

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 Two

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05000 270

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TITLE (4) Technical Specification Required Shutdown Due To Inadequate Work Planning

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)	
09	18	96	96	-	03	-	01	01	21	99	05000

OPERATING MODE (9) N

POWER LEVEL (10) 100%

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)

20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME

J. E. Burchfield, Jr. - 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
F	BG	MO	W120	Yes					

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)

On September 18, 1996, at 0132 hours, with Unit 2 at 100% full power the 2B High Pressure Injection pump tripped. The alternate pump automatically started as designed. This required Unit 2 to enter a Technical Specification (TS) 72 hour Limiting Condition for Operation (LCO). An investigation was initiated to determine the cause of the failure. Problems were encountered in the process of investigation and replacing the failed motor. On September 21, 1996, at 0132 hours, the LCO time frame expired and a 12 hours to Hot Shutdown action statement was entered. At 0800 hours, Unit 2 shutdown was initiated and at 1235 hours, the unit was at hot shutdown. At 1606 hours, the 2B HPI pump motor was replaced and tested satisfactorily. The root cause of the required shutdown is Work Planning; Job scoping did not identify special circumstances. A contributing cause is inadequate management monitoring activities. Corrective actions include revising the work processes. Revision 1 identifies that the HPI discharge headers were cross-connected for greater than the 24 hours permitted by TS 3.3.1.a.(2). Also, the shutdown requirements of TS 3.3.1.a.(2) were not met. This condition was identified on September 22, 1998, and was caused by an inadequate technical specification. Corrective actions include procedure revisions, developing a Technical Specification interpretation and submitting a License Amendment Request.

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**EVALUATION:****Background**

The High Pressure Injection (HPI) [EIIS:BG] is a safety related system providing the Reactor Coolant (RC) [EIIS:AB] system makeup, RC volume control, seal injection to the RC pumps, and Emergency Core Cooling during an accident. There are three HPI pumps, each capable of taking suction from the Letdown Storage Tank during normal operation or the Borated Water Storage Tank during an emergency. Each HPI pump is a 24 stage, vertical centrifugal pump and is powered by a 600 HP electric motor.

When the Reactor Coolant System (RCS), with fuel in the core, is in a condition with temperature > 350°F and reactor power less than 60% full power, Technical Specification 3.3.1.a.(1) requires two independent trains to be operable; each train is comprised of an HPI pump and a flow path capable of taking suction from the borated water storage tank and discharging into the RCS automatically upon Engineered Safeguard Protective System actuation. TS 3.3.1.a.(2) permits this requirement to not be met for 24 hours, following this allowed outage time the plant is required to be placed in hot shutdown within 12 hours. If the requirements are not met within 24 hours following hot shutdown, the reactor is required to be placed in a condition with the RCS temperature below 350°F within an additional 24 hours.

When reactor power is > 60% full power, TS 3.3.1.c.(1) requires TS 3.3.1.a.(1) to be met, the remaining HPI pump and valves HP-409 and HP-410 to be operable, and valves HP-99 and HP-100 to be open. TS 3.3.1.c.(2) permits any component of the HPI system to be inoperable for 72 hours provided two trains of the HPI system are operable. If the component is not restored within 72 hours, the plant is required to be placed in a condition with reactor power < 60% full power within an additional 12 hours.

The Failure Investigation Process is a method used by Oconee Nuclear Station to identify the factors that contributed to the failure of a component.

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**Description of Event**

On September 18, 1996, at 0132 hours, with Unit 2 at 100% full power, the 2B High Pressure Injection (HPI) pump tripped. The 2A HPI pump automatically started to supply the makeup. A 72 hour Technical Specification (TS) Limiting Condition for Operation (LCO) was entered. A HPI pump area fire alarm was received concurrent with the 2B HPI pump trip. Operations personnel inspected the area and discovered heat damage at the 2B HPI pump motor junction box. There was no fire observed at the pump or in the area. At 0200 hours, a work request was written to investigate/repair the motor. At 0201 hours, Operations personnel began to implement OP/2/A/1104/02, Enclosure 6.17, which defined operation with either HPI pump 2A or 2B inoperable. The following actions were performed in accordance with this procedure:

- At 0225 hours, the HPI discharge headers were cross-connected by opening 2HP-116. TS 3.3.1.a.(2) should have been entered at this time, but it wasn't.
- At 0232 hours, HPI pump 2C was started, and HPI pump 2A was stopped and placed in auto.

At 0235 hours, the electrical isolation was completed. Operations personnel and the Shift Work Manager (SWM) discussed the Failure Investigation Process (FIP) and how this should be coordinated with the troubleshooting and repair. The SWM began the process of determining who would be needed to perform the FIP and repair of the HPI pump. There was an oil leak associated with a main transformer that was discovered at 0325 hours. As a result of this situation, the SWM decided to notify the appropriate personnel for the HPI problem later in the shift.

At approximately 0515 hours, the Shift Work Manager contacted the appropriate duty person to initiate the FIP process. The appropriate equipment failure engineering manager was contacted at 0530 hours. The engineering manager contacted an engineering supervisor who contacted engineer A for initiating a FIP at 0600 hours. When the engineer A reported to work at 0700 hours he attended the morning meeting for the discussion of the failure and the identification of FIP team members. A FIP team meeting was conducted at 0745 hours to determine the actions to

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take and who would be required to perform the work. At 0830 hours, an observation of the 2B HPI pump area was performed. The qualified technicians normally assigned to perform the work were in training. Other qualified technicians were obtained from a different work discipline. Another FIP meeting was held at 1000 hours to determine the work scope. The total isolation of the 2B HPI pump electrically and hydraulically was completed and the pump had been rotated at 1130 hours. A third FIP meeting was held at 1230 hours, to identify the proper method to strip the motor leads for testing. The technicians had problems with the test setup but eventually completed the testing at 1430 hours. The motor failed the test and the decision to replace the motor was made at the fourth FIP meeting at 1530 hours. The final actions required for removal of the motor began at 1600 hours.

On September 19, 1996, at 0600 hours the HPI pump motor had been replaced and preparations were in progress for alignment of the motor to the pump. Engineer B, who has the responsibility for large pumps, decided to use an existing coupling set that had been previously used on the spare HPI pump motor. A motor run uncoupled was completed at 2312 hours. Work associated with installation of the pump coupling was initiated.

On September 19, 1996, at 0225 hours, the 24-hour LCO of TS 3.3.1.a.(2) expired. Thus, the plant should have closed 2HP-116 or entered a 12-hour action statement for placing the plant in hot shutdown. This condition was not identified. On September 19, 1996, at 1425 hours, the plant should have been in hot shutdown. However, this did not occur, because the Operations personnel did not recognize that TS-3.3.1.a.(2) applied. The applicable procedure OP/2/A/1104/02, "High Pressure Injection System," contained an interpretation which directed the operators to enter the 72-hour LCO of TS 3.3.1 when the HPI discharge headers are cross-connected and RCS temperature > 350°F.

On September 20, 1996, at approximately 1200 hours, problems with the alignment of the couplings were encountered. At approximately 1400 hours engineer B discussed the situation with the Maintenance Superintendent. A decision was made to begin machining a custom coupling set while continuing the attempt to align the existing couplings to the pump and motor. There were delays in locating machinists to perform the work on the coupling set. At approximately 1800 hours, the machinists were on site to begin work on

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the coupling set. The existing coupling alignment attempt was discontinued at approximately 2200 hours and the new couplings were ready for installation at 2400 hours. The technicians worked through the night to remove the existing couplings.

On September 21, 1996, at 0132 hours, the allowed outage time of TS 3.3.1.c.(2) expired when HPI pump 2B had been inoperable for greater than 72 hours. A 12 hour action statement was entered to be at Hot Shutdown conditions by 1332 hours.

On September 21, 1996, at approximately 0700 hours, the work to remove the existing couplings was complete. At 0800 hours, Operations began power reduction. At 0801 hours, a one hour non-emergency phone call was made to the NRC, per 10 CFR 50.72. At 1235 hours, the unit was subcritical at Hot Shutdown. At 1300 hours, the alignment was completed.

Following satisfactory testing at 1606 hours, the pump was declared operable and placed in service. At 1646 hours, 2HP-116 was closed, and the discharge headers were hydraulically separated.

The failed motor was shipped to the manufacturer and disassembled on September 26, 1996. On October 2, 1996, the results of the analysis indicated that the probable cause of the motor failure is a random insulation failure due to localized degradation of insulation.

Conclusions for Revision 0

The root cause of this event is Work Organization/Planning; Job scoping did not identify special circumstances. Items which added time to the process were:

1. The Shift Work Manager did not expedite the Failure Investigation Process (FIP) or decide the priority of repair versus investigation. A transformer oil leak, that occurred about the same time, had some impact on this process.
2. The FIP process is not well understood by the personnel involved.

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3. Since qualified personnel were in training, extra time was spent obtaining qualified personnel to do the troubleshooting and repair.

4. Since the decision to use the existing coupling set was made, there was no machinist scheduled for work on the weekend. Extra time was spent locating machinists.

It is concluded that successful completion of any of these items could have prevented exceeding the Technical Specification (TS) Limiting Condition for Operation (LCO).

A contributing cause to the event is less than adequate monitoring and oversight of the total job scope.

A historical search of events and problem reports over the last two years indicates there have not been any failures resulting in TS required shutdown of a unit. The Operating Experience database indicated that there have been motor failures, however, there have been no motor failures of this type.

The HPI pump motor is a Westinghouse model number CSP-688.5P30. The failure of the motor is NPRDS reportable.

There were no personnel injuries, radiation exposures, or releases of radioactive materials associated with this event.

#### Conclusions for Revision 1

When the RCS temperature is > 350°F and the reactor power is < 60% FP, TS 3.3.1.a(1) requires two independent HPI trains to be operable. Compliance with this specification requires the physical separation of the two HPI trains.

When reactor power is > 60% FP, TS 3.3.1.c(1) requires the HPI suction headers to be cross-connected (i.e., valves HP-99 and HP-100 to be open) and HP-409 and HP-410 to be operable. The requirement to cross-connect the HPI suction headers conflicts with the requirements of TS 3.3.1.a(1). However, operation with the HPI suction headers cross-connected was

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approved by the Nuclear Regulatory Commission (NRC) in a Safety Evaluation Report dated December 13, 1978.

Additionally, the NRC granted approval in this SER to utilize manual operator actions, in lieu of automatic actuation, to place a second HPI train in service within 10 minutes post-accident. These operator actions include cross-connecting the HPI discharge headers post-accident. The ability to perform this action is assured by TS 3.3.1.c(1) which requires that HP-409 and HP-410 be operable. However, operation with the HPI discharge headers cross-connected during normal operation was never approved by the NRC.

The Technical Specifications were revised to reflect the modification regarding HP-409 and HP-410 after the modification was installed at each of the units. These Amendments were:

Amendment Nos. 81, 81, and 78 for Unit 1  
 Amendment Nos. 105, 105, and 102 for Unit 2  
 Amendment Nos. 73, 73, and 70 for Unit 3

These amendments were deficient, in that they resulted in inconsistencies between the technical specification requirements for HPI when reactor power is < 60% full power and when reactor power is > 60% full power. There are a number of inconsistencies between TS 3.3.1.a and TS 3.3.1.c. TS 3.3.1.a.(1) requires two independent flow paths to be operable, while TS 3.3.1.c.(1) requires the HPI suction headers to be cross connected (i.e., HP-99 and HP-100 opened). Additionally, TS 3.3.1.c.(1) requires HP-409 and HP-410 to be operable; this requirement ensures that the capability exists to manually cross-connect the discharge headers. Also TS 3.3.1.a.(1) requires the trains to be capable of automatic injection, while TS 3.3.1.b.(2) simply states that two trains must be operable.

Additionally, several interpretations (issued on November 26, 1990, November 21, 1990, and July 7, 1995) and a special report (October 22, 1990) have been issued regarding Technical Specification 3.3.1. This provides additional evidence that the requirements of Technical Specification 3.3.1 are poorly worded.

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Thus, the root cause of this condition is an inadequate technical specification. As a result, the verbatim requirements of TS 3.3.1 were not fully understood. On January 7, 1992, a non-conservative interpretation of TS 3.3.1 was incorporated into OP/2/A/1104/02, "High Pressure Injection System." A caution was provided to inform the operators that a 72-hour LCO per TS 3.3.1 applied when the HPI discharge headers are cross-connected and RCS temperature > 350°F.

**CORRECTIVE ACTION:****Immediate:**

1. Operations verified the 2A High Pressure Injection (HPI) pump was supplying proper Reactor Coolant Pump seal injection flow.
2. A problem investigation process (PIP) form was issued to document the non-conservative interpretation.

**Subsequent:**

1. The 2B HPI pump motor was removed and shipped to the manufacturer for further analysis.
2. The spare motor was installed and tested satisfactorily.
3. A License Amendment Request (LAR) was submitted on December 16, 1998, resolving the issue. It incorporates specific requirements regarding the hydraulic separation of the HPI discharge headers when RCS temperature is > 350°F. Also, the LAR resolves other known deficiencies with the Technical Specification (TS) requirements regarding the HPI System.
4. A TS interpretation was developed to ensure that TS 3.3.1.a.(2) is entered when the HPI discharge headers are cross-connected with Reactor Coolant System (RCS) temperature > 350°F. It was approved by the Station Manager on January 21, 1999.



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5. The applicable operating procedures were revised by replacing the reference to the 72-hour allowed outage time with a general reference to the TS.

**Planned:**

1. Review the process for addressing the failure of Technical Specification (TS) required equipment and revise as necessary to ensure all work is coordinated in a timely manner.
2. Provide more detailed training to appropriate personnel on the Failure Investigation Process.

**SAFETY ANALYSIS:**

The failure of one High Pressure Injection pump is identified in the Technical Specification (TS) as a 72 hour Limiting Condition for Operation. In this event, the HPI pump was inoperable for a time period which exceeded the LCO. The unit was shutdown within the 12 hour time frame. On September 21, 1996, the HPI pump was returned to operable status at 1606 hours (2 hours 34 minutes after the unit had been shutdown).

The HPI system prevents uncovering the core for small Reactor Coolant System (RCS) piping leaks where high system pressure is maintained, and to delay uncovering the core for intermediate sized leaks. The Final Safety Analysis Report Chapter 15 has shown that two HPI pumps through two injection trains are sufficient to prevent core damage for those smaller leak sizes which do not allow the RCS pressure to decrease rapidly to the point where the Low Pressure Injection system is initiated.

This event was evaluated for Probability Risk Assessment concerns and the resulting conditional core damage frequency is much less than  $1.0E-06$ .

Cross-connecting the discharge headers places the plant in TS 3.3.1.a.(2). The Operations personnel did not realize that TS 3.3.1.a.(2) applied. Thus, the requirements of this TS were not met. The plant was shutdown at 1235 on September 21, 1996, (46 hours and 10 minutes later than it should have been). The HPI discharge headers were hydraulically separated on September 21, 1996, at 0646 hours. This was 3 hours 14 minutes after the

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unit had been shutdown in accordance with TS 3.3.1.c.(2). During this time, two HPI pumps were operable; thus, the HPI system remained capable of performing its safety function even with the HPI discharge headers cross-connected.

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