

NRC FORM 366 (4-95)				U.S. NUCLEAR REGULATORY COMMISSION				APPROVED OMD NO. 3150-0104 EXPIRES: 04/30/98 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) Ocone Nuclear Station, Unit 2								DOCKET NUMBER (2) 05000270		PAGE (3) 1 of 10		
TITLE (4) Two Trains of Essential Siphon Vacuum System Inoperable Due To Ineffective Corrective Action.												
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)	
08	31	98	1998	06	00	09	30	98			05000	
OPERATING MODE (9)		N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)									
POWER LEVEL (10)		100	20.402(b) 20.405(a)(1)(i) 20.405(a)(1)(ii) 20.405(a)(1)(iii) 20.405(a)(1)(iv) 20.405(a)(1)(v)			20.405(c) 50.36(c)(1) 50.36(c)(2) 50.73(a)(2)(i)(B) 50.73(a)(2)(ii) 50.73(a)(2)(iii)			50.73(a)(2)(iv) 50.73(a)(2)(v) 50.73(a)(2)(vii) 50.73(a)(2)(viii)(A) 50.73(a)(2)(viii)(B) 50.73(a)(2)(x)		73.71(b) 73.71(c) OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
LICENSEE CONTACT FOR THIS LER (12)												
NAME J.E. Burchfield, Regulatory Compliance Manager								TELEPHONE NUMBER 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)								X NO				
ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)												
<p>On August 28, 1998, with Unit 2 at 100% power, while performing Essential Siphon Vacuum System (ESV) Test (PT/2/A/0261/010), valve 2CCW-462 (CCW Inlet High Point Vent Block) was closed as required by procedure. This valve isolated the 2A train of ESV. On August 31, 1998, the ESV 2B train was being tested and 2CCW-463 was closed per procedure. The Test Technicians questioned why 2CCW-463 was not re-opened by the procedure. It was discovered that the procedure did not reopen 2CCW-462 or 2CCW-463. The 2A train had been inoperable since 0942 hours on August 28, 1998 and the 2B train had been inoperable since 1034 hours on August 31, 1998. At 1345 hours on August 31, 1998, Operations declared an unplanned entry into Technical Specification (TS) 3.0. Operations opened 2CCW-462 at 1404 hours so that the 2A train would be operable, and exited TS 3.0. The initiating cause for this event was an inadequate procedure due to inappropriate actions during the preparation and review of the procedure. However, due to previous similar events, the root cause is failure to take effective corrective action. Corrective actions include procedure revisions, enhancements of the procedure review process, and counseling of involved personnel.</p>												

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EVALUATION:**Background**

The Essential Siphon Vacuum System (ESV) is a new system installed by Nuclear Station Modification ON-13000, 23000, and 33000 on Oconee Units 1, 2, and 3 respectively. The Unit 2 system was completed during the Unit 2 EOC16 refueling outage, which ended in May, 1998. The Unit 1 and 3 systems are scheduled to be installed during the next refueling outage on each unit.

ESV is a support system for the Emergency Condenser Circulating Water (ECCW) System, which in turn is a support system for the Low Pressure Service Water (LPSW) System [EIIS:BI]. (The ECCW System is a subset of the Condenser Circulating Water (CCW) System [EIIS:BS].) The ESV System is designed to remove accumulated air from the ECCW siphon headers after a LOCA/LOOP or other LOOP events to maintain an adequate water supply to the suction of the LPSW pumps for long term core and containment cooling. It will also maintain the ECCW piping primed and "siphon ready" during normal operation by removing accumulated air.

Valves 2CCW-462 and 463 are CCW Inlet High Point Vent Block valves located at the ESV suction to the CCW piping.

Technical Specification (TS) 3.19.1 requires two ESV headers to be operable on Unit 2, except that TS 3.19.1c allows operation with only one header for up to 72 hours, after which the Unit must be placed in hot shutdown within 12 hours. TS 3.19 does not contain a provision for the condition where no headers are available. TS 3.0 contains provisions equivalent to TS 3.0.3 of Standardized TS.

Description of Event

A Temporary Test (TT) Procedure (Essential Siphon Vacuum System Post Modification Test, TT/2/A/0261/009) was prepared to test the new Essential Siphon Vacuum (ESV) system which was installed on Unit 2 per NSM ON-23000 and related modifications. This procedure was prepared by System Engineer

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A, and the cross disciplinary review was performed by Operations SRO A. This procedure was performed on April 26, 1998.

In accordance with Technical Specification (TS) 4.1.2 and TS Table 4.1-2, the ESV must be tested quarterly. Therefore, following the completion of TT/2/A/0261/009, a new Periodic Test (PT) procedure, designated PT/2/A/0261/010 (Essential Siphon Vacuum System Test), was created for routine periodic testing of the ESV. The test due date was July 26, 1998, with a latest acceptable date of September 8, 1998.

On Friday, August 28, 1998, the Operations Test Group (OTG) began performing PT/2/A/0261/010 for the first time. At 0942 hours the ESV Train A was logged as Out of Service (OOS) for the test. Several problems were encountered, such as a rotometer flow meter which read off scale high and a Test Acceptance Criteria which had been inaccurately converted from PSIA to Inches Hg vacuum. These required procedure changes to be processed to correct the procedural deficiencies.

As a result, it was late in the afternoon when the OTG technicians completed the Train A portion of the ESV procedure. It was decided that the Train B portion of the procedure would be performed on Monday, August 31, 1998. The Operators logged that the LCO for the ESV Train A was exited at 1650 hours.

On August 31, 1998, OTG personnel began preparations for completing the Train B portion of the test. However, the work schedule had not been properly updated to show that this activity was being carried over. As a result, there was a delay while the risk impact of this test was evaluated with respect to other activities on the schedule.

At 1034 hours the ESV Train B was declared OOS and the LCO entered for the test. The testing began at 1100 hours. At approximately 1300 hours, two OTG Technicians closed 2CCW-463 (located at the CCW Intake) to isolate the 2B header from the CCW System. As the two OTG Technicians returned to ESV Building, they recognized that the procedure did not return 2CCW-463 to the open position when the test is complete. At that time, they called System Engineer A and it was discovered that 2CCW-462 was also not reopened by the procedure. It had been closed since Train A was tested on August 28, 1998.

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Operations was notified that Train A had been OOS since 0942 hours on August 28, 1998, and Train B was OOS since approximately 1034 hours, when the LCO was entered. At 1345 hours, Operations declared and logged an unplanned entry into TS 3.0.

At 1404 hours the Operators reopened 2CCW-462, which returned Train A to service and allowed Unit 2 to exit TS 3.0

A Red Phone notification was made to the NRC at 1443 hours.

Problem Investigation Process (PIP) report 2-098-4153 was generated to document the event.

At 2000 hours, 2CCW-463 was opened following a procedure change and completion of the Train B portion of the test.

Also during the completion of the test on August 31, 1998, several other procedure deficiencies and enhancements were noted.

A root cause investigation was initiated.

The investigation found that TT/2/A/0261/009 verified that 2CCW-462 and 2CCW-463 were initially closed. The valves were left closed by the TT but were properly aligned by the appropriate Operating Procedure prior to Unit 2 start-up from the outage.

System Engineer A developed a draft periodic test procedure based on TT/2/A/0261/009 and gave the draft to the Operations Procedure Group on June 5, 1998 for their use in preparing PT/2/A/0261/010.

On July 21, 1998, PT/2/A/0261/010 was prepared and signed by Operations Procedure Writer A.

PT/2/A/0261/010 was initially scheduled for July 30, 1998 by the OTG Scheduler. The test was rescheduled to August 25, 1998, at the request of Operations Procedure Writer A to allow additional time for procedure validation and additional reviews, due to this being a first time test.

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On July 22, 1998, the OTG Procedure Validation was performed. The validation identified several significant problems with the information provided in the procedure and labeling in the field.

On August 12, 1998, an additional review was completed by System Engineer A, after incorporation of several requested enhancements.

On August 21, 1998, Operations Qualified Reviewer A completed the cross disciplinary review of the PT.

On August 24, 1998, System Engineer B completed the Qualified Review and Operations SRO B signed the approval of the PT.

On August 25, 1998, the PT was scheduled to be performed at 0800 hours. At 0730 hours, at an OTG Status Meeting, specific team members were assigned to run the test. The OTG personnel began reviewing the procedure and it became apparent that no OTG personnel were formally qualified on the system in accordance with the Employee Training and Qualification System (ETQS). At this time, the OTG lead person contacted System Engineer A to request "just in time training" and also notified the Work Control Center of the delay. The "just in time training" was performed by System Engineer A. During the training, several additional labeling discrepancies were observed and a temperature monitoring device was found not working.

On August 27, 1998, System Engineer A initiated PIP 2-098-4107 to address the adequacy of the portion of the procedure which tested the ESV float valves. Also, PIP 2-098-4116 was initiated to document the problems identified during the performance of the procedure validation and training which resulted in delays such that the procedure could not be performed as scheduled.

On August 28, 1998, the PT/2/A/0261/010 was initiated. As described earlier, additional issues were discovered related to rotometer readings and the accuracy of the Test Acceptance Criteria which led to the decision to defer the Train B portion of the test until August 31, 1998. In addition, several other procedure deficiencies and enhancements were noted during the completion of the test on August 31, 1998.

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On September 1, 1998, PT/2/A/0261/010 was placed on administrative hold until all deficiencies and enhancements associated with this procedure were addressed.

CONCLUSIONS:

The initiating cause of this event was a Procedural Deficiency in that PT/2/A/0261/010 did not contain appropriate steps to re-open 2CCW-462 and 2CCW-463. This Procedural Deficiency resulted from a series of inadequate reviews and oversights on the part of System Engineer A (the author of the initial draft), Operations Procedure Writer A (who produced the final draft), Operations Qualified Reviewer A (the cross disciplinary reviewer), and System Engineer B (the Qualified Reviewer) as they prepared and reviewed this procedure.

The number of problems which occurred, and deficiencies which were observed, during the performance of this test indicates that the overall quality of the procedure reviews was not adequate.

The root cause investigation noted that the guidance provided for use when performing procedure reviews does not appear to assist the reviewer in addressing issues of technical content. However, it has long been an established principle that components manipulated during a test should be returned to their initial or normal state by the test procedure.

There have been a number of events which have occurred within the last year resulting from inadequate preparation and review of Operating Procedures (OPs) and Operations Periodic Test (PTs) procedures and procedure changes (see below). Most of these have been classified as Less Significant Events as defined by the PIP process but one was a More Significant Event (MSE). The Operations Group implemented several corrective actions which were intended to address the issue of inadequate preparation and review of Operations Group procedures and procedure changes. Most of these corrective actions were documented as being complete and in place but failed to prevent this event. Therefore, the root cause of this event is considered to be failure to take effective corrective action.

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A review of the Oconee PIP data base identified the following PIPs involving Operations Group procedures, including both OP and PT Procedures:

PIPs 2-097-0437 and 1-097-4363 addressed PTs which either specified incorrect positions of components or did not return components to the proper position. PIP 0-097-3877 addressed the general quality of procedure validations. Corrective actions from these PIPs did not address program enhancements. PIP 0-097-3642 resulted from a Self Assessment and addressed the expectations of reviewers (Corrective action complete in January, 1998) and prioritization of changes with the intent to address timeliness of reviews and time pressure (Corrective action complete in May, 1998).

PIPs 1-097-4578, 1-097-4270, 1-097-4273 and 1-097-4286 involved OPs which resulted in mispositioned components leading to alarms, spills, and an inability to make-up to the RCS using a path which was believed to be in service. The corrective actions from the individual PIPs did not address program enhancements.

These four PIPs were referenced as examples in Violation 97-16-03. PIP 0-98-0068 was issued to track the response to the violation and included corrective actions which addressed the organization of the Operations Procedure Writers section, and communication of "raised expectations" for quality and accuracy of procedures. Additionally, the Oconee Recovery Plan was amended to include a new initiative entitled "Technical Accuracy of Operating Procedures". This initiative established milestones and measures for raising the standards of Oconee Operating Procedures. The milestones and measures included:

- Conversion of procedures from WordPerfect to Word (complete July 31, 1998)
- Reduce backlog of unprocessed procedure changes (reduced backlog from 1470 in January, 1998 to 566 in September 1998)
- Standardized Milestones for pre-outage preparation and revision of procedures for, or affected by, outage activities (included specified milestones for completion of various reviews prior to the

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start of the Unit 3 EOC 17 Refueling outage - milestones created May 1998, procedures completed September, 1998)

- Implementation of the priority system from the PIP 0-097-3642 Self Assessment (complete May, 1998)
- Benchmarking visits to non-Duke sites (Visits not complete, no process revisions implemented yet)
- Implementation of Improved Technical Specifications (ITS) - (in progress, due approximately January 1, 1999).

The cumulative effects of these changes were expected to lead to higher quality Operations procedures while minimizing the potential for human error. However, they were not adequate to prevent this event.

There were no radioactive releases, personnel injuries or over exposures, or NPRDS reportable failures associated with this event.

CORRECTIVE ACTIONS:**Immediate:**

1. Entered Technical Specification (TS) 3.0, then reopened 2CCW-462 to exit TS 3.0.
2. Revised the Periodic Test procedure to reopen 2CCW-462 and 2CCW-463.
3. Completed the test on Train B which included reopening 2CCW-463.

Subsequent:

1. Placed the Periodic Test procedure on "Administrative Hold" pending revision to resolve other observed deficiencies.
2. Appropriate revisions were made to PT/2/A/0261/010.

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Planned:

1. Counsel individuals who performed the inappropriate actions in this event. Other procedure writers and reviewers in Operations will receive training on the issues and lessons learned from this event.
2. Develop a more detailed technical issues checklist for use within Operations and Engineering during Operating and Operations Test Group Periodic Test procedure development and review. This checklist should utilize lessons learned from past Operating Experience items involving procedure deficiencies.
3. Review and revise, as appropriate, the Operations procedure validation process to ensure technical deficiencies are identified.
4. Initiate a trial process to perform roundtable reviews of new Operating and Operations Test Group Periodic Test procedures. This should involve the procedure author, operators and/or Test Group personnel who would perform the procedure, and appropriate System Engineers.

Planned corrective actions 1, 2, and 3 are considered to be NRC Commitment Items. These are the only NRC Commitment items contained in this LER.

SAFETY ANALYSIS:

The Essential Siphon Vacuum System (ESV) is a new support system for the Emergency Condenser Circulating Water (ECCW) System, which in turn is a support system for the Low Pressure Service Water (LPSW) System. (The ECCW System is a subset of the Condenser Circulating Water (CCW) System.) The ESV System is designed to remove accumulated air from the ECCW siphon headers after a LOCA/LOOP or other LOOP events to maintain an adequate water supply to the suction of the LPSW pumps for long term core and containment cooling. It will also maintain the ECCW piping primed and "siphon ready" during normal operation by removing accumulated air.

Prior to installation of the ESV on Unit 2 and it's incorporation into Technical Specifications (TS), the operability of the emergency function of

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the CCW system as a source of LPSW was controlled by Selected Licensee Commitment (SLC) 16.9.7. Throughout this event, the Unit 2 ECCW System continued to meet the requirements of SLC 16.9.7 and would have been considered fully operable if the new TS was not in force. In addition, the Unit 1 and 2 LPSW system is a shared system. The LPSW suction source is a shared header supplied from the CCW systems of Units 1, 2 and 3. The Unit 1 and 3 supplies have not yet been modified, and, therefore, are not yet subject to the new TS. The Unit 1 and 3 supplies were fully operable throughout the event.

Therefore, although Unit 2's systems would not have had the benefit of the enhancements provided by the ESV system, they were fully capable of performing their safety function. Also, Units 1 and 3 each provided a fully redundant system performing the same function. Therefore, this event had no impact on the health or safety of the public.