

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Catawba Nuclear Station, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 4 1 4	PAGE (3) 1 OF 0 4
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TITLE (4)
Technical Specification Violation Caused By Missed Retest Due To A Personnel Error

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)
0 4	0 5	8 8	8 8	0 1	5	0 0	0 5	0 5	N/A		0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) 4	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	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(e)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.36(e)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(e)						
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.36(e)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)(A)							
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(vii)(B)							
	<input type="checkbox"/> 20.406(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)		TELEPHONE NUMBER	
NAME	AREA CODE		
Julio G. Torre, Associate Engineer - Licensing	7 1 0 4	3 1 7 1 3 1 - 1 8 1 0 1 2 9	

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO				

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

On April 5, 1988, at approximately 1600 hours, a Duke Power Performance Engineer discovered that 2BB-61B, Steam Generator 2C Blowdown Containment Outside Isolation valve, had not been retested following repair. On March 14, 1988, a work request had been initiated to investigate and repair a packing leak on 2BB-61B. On March 15, 1988, the work request was signed on, the repair was performed, and control of 2BB-61B was accepted by Operations. When this incident occurred, the Unit was in Mode 4, Hot Shutdown, and in the process of starting up following asiatic clam flush testing. Following discovery of the incident, Performance personnel verified that a quarterly surveillance test had been satisfactorily performed on 2BB-61B on March 29, 1988. The valve was in service from March 15, 1988, until March 29, 1988, without a retest having been performed. During this period, the Unit moved through Mode 3, Hot Standby, Mode 2, Startup, and into Mode 1, Power Operation. This valve is required by Technical Specifications to be operable in Modes 1 through 4. This incident has been attributed to personnel errors. The repair of 2BB-61B was not identified as a Technical Specification item by Operations personnel. The Unit Supervisor, who gave clearance to begin work on and eventually accepted control of 2BB-61B, did not recognize the work request as being a Technical Specification item. The valve was not declared inoperable pending a performance retest. The Maintenance Supervisor did not contact Performance to perform a retest, following completion of the work, as required by Maintenance Management Procedures.

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This incident has been reviewed with the personnel involved and their supervisors. The health and safety of the public was unaffected by this event.

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

BACKGROUND:

Technical Specification Surveillance Requirement 4.6.3.1 states that the Containment Isolation valves (EIIS:V) listed in Tables 3.6-2a and 3.6-2b must be shown to be operable prior to returning them to service following maintenance, repair or replacement. This operability is demonstrated by cycling the valve and verifying its stroke time. This surveillance is applicable in Modes 1, Power Operation, 2, Startup, 3, Hot Standby, and 4, Hot Shutdown. 2BB-61B, Steam Generator (EIIS:SG) 2C Blowdown Containment Outside Isolation valve, is listed in Table 3.6-2b. The valve is stroke time tested quarterly by Performance under PT/2/A/4200/17, BB Valve Inservice Test.

The Steam Generator Blowdown (EIIS:WJ) (BB) System is used to maintain proper secondary side water chemistry. The BB System is designed to control the concentration of impurities in the Steam Generators (such as solids resulting from corrosion, or condenser (EIIS:COND) tube leaks) by continuously removing fluid from the shell side. This blowdown is either discharged to the Turbine (EIIS:TRB) Building sump, or purified and discharged to the condenser hotwell. The blowdown header from each Steam Generator blowdown nozzle (EIIS:NZL) runs from inside Containment, out through Containment Isolation valves, and eventually to the Steam Generator Blowdown Tank (EIIS:TK) in the Turbine Building.

DESCRIPTION OF INCIDENT:

On March 14, 1988, at 1720 hours, an Operations Staff Engineer initiated a Priority 5D work request to investigate and repair a packing leak on 2BB-61B, Steam Generator 2C Blowdown Containment Outside Isolation valve. The work request was not stamped "TECH SPEC RELATED", nor were the mode requirements indicated. In addition, in Section I of the work request, the valve was described as 2BB-61 rather than 2BB-61B. On March 15, 1988, the Unit Supervisor reviewed the work request (39631 OPS) and gave clearance to Maintenance personnel to begin work. At this time, the Unit was in Mode 4 and in the process of preparing to move into Mode 3, following the recent completion of Asiatic clam flush testing (see LER 414/88-12). Auxiliary Feedwater Pump (EIIS:P) 2A testing was in progress during this shift. The valve was not declared inoperable and no entry was made into the Technical Specification Action Item Logbook (TSAIL). Work was completed on March 15, 1988, and the decision was made by the Shift Supervisor and Unit Supervisor to delay functional verification until 900 psig steam pressure was reached. The Unit Supervisor signed to accept operational control of 2BB-61B in Section II of the work request. Both Performance retest and functional verification had been specified in Section II of the work request. The Maintenance Supervisor did not contact Performance to perform a retest on 2BB-61B.

On March 16, 1988, Maintenance returned the work request to Planning, where it was to remain until a functional verification could be performed. On March 29, 1988, 2BB-61B was tested by Performance during a quarterly test (PT/2/A/4200/17). On April 5, 1988, a Performance Staff Engineer discovered that work had been done on 2BB-61B without subsequent retest, and on April 6, 1988, initiated a Problem Investigation Report. A successful functional verification has not been performed since the packing gland leaks at full steam pressure.

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

CONCLUSION:

This incident has been attributed to several personnel errors. The Priority 5D work request should have been stamped "TECH SPEC RELATED" as required by Station Directive 3.3.7. In addition, the mode in which 2BB-61B was required to be operable was not entered in Section II of the work request, which is also required by this Station Directive. The Unit Supervisor did not declare 2BB-61B inoperable when work was performed on the valve, and the work request was not logged into the Technical Specification Action Item Logbook. The work request was not recognized by the Unit Supervisor as being a Technical Specification item, when a retest was specified on a Containment Isolation valve. The refueling outage was complete at the time of this incident and normal TSAIL logging procedures had been resumed for all work requests being signed on. The Maintenance Supervisor responsible for the repair did not inform Performance personnel that corrective maintenance had been completed on 2BB-61B, as required by Maintenance Management Procedure. According to Maintenance Management Procedure 1.0, the Responsible Supervisor is to ensure that Section VIII of a work request (documenting functional verification and retest) is performed. This includes notification of Performance personnel for retest after maintenance has been performed.

The Work Control Module of the Station Work Management System (an electronic work request system expected to be fully implemented in 1990) will incorporate pertinent Technical Specification, retest, and equipment information on each work request. Controls instituted by this system should prevent future occurrences of this type of incident by requiring these job aspects to be reviewed before work has begun.

A review of previous reports indicates that Technical Specification Violations resulting from not following procedures or not recognizing inoperability, have occurred on several occasions. Therefore, this incident is considered to be recurring. In reviewing previous Technical Specification violations resulting from not following procedures (in this case Station Directives and Maintenance Management Procedures), a similar LER (LER 413/85-38) was discovered in which a valve retest was not identified by Planning, as required by Maintenance Management Procedure and Station Directives. In reviewing previous Technical Specification Violations resulting from action not being taken because either the need was not recognized or there was a lack of attention to detail, several events were found. The only incident having a strong similarity to this was documented in LER 414/86-25, in which 2CF87 and 2BB-57B, both Containment Isolation valves, were not identified by Operations personnel as Technical Specification items following packing adjustments. As a corrective action to LER 414/86-25, Section 4.11 was added to Station Directive 3.3.7 (Rev. 5, 9/6/86). This section explains when the use of the "TECH SPEC RELATED" stamp on Priority 5 work requests is required. Use of this stamp in preparing this work request may have prevented this incident. A sampling of Priority 5 work requests has shown that the stamp is not consistently being used.

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

CORRECTIVE ACTION:

SUBSEQUENT

- (1) 2RB-61B was tested satisfactorily on March 29, 1988, by a quarterly Performance surveillance test.
- (2) This incident was discussed with the personnel involved and their supervisors.

PLANNED

A Station Manager's letter to all the Station Superintendents will emphasize the need to carefully follow Station Directive 3.3.7 and Maintenance Management Procedure 1.0 when originating, planning, implementing, and completing station work request.

SAFETY ANALYSIS:

2BB-61B is the Outside Containment Isolation valve on the blowdown line for Steam Generator 2C. It is required by Technical Specifications to close within 10 seconds following a Phase A Containment Isolation signal. The subsequent stroke time test of 2BB-61B on March 29, 1988, proved the valve to be operable from the standpoint of Containment Isolation. In addition, none of the other valves in the penetration were inoperable during the period that 2BB-61B was not retested (including 2BB-60A, S/G 2C Blowdown Containment Inside Isolation valve, the Containment Isolation valve in series with 2BB-61B, and the check valve in parallel with 2BB-60A, 2BB-54, S/G 2C Blowdown Containment Isolation Pressure Relief Check). From the standpoint of BB System operability, the ability to control Steam Generator chemistry was not affected by this incident.

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

The health and safety of the public were not affected by this incident.

DUKE POWER COMPANY

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HAL B. TUCKER
VICE PRESIDENT
NUCLEAR PRODUCTION

TELEPHONE
(704) 373-4531

May 5, 1988

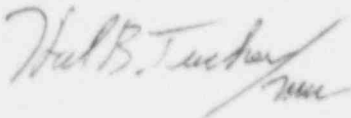
Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Subject: Catawba Nuclear Station, Unit 2
Docket No. 50-414
LER 414/88-15

Gentlemen:

Pursuant to 10 CFR 50.73 Section (a) (1) and (d), attached is Licensee Event Report 414/88-15 concerning a Technical Specification violation due to a missed retest because of a personnel error. 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

JGT/14/sbn

Attachment

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