

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Callaway Plant Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 4 8 3 8 6	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		- 0 0 9	- 0 1 0	3	OF	0 5

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

included on the restoration checklist of OSP-EP-V0003. Restoration was not included in this procedure since it should have been performed in Mode 4 and the valve properly restored with a separate IHSI system procedural lineup performed for Mode 3 entry.

Immediate Action

The problem was discovered at 1010 CST on 4/12/86, when an operator performing the routine Control Room, (CR) Shift and Daily Log Readings and Channel Checks, found EM-HIS-8835⁽⁴⁾ indicating closed. T/S 3.0.3 was immediately entered since T/S 3.5.2, ECCS Subsystems - Tavg greater than or equal to 350° F., does not provide Action Statements for two inoperable SI trains. EM-HV-8835 was restored to the open position within the one hour T/S 3.0.3 time constraint.

Root Cause

This event is an isolated case of unintentional utility personnel error during the scheduling, reviewing and running of OSP-EP-V0003. These errors and contributing factors are summarized as follows:

1. Scheduling personnel identified OSP-EP-V0003 as required to be performed in Mode 3 prior to RCS pressure reaching 1000 p.s.i.g. which failed to recognize the Surveillance Task Sheet (STS) "Task Performance Mode" requirements. This "Task Performance Mode" required performance of the surveillance in Mode 4 ONLY.
2. The 4/12/86 Mode 3 change letter confused operating personnel. In an attempt to provide additional information to the CR, mode change letters have historically identified surveillances that will be due in the near future that would be affected by the mode change as well as surveillances required for the mode change. Surveillance tracking personnel identified OSP-EP-V0003 on the Mode 3 change letter to be performed in Mode 3 when conditions permit (RCS pressure greater than 300 p.s.i.g.). This was based on the need to perform the surveillance (18 month surveillance - due June 1986) prior to declaring the SI accumulators⁽⁵⁾ operable.
3. Operations personnel erroneously authorized performance of the OSP in Mode 3. During review of OSP-EP-V0003 prior to running the test, Operations personnel noted that the OSP initial conditions required performance of the procedure in Mode 4 only. They reviewed the OSP, mode change letter and schedule and erroneously authorized performance of the surveillance in Mode 3 by a TCN. This action was caused by the discrepancy between the schedule, initial conditions of the procedure, and the mode change letter. The schedule required

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FACILITY NAME (1) Callaway Plant Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 4 8 3 8 6 - 0 0 9 - 0 1 0 4 OF 0 5	LER NUMBER (8)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		

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performance prior to 1000 p.s.i.g. The mode change letter required the RCS to be greater than 300 p.s.i.g. Finally, the Operators overlooked the effect of closing EM-HV-8835 when in Mode 3.

4. Revision of the STS did not follow the existing review and approval cycle. With issuance of the TCN, the STS "Task Performance Mode" was changed by Operations personnel without the appropriate review and approvals.

Actions Taken to Prevent Recurrence

The following action to prevent recurrence items are numbered to correspond with those used in the Root Cause section above:

- 1.(a) For future outages, Outage Scheduling will schedule OSP-EP-V0003 in Mode 4 as a Mode 3 restraint.
- (b) Progressive discipline has been initiated for appropriate Outage personnel. Outages Planning and Scheduling personnel have been advised concerning Outages involvement in this event.
- (c) An Outages procedure currently in draft form will specifically address use of the STS "Task Performance Mode" for scheduling surveillances.
2. Future mode change letters will reflect only required task performance conditions and T/S requirements for mode changes.
- 3.(a) The TCN that allowed performance of the OSP in Mode 3 was voided.
- (b) Progressive discipline has been initiated for Operations personnel involved in this event and the necessity to comply with programmatic controls has been re-emphasized.
- (c) Additional guidance will address the utilization of Temporary Change Notices for surveillance procedures. This guidance will be incorporated into plant administrative procedures.
4. Management will re-emphasize the existing administrative controls for revisions to task sheets and surveillance procedures to appropriate plant personnel.

To correct the problem relative to failure to provide the four hour ENS notification, appropriate personnel will be advised of guidance concerning reporting items pursuant to 10 CFR 50.72(b)(2)(iii).

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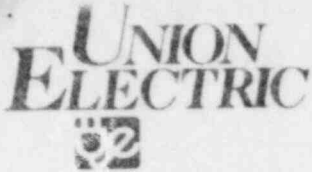
Safety Significance

Although the closure of EM-HV-8835 isolated the IHSI flowpath from the SI pumps to the RCS cold legs for approximately 6 hours, the SI pumps remained functional. Additionally, if a situation had occurred requiring IHSI, Operations Emergency procedure E.0 calls for verification of SI pump start and flow. Steps require reverification of valve lineups if no flow is indicated. EM-HV-8835 can be opened from the Control Room. Other portions of the ECCS, which provide High Head and Low Head Safety Injection were available during the event. At the time of this event, the reactor had been shut down for approximately 42 days. EM-HV-8835 is routinely verified to be opened every shift while in Modes 1, 2, and 3. This operating routine minimizes the time EM-HV-8835 could have remained shut and remained undetected. The discovery of this event was by an operator performing this routine shift valve verification. At no time did this event endanger the public health and safety.

Previous occurrences: none

Footnotes

- (1) IEEE Standard 805-1983 Systems - BP, BQ, CB
- (2) IEEE Standard 805-1983 System - BQ
IEEE Standard 803A-1983 Component - HCV
- (3) IEEE Standard 805-1983 System - BQ
IEEE Standard 803A-1983 Component - P
- (4) IEEE Standard 805-1983 System - BQ
IEEE Standard 803A-1983 Component - HIS
- (5) IEEE Standard 805-1983 System - BQ
IEEE Standard 803A-1983 Component - ACC



Callaway Plant

May 16, 1986

DMA

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

ULNRC-1316

Gentlemen:

DOCKET NUMBER 50-483
CALLAWAY PLANT UNIT 1
FACILITY OPERATING LICENSE NPF-30
LICENSEE EVENT REPORT 86-009-01
INOPERABLE SAFETY INJECTION TRAINS
DUE TO PERSONNEL ERROR

The enclosed Licensee Event Report is submitted to amend LER 86-009-00, transmitted via ULNRC-1307 dated 5/12/86, concerning operation of the Callaway Plant with a condition prohibited by the plant's Technical Specifications. The condition resulted from inoperability of both Intermediate Head Safety Injection Trains due to personnel errors and required entry into Technical Specification 3.0.3.

G. L. Randolph
G. L. Randolph
Manager, Callaway Plant

TPS/SEMe/drs
TPS/SEMe/drs
Enclosure

cc: Distribution attached

MAY 19 1986

JE22

cc distribution for ULNRC-1316

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