NRC Form 366 (9-63)					LIC	CENSEE EVENT REPORT (LER)				U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/86															
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taken out of service for preventive maintenance. A Shift Supervisor declared Train B of the NS System inoperable. On March 1, 1988, another Shift Supervisor entered Train A of the Containment Pressure Control System (CPCS) into the TSAIL for calibrations but did not declare NS Train A inoperable. This placed both

On the evening of February 29, 1988, Containment Spray (NS) System Pump 1B was

X

trains of the NS System in an inoperable condition violating Technical Specifications. The NS System would have initiated on a High-High Containment Pressure signal and secured at the low pressure setpoint. The inoperability was due to not meeting one sectior of the surveillance requirements. The Technical

Specification violation ended at 2228 hours, on March 1, 1988. The Unit was in

Mode 1, Power Operation, at the time of this incident.

SUPPLEMENTAL REPORT EXPECTED (14)

This incident has been attributed to a management deficiency due to the Shift Supervisor not recognizing that allowing the calibration of the CPCS would render NS Train A inoperable. At the time of this incident, the correct interpretation for NS operability when the CPCS was taken out of service was not identified in the Control Room Technical Specifications. This contributed to the Shift Supervisor allowing the Train A CPCS work to commence. This discrepancy in Technical Specifications with respect to the operability requirements for the CPCS had previously been identified and a Technical Specification change had been initiated. This incident has been reviewed with the involved personnel, and the Control Room Technical Specification copy has been highlighted to direct the Shift Supervisors to the appropriate interpretation. The health and safety of 15.35 the public were unaffected by this event.

YES (If yes, complete EXPECTED SUBMISSION DATE)

YEAR

MONTH

EXPECTED

DAY

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104

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FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)	PAGE (3)					
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

BACKGROUND:

The Containment Spray (EIIS:BE) (NS) System is an engineered safety feature which keeps the Containment Building pressure within design limits by removing thermal energy after an accident.

The system consists of two parallel flow paths, each with its associated pump (EIIS:P), heat exchanger (EIIS:HX), valves (EIIS:V), spray header and piping.

The Solid State Protection (EIIS:JC) System automatically initiates operation of the NS System upon high-high Containment pressure. To prevent depressurization, the operation of the NS System is automatically terminated when Containment pressure returns to normal by the Containment Pressure Control System (CPCS).

The CPCS is designed to prevent excessive or inadvertent operation of the NS System. It ensures that both trains of the NS System are inhibited when the Containment pressure is less than or equal to 0.25 psig. To function in this manner, the CPCS is designed to ensure that a single fault will not allow an erronecus operation of an NS train when Containment pressure is less than or equal to 0.25 psig. It also ensures that a single fault in the CPCS will not incapacitate both trains of NS when Containment pressure is greater than 0.25 psig and that the Control Room Operator is aware when portions of the NS System are nonresponsive to control demands.

DESCRIPTION OF INCIDENT:

On the evening of February 29, 1988, the Train B NS Pump was taken out of service for preventive maintenance. The Shift Supervisor entered the NS System inoperability into the Technical Specification Action Item Log (TSAIL). On March 1, 1988, at 0824 hours, the Shift Supervisor was requested to sign on Work Request 3646 SWR to calibrate Train A of the CPCS. He reviewed the Technical Specification requirements, Table 3.3-3, for operability of the CPCS and complied with the action statement requirements. He then entered Train A of the CPCS as being inoperable and that one channel was out of service for calibration in the TSAIL. The channel of the CPCS that was taken out of service resulted in the Train A of NS being inoperable. This caused both trains of NS to be inoperable but this was not recognized at the time. With both trains of the NS System inoperable Technical Specification 3.0.3 applied and required that one channel of the NS System be returned to operable status within one hour or within certain time limits be in a Mode which the specification did not apply. At 2130 hours, on March 1, 1988, during a review of the TSAIL, it was discovered that both trains of the NS System were inoperable and Technical Specification 3.0.3 was entered. At 2228 hours, Train B of the NS System was restored to operability and Technical Specification 3.0.3 was exited.

Through discussions with the Technicians involved with the calibration of the CPCS, it was determined that the Train A CPCS was returned to operable status at approximately 1445 hours, on March 1, 1988. However, it was not removed from the TSAIL because the work request signature process could not be completed until the next day. The actual Technical Specification violation lasted from 0824 hours to approximately 1445 hours, on March 1, 1988.

NRC Form 366A (9.83)	LICENSEE EVENT RE	ICENSEE EVENT REPORT (LER) TEXT CONTINUATION				
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NUCLEAR REGULATORY COMMISSION APPROVED OMB NO 3150-0104 EXPIRES 8/31/85

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Catawba Nuclear Station, Unit 1

CONCLUSION:

This incident has been attributed to a management deficiency. The Shift Supervisor did not recognize that allowing calibration of CPCS Train A would render NS Train A inoperable. The Shift Supervisor relied on the Control Room copy of Tachnical Specifications to indicate the operability requirements for equipment taken out of service. He also used this copy to reference the Technical Specification Interpretation to review before making decisions to release equipment for maintenance. The Containment Spray, and the Containment Air Paturn And Hydrogen Skimmer System Technical Specifications were highlighted and the correct Technical Specification Interpretation noted. When the Technical Specification requirements for operability of the CPCS were reviewed, it did not reference the Containment Spray Technical Specification Interpretation and the Shift Supervisor assumed that the only operability requirements were those specified by the action statement requirements for the CPCS.

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Technical Specification Interpretations are entered into the Technical Specification Interpretation Manual by the Technical Specification number noted on the interpretation. An interpretation for Technical Specification 3/4.6 had previously been issued but referenced Section 3/4.3, Table 4.3-2. If the interpretation had referenced Section 3/4.3, Table 3.3-3, the Control Room copy of Technical Specifications would have been highlighted and the Shift Supervisor would have been aware of the interpretation.

The inconsistency in the CPCS Technical Specification action statement had previously been recognized and a Technical Specification change had been submitted.

There has been at least one previous Technical Specification violation due to inconsistencies in interpreting Technical Specifications (see LER 413/87-44). Therefore, this incident satisfies the Nuclear Safety Assurance guidelines for a recurring event.

CORRECTIVE ACTION:

SUBSEQUENT

- (1) This event was reviewed with the involved personnel.
- (2) The Control Room copy of Technical Specifications was highlighted to direct the Shift Supervisors to the appropriate Technical Specification interpretation.
- (3) Technical Specification Interpretation 3/4.6, Containment Systems, was revised to include Instrumentation Section 3/4.3, Table 3.3-3.

(9-83)	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED ON NO 3150-0104 EXPIRES 8/31/86									
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CARROLL ANALYSTS

SAFETY ANALYSIS:

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Had an inadvertent Engineered Safeguards Containment Spray Actuation (Sp) signal occurred during this event with the Containment pressure below the permissive set point, the NS System would have been prevented from actuating due to the interlocked Train A pump. The opening of the NS valves would have caused no adverse affects and would have been repositioned by the Control Room Operator.

Had an actual High-High Containment Pressure occurred, the NS System would have functioned normally on initiation. Upon securing at the low pressure set point, the Train A pump would have tripped as expected and Containment Spray would have terminated. However, the NS valves would have remained open. The open NS valves would have no adverse effects.

This event is reportable pursuant to 10 CFR 50.73, Section (a)(2)(i)(B).

The health and safety of the public were unaffected by this incident.

P.O. BOX 33189 CHARLOTTE, N.C. 28242

HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

TELEPHONE (704) 373-4531

March 31, 1988

Document Control Desk U. S. Nuclear Regulatory Commission Washington, D. C. 2055

Subject: Catawba Nuclear Station, Unit 1

Docket No. 50-41; LER 413/88-13

Gentlemen:

Pursuant to 10 CFR 50.73 Section (a) (1) and (d), attached is Licensee Event Report 413/88-13 concerning a Technical Specification violation due to a management deficiency. This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Hall. Tucker pur

Hal B. Tucker

JGT/10014/sbn

Attachment

xc: Dr. J. Nelson Grace
Regional Administrator, Region II
U. S. Nuclear Regulatory Commission
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Atlanta, Georgia 30323

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Mr. P. K. Van Doorn NRC Resident Inspector Catawba Nuclear Station

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