS Surveillance Interval had been exceeded was not known until after the required surveillance was performed. The preventive maintenance program, which allowed this incident to occur, will be examined and necessary revisions incorporated. This step should prevent the recurrence of an event of this kind.

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December 17, 1984

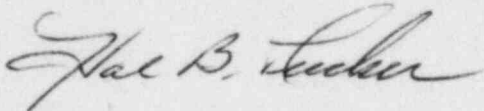
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Washington, D. C. 20555

Subject: Oconee Nuclear Station, Unit 1
Docket No. 50-269
LER 269/84-05

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report 269/84-05 concerning an incident in which the surveillance inspection interval for some Keowee Hydroelectric Station fire protection equipment was exceeded; the report is submitted in accordance with §50.73 (a)(2)(i). This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,



Hal B. Tucker

RFH:slb

Attachment

cc: Mr. James P. O'Reilly, Regional Administrator
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