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December 10, 1999

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

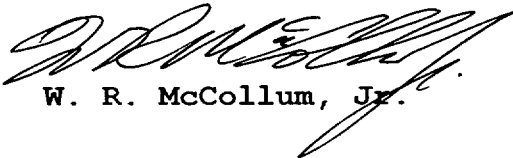
Subject: Oconee Nuclear Station
Docket Nos. 50-269, -270, -287
Licensee Event Report 269/99-08, Revision 0
Problem Investigation Process No.: 0-099-4474

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 269/99-08, concerning technical specification prohibited operation or condition as required by Technical Specification 3.8.3 involving Units 1 and 3.

This report is being submitted in accordance with 10 CFR 50.73 (a) (2) (i) (B). This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,



W. R. McCollum, Jr.

Attachment

IE22

PPR ADDON 05000269

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Date: December 10, 1999

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cc: Mr. Luis A. Reyes
Administrator, Region II
U.S. Nuclear Regulatory Commission
61 Forsyth Street, S. W., Suite 23T85
Atlanta, GA 30303

Mr. D. E. LaBarge
U.S. Nuclear Regulatory Commission
Office of Nuclear Reactor Regulation
Washington, D.C. 20555

INPO Records Center
700 Galleria Parkway, NW
Atlanta, GA 30339-5957

Mr. M. C. Shannon
NRC Senior Resident Inspector
Oconee Nuclear Station

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oconee Nuclear Station, Unit 1		DOCKET NUMBER (2) 05000-269	PAGE (3) 1 OF 5
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TITLE (4)
Improper Notification Prevents Required Technical Specification Actions

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 NAME	DOCKET NUMBER(S)	
11	10	99	1999	-08	-00	12	10	99	Unit 3	05000-287	

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)																				
POWER LEVEL (10) 100	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.36(c)(2)	<input checked="" type="checkbox"/> 50.73(a)(2)(I)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	<input type="checkbox"/> 50.73(a)(2)(x)	<input type="checkbox"/> 73.71(b)	<input type="checkbox"/> 73.71(c)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME L.E. Nicholson, Regulatory Compliance Manager		AREA CODE (864)	885-3292

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)				EXPECTED SUBMISSION DATE (15)			MONTH	DAY	YEAR
YES (if yes, complete EXPECTED SUBMISSION DATE)				<input checked="" type="checkbox"/> X	NO				

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

On November 10, 1999, at 2347 hours with Oconee Units 1 and 3 in Mode 1, at approximately 100% Power and Unit 2 in Mode 6, Refueling, it was discovered that a condition had existed where one control battery (CB) had been removed from service and a second CB was in a degraded state without the necessary actions being completed per TS for Units 1 and 3. On September 20, 1999, the weekly cell parameter surveillance for control battery (CB) 3CB found one of the sixty cells below the minimum voltage. On October 7, 1999, the quarterly cell parameter surveillance for CB 3CB found two of the sixty cells below the minimum voltage. Operations (OPS) was not notified to evaluate battery operability for either surveillance. On November 4, 1999, at 2200 hours, OPS authorized removal of CB 2CA from service to perform testing. OPS was unaware that CB 3CB was already inoperable. CB 2CA was returned to service on November 10, 1999, at 1625 hours. This problem was discovered during a review of outstanding work orders. The cause of the event was Maintenance failure to notify OPS. Corrective actions include procedure changes to add a step for OPS notification, training for Maintenance on proper notification and benchmarking of the notification process at other utilities.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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EVALUATION:

BACKGROUND

This report addresses having a required DC power source out of service longer than the allowable completion time as specified by Technical Specification (TS) 3.8.3 for Units 1 and 3. This is reportable per 10 CFR 50.73 (a) (2) (i) (B), Technical Specification Prohibited Operation Or Condition.

At the time this condition was identified, Units 1 and 3 were in Mode 1 at approximately 100% power and Unit 2 was in Mode 6, Refueling. Control Battery [EIIS:BT] 3CB was inoperable due to a low battery cell float voltage.

The 125 VDC Vital Instrumentation and Control (I&C) [EIIS:EJ] electrical power system provides the AC emergency power system with control power, as well as both motive power and control power for selected safety related equipment. Additionally, the 125 VDC Vital I&C electrical power system provides DC electrical power through DC panelboards to inverters, which in turn supply the AC Vital instrumentation power panelboards.

The 125 VDC Vital I&C electrical power system consists of six power sources shared by the three Oconee Units. Each unit has two power sources with backup sources supplied to the unit's 125 VDC Vital instrumentation distribution system from another unit using a network of isolating diode assemblies. This provides necessary redundancy and independence for the 125 VDC Vital I&C power sources. Each source consists of one 125 VDC battery, a battery charger [EIIS:BYC] for each battery, a distribution center, associated control equipment, isolating transfer diodes and interconnecting cabling [EIIS:CBL]. Additionally, there is one standby battery charger shared between each unit's batteries which provide backup service in the event the preferred battery charger is out of service.

TS 3.8.3 establishes the operability requirements for 125 VDC Vital I&C power sources. When more than one unit is operating, five of the six power sources listed are required to be operable. TS considers the sixth power source as an extra. TS 3.8.5 requires that the battery cell parameters be met for the batteries listed in TS 3.8.3 when the associated power sources are required to be operable. Therefore, an inoperable cell in the sixth battery does not require an operability decision and TS 3.8.5 entry. However, it is essential to track the status of the sixth battery in order to prevent the removal of any other battery from service. Oconee has

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chosen to track the status of the sixth battery by voluntarily logging it as inoperable.

Description of Event

On September 20, 1999, during a weekly battery test on control battery 3CB, pilot cell number 3 float voltage was found to be low. A work request was written, Maintenance Supervision and Engineering were notified. Operations (OPS) was not notified.

On October 7, 1999, during the quarterly battery test on control battery 3CB, cells number 3 and 33 float voltages were found to be low. One work request already existed to upgrade pilot cell number 3. A new work request was written, Maintenance Supervision and Engineering were notified. OPS was not notified.

On November 4, 1999, an Operator removed control battery 2CA from service to perform breaker testing. Breaker testing was performed, completed and control battery 2CA was returned to service on November 10, 1999, at 1625 hours. The Operations group was not aware that battery 3CB was in a degraded condition, since they had not been notified of the change of its condition identified by Maintenance on September 20, 1999 and October 7, 1999.

On November 10, 1999, during a review of outstanding work orders, OPS noted that two work orders existed to upgrade cell number 3 and 33 on control battery 3CB. This was immediately brought to the attention of the Operations Shift Manager.

During the time period that control battery 2CA was out of service, TS 3.8.3 DC Sources - Operating was not met. TS 3.8.3.b states that two additional 125 VDC Vital I&C power sources are required when any other Unit is in Modes 1, 2, 3 or 4. This was not met for Units 1 and 3. Condition A and required action A.1 requires restoring the power source to an operable status within 24 hours. Condition E addresses required actions and completion times not met. The unit is required to be in Mode 3 within 12 hours and Mode 5 within 84 hours. These conditions were not entered; therefore, the required actions and completion times were not met.

Conclusion

The cause of this event is Maintenance failure to notify OPS. The battery cell parameters are listed in the procedure and instructions are provided to notify Maintenance Supervision if the parameters are not met.

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Maintenance Supervision was notified; however, they did not understand that OPS should be contacted. Company policy states that when performing surveillance test procedures to meet TS requirements, the responsible supervisor shall be notified as soon as possible if the acceptance criteria are not met. The supervisor shall immediately notify Operations to determine reportability. Notification of Operations is normally considered a work practice. It has not been a common practice to have a sign-off step in instrumentation and electrical procedures for notifying Operations. While it is not necessary, a procedure step to notify Operations may have prevented this event from occurring.

A review of prior events regarding Maintenance failure to notify OPS was conducted. There were no similar notification problems concerning control batteries. Therefore, this event is considered non-recurring.

CORRECTIVE ACTION:

Immediate:

1. Operations made voluntary TS log entries for control battery 3CB for tracking purposes. Maintenance performed appropriate TS requirements for control battery 3CB and it was declared inoperable on November 11, 1999 at 0023 hours.

Subsequent:

1. Work activities related to control batteries were reviewed and confirmed that no other event had occurred between March 27, 1999 when ITS was implemented and when this problem was discovered on November 10, 1999.
2. An initial Communications Package entitled "Interim Measure on Required Notifications for Tech Spec Conditions" was issued to Maintenance personnel to emphasize that anytime a technical specification condition is entered or not met that Operations, Engineering and Maintenance Technical Support must be notified immediately.

Planned:

1. Appropriate personnel corrective actions will be administered with those involved after the root cause investigation is completed.
2. Review and revise Maintenance battery surveillance procedures that are TS related to include a step for OPS notification.

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3. Lessons learned from the root cause investigation will be incorporated into future Maintenance work plans.

4. Maintenance will evaluate the notification process at other utilities. Recommendations for improvement will be made and implemented on a site basis, as appropriate.

Planned corrective action 2 is considered to be an NRC Commitment Item.

SAFETY ANALYSIS:

Four DC power sources remained operable during this event. These four sources are fully capable of providing adequate voltage to shut down an operating unit and maintain it in a safe shutdown condition. In addition, although slightly degraded, control battery 3CB was still available to provide additional capacity to the entire control battery system.

There were no operational transients or change in operating conditions while the control batteries were in this condition. Having two control batteries inoperable at the same time did not affect the plant's ability to respond appropriately in the event of an accident and/or transient. There were no releases of radioactive materials, radiation exposures in excess of limits, or personnel injuries associated with this event. Therefore, this event is of no safety significance.

The health and safety of the public was not compromised by this event.