LICENSEE EVENT REPORT (LER)					U.S. NUCLEAR REGULATORY COMMITMION APPROVED OMB NO 3150-0104 EXPIRES 8/31 195						
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NRC Form 366 (9.83)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APP::OVED OMB NO. 3150-0104 EXPIRES 8/31/85

ACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)				PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER					
Catawba Nuclear Station, Unit 1	0 5 0 0 4 1 3	8 6	-0 1 2	-010	012	OF	0 4		

BACKGROUND

RC Form 366A

The Containment Valve Injection Water (NW) System (EIIS:JM) is designed to inject water between the two seating surfaces of gate valves used for containment isolation. The injection pressure is higher than containment design peak pressure during a LOCA. This will prevent leakage of the containment atmosphere through the gate valves, thereby reducing potential dose following the postulated accident. Each NW line to a containment isolation valve has a solenoid valve that opens to supply injection water upon the appropriate safety signal. These solenoid valves are response time tested. Periodic test procedure PT/1/A/4200/27, NW Valve Inservice Test (QU), is used to satisfy these requirements. The assured water supply for both trains of NW is provided by the essential header of the Nuclear Service Water (RN) System (EIIS:BI). This water supply is isolated by two solenoid valves, 1NW-8A and 1NW-61B. These valves are also response time tested.

PT/1/A/4200/27, is used to verify NW solenoid valve response times and other performance factors. The response times are obtained by timing the opening of the valves. Two valves require manual isolation to prevent Nuclear Service water from entering the system while the valve is cycled. These valves are 1NW-8A and 1NW-61B. While these valves are isolated, the respective train of NW is technically inoperable.

Technical Specification (Tech Spec) 3.6.6 requires both trains of NW to be operable in Modes 1, 2, 3, and 4. If both trains are inoperable then the requirements of Tech Spec 3.0.3 apply. This Tech Spec states that within one hour, action shall be initiated to place the unit in a mode in which the specification does not apply.

DESCRIPTION OF INCIDENT

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On March 5, 1986, at 0115 hours, Diesel Generator 1A was declared inoperable. This made all Train A equipment technically inoperable, including NW Train A. On March 6, at 1330 hours, PT/1/A/4200/27 was begun on 18 NW valves, including 1NW-8A and 1NW-61B. Unit Supervisor A was requested to have the test logged and have the valve lineups for INW-8A and 1NW-61B performed. Unit Supervisor A informed the test personnel that Train A equipment was inoperable and that the Train A alignment could be done as soon as manpower was available. Test personnel were also informed of the need to see the Shift Supervisor to have the test logged into the Test Logbook. The Shift Supervisor logged the test in and cautioned them not to render any portion of the NW System inoperable. The test on the 16 NW valves that required no valve lineups was then begun. After completing the test for those 16 valves, the test personnel returned to Unit Supervisor A to see if the lineups of the two remaining valves could be done. Unit Supervisor A informed them that manpower would be available soon and to leave the valve

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)		
		YEAR SEQUENTIAL REVISION NUMBER NUMBER			
Catawba Nuclear Station, Unit 1	0 5 0 0 0 4 1 3	8 6 - 0 1 2 - 0 0	013 OF 0 14		

lineup sheets and that they would be called as soon as the alignments were complete. They left both Train A and Train B valve lineup sheets with Unit Supervisor A and at 1558 hours, manpower became available. Unit Supervisor A had both valve lineups performed, isolating both trains of NW from their assured water supply. The test personnel finished testing the last two valves and returned the valve lineup sheets to Unit Supervisor A so that the system alignment could be returned to normal. The workload on the operators was such that it did not allow the valve lineups to be returned to normal until after shift change at 1900 hours. At approximately 2200 hours the system was returned to normal.

On March 7, 1986, at 0230 hours, it was realized that both trains of NW had been inoperable.

CONCLUSION

NRC Form 366A

This incident is classified as being caused by a Defective Procedure, because the test procedure did not provide adequate precautions co indicate that both trains of NW would be inoperable if 1NW-8A and 1NW-61B were tested simultaneously. All test procedures are responsible for including precautions to avoid an abnormal or an emergency situation. A contributing cause to this incident is classified as a Personnel Error. Unit Supervisor A did not adequately check the valve lineups to verify that system operability would not be affected.

The technician who was performing the test had been qualified to the procedure one week before he performed the test. Technicians have not been trained to recognize NW System inoperability. The technician was assigned the test at 1330 hours, and asked to complete the test by 1630 hours in order to get ahead in the test schedule. The test had been scheduled for the next several days and the two valves, 1NW-8A and 1NW-61B had been scheduled to be performed on separate days. The normal procedure for scheduling tests is to interface with the Unit Coordinator to have Operations support scheduled. This allows Operations time to review the test effect on system operability before the work reaches the Shift Supervisor or Unit Supervisor.

Unit Supervisor A made the correct decision as to the effect the valve lineups would have on NW operability the first time he was asked to perform the alignment. When manpower became available later that day, he had both alignments performed making both trains of NW inoperable. Issuance of the valve lineup sheets also required a Tech Spec Action Item Logbook entry to indicate inoperability. Unit Supervisor A was heavily involved with efforts to return Diesel Generator 1A to operability when the technician requested Operations support for the test. Unit Supervisor A was under the impression that the test had to be completed by 1630 hours since that was the time the technician was requested to have the test completed. Operations Management determined that no corrective action was required for this personnel error. LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

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FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)	PAGE (3)	
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The Unit should have been entered into Tech Spec 3.0.3 at 1558 hours, when NW Train B became inoperable. NW Train B remained inoperable until approximately 2200 hours when the alignment was returned to normal. Train A was inoperable throughout this incident due to the inoperability of Diesel Generator 1A.

CORRECTIVE ACTION

NRC Form 366A

- An Intrastation Letter was issued clarifying responsibilities of different Senior Reactor Operators (SRO's) on shift.
- (2) PT/1/A/4200/27, NW Valve Inservice Test (QU), will be revised to include limits and precautions that will prevent valves INW-8A and INW-61B from being tested simultaneously.

SAFETY ANALYSIS

During this incident both trains of NW were technically inoperable. If the system was required to perform its safety function it could have responded properly by using makeup from the Makeup Demineralized Water (YM) System (EIIS:KJ). The YM System had sufficient capacity to makeup to the NW System. In the event that neither YM nor RN makeup is available to the NW System when an Engineered Safety Features signal is actuated, Containment Isolation Valves would likely leak-by at their measured rates. Any leakage would be contained within the various piping systems.

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

DUKE POWER COMPANY P.O. BOX 33189 CHARLOTTE, N.C. 28242

HAL B. TUCKER VICE PRESIDENT NUCLEAR FRODUCTION TELEPHONE (704) 373-4531

JEZZ

April 4, 1986

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

Subject: Catawba Nuclear Station, Unit 1 Docket No. 50-413

Gentlemen:

Pursuant to 10 CFR 50.73 Section (a) (1) and (d), attached is Licensee Event Report 413/86-12 concerning both trains of the Containment Valve Injection Water System being inoperable due to a defective procedure. This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

Hal B. Turker me

Hal B. Tucker

RWO:s1b

Attachment

Document Control Desk April 4, 1986 Page Two

xc: Dr. J. Nelson Grace, Regional Administrator U. S. Nuclear Regulatory Commission Region II 101 Marietta Street, NW, Suite 2900 Atlanta, Georgia 30323

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NRC Resident Inspector Catawba Nuclear Station