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McGuire Nuclear Station
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DUKE POWER

October 5, 1994

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

Subject: McGuire Nuclear Station Unit 1
Docket No. 50-369
Licensee Event Report 369/94-06
Problem Investigation Process No.: 1-M94-0959

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 369/94-06 concerning a missed Technical Specification Surveillance Test. This report is being submitted in accordance with 10 CFR 50.73 (a) (2) (i). This event is considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

A handwritten signature in cursive script, appearing to read 'T.C. McMeekin'.
T.C. McMeekin

jca

Attachment

xc: Mr. S.D. Ebnetter
Administrator, Region II
U.S. Nuclear Regulatory Commission
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Atlanta, GA 30323

INPO Records Center
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Mr. Victor Nerses
U.S. Nuclear Regulatory Commission
Office of Nuclear Reactor Regulation
Washington, D.C. 20555

Mr. George Maxwell
NRC Resident Inspector
McGuire Nuclear Station

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PDR ADDCK 05000369
S PDR

JE22

bxc: B.L. Walsh (EC11C)
P.R. Herran (MG01VP)
R.C. Norcutt (MG01WC)
K.L. Crane (MG01RC)
B.F. Caldwell (MG01VP)
R.N. Casler (EC05N)
S.G. Benesole (ON03RC)
G.H. Savage (EC06E)
G.B. Swindlehurst (EC11-0842)
M.S. Tuckman (EC07H)
R.F. Cole (EC05N)
D.B. Cook (EC13A)
G.A. Copp (EC05O)
Tim Becker (PB02L)
J.I. Glenn (MG02ME)
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Zach Taylor (CN01RC)
L.V. Wilkie (ON05SR)
D.P. Kimball (CN03SR)
NSRB Support Staff (EC05N)

LICENSEE EVENT REPORT (LER)

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 (MNRB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME(1)

McGuire Nuclear Station, Unit 1

DOCKET

NUMBER(2)
05000 369

PAGE(3)

1 OF 4

TITLE(4)

Failure To Perform A Slave Relay Test Associated With One Containment Isolation Valve Due To Improper Work Practices.

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 NAMES	DOCKET NUMBER(S)
09	09	94	94	06	0	10	09	94	N/A	05000
										05000

OPERATING

1

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

MODE(9)

20.402(b)

20.405(c)

50.73(a)(2)(iv)

73.71(b)

POWER

100%

20.405(a)(1)(i)

50.36(c)(1)

50.73(a)(2)(v)

73.71(c)

LEVEL(10)

20.405(a)(1)(ii)

50.36(c)(2)

50.73(a)(2)(vii)

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)

OTHER
(Specify in
Abstract below
and in Text
NRC Form 366A)

LICENSEE CONTACT FOR THIS LER(12)

NAME

Ricky J. Deese, Manager, McGuire Safety Review Group

TELEPHONE NUMBER

AREA CODE

704

875-4065

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

MONTH

DAY

YEAR

SUBMISSION

DATE(15)

YES (If yes, complete EXPECTED SUBMISSION DATE)

X

NO

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

On August 10, 1994, at 0845, a staff member in the Operations Procedure group was preparing a procedure change for both Unit 1 and Unit 2 Slave Relay Test Procedures. While comparing the procedures, a discrepancy was noted. Further investigation revealed that the Steam Generator 1B, Blowdown Line Sample Inside Containment Isolation Valve, 1NM200B, was not included in the Unit 1 procedure. The staff member revised the procedure and had the slave relay test performed. The test verified that the valve would have operated as designed. The valve is normally closed. The slave relay associated with this valve was periodically tested as required; however, the contacts associated with valve 1NM200B were not verified operable. The cause of this event is attributed to improper Work Practices due to the failure to identify an error made during a procedure revision. The valve was inadvertently omitted from the procedure during a revision in August, 1991. Corrective actions include a review of all Slave Relay Test procedures to assure all equipment is tested and continuing training for all Qualified Reviewers. Unit 1 was in Mode 1, Power Operation, at 100% power, at the time of discovery.

LICENSEE EVENT REPORT
(LER) TEXT CONTINUATION

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.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
McGuire Nuclear Station, Unit 1	05000 369	94	06	0	2	OF	4

EVALUATION:

Description of Event

In August of 1991, Performance personnel made administrative changes to the Unit 1 Train B Slave Relay [EIIS:RLY] Test procedure, PT/1/A/4200/28B. The reissue included updating the procedure to incorporate several minor changes that had been made to the procedure previously and made some extensive changes to the procedure format. During the process, the Steam Generator [EIIS:SG] 1B, Blowdown [EIIS:WI] Line Sample (NM System) [EIIS:KN] Inside Containment Isolation Valve [EIIS:ISV], 1NM200B was inadvertently omitted from the procedure. The procedure change was approved on September 10, 1991. Subsequent quarterly slave relay tests failed to include a continuity check of the contacts associated with valve 1NM200B.

On August 10, 1994, a staff member in the Operations Procedure group was preparing a change to all four slave relay test procedures associated with Unit 1 and 2, Train A and B. A discrepancy was found between the Unit 1 and Unit 2, Train A procedures. Investigation revealed that the Unit 1 procedure did not include valve 1NM200B. The valve was declared inoperable and entered into the Technical Specification Action Item Log book. Action was then immediately taken to revise the procedure and perform the slave relay test associated with valve 1NM200B. The test was performed successfully on August 10, 1994, confirming the contacts had been operable since the last test. Unit 1 was in Mode 1, Power Operation, at 100% power, at the time of discovery.

Conclusion

This event is assigned a cause of improper Work Practices. Both the individual making the change and the individual performing the Qualified Review of the revision failed to identify the valve being omitted. Discussions with them during this investigation did not reveal a cause for the oversight; however, both agreed that the omission of valve 1NM200B was an error and should have been identified during their review. Corrective actions include a review of all four slave relay test procedures to assure all components actuated by the slave relays are included in the test procedures. Also, management will review this LER with all Qualified Reviewers emphasizing their responsibility to assure procedures are changed accurately.

A review of the Problem Investigation Process (PIP) data base for the past 24 months revealed 4 reportable events which involve the failure to perform a TS required

LICENSEE EVENT REPORT
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surveillance due to improper Work Practices. These events were documented on Licensee Event Reports 369/93-07, 370/94-01, 370/94-02, and 370/94-03. Even though these events involved groups other than the Performance/Operations Test Group, as well as different procedures, and different improper actions; missed TS Surveillance Tests are a recurring problem. Corrective Actions were specific to those events and even though they were put in place after this event, they would not have prevented this event from occurring. An adverse trend involving missed TS Surveillance Tests had been entered into the PIP data base prior to this event. A self assessment of the TS Surveillance Testing program has been completed. Corrective Actions associated with the self assessment have been identified.

This event is not Nuclear Plant Reliability Program (NPRDS) reportable.

There were no personnel injuries, radiation overexposures, or uncontrolled releases of radioactive material resulting from this event.

CORRECTIVE ACTIONS:

- Immediate:
- 1) Operations personnel declared valve 1NM200B inoperable and listed it in the Technical Specification Action Item Log book.
 - 2) Operations Procedure Group personnel revised PT/1/A/4200/28B to include valve 1NM200B.
 - 3) Operations Test Group personnel tested the slave relay associated with 1NM200B.
- Subsequent:
- 1) Operations Procedure Group personnel originated PIP 1-M94-0959 to document the discrepancy and have it investigated.
 - 2) Performance personnel and the Qualified Reviewer responsible for the August, 1991 procedure change have reviewed this event and understand the significance of the error that was made.

LICENSEE EVENT REPORT
(LER) TEXT CONTINUATION

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- Planned:
- 1) Electrical System Engineering personnel will coordinate a review of all slave relay test procedures to assure all components actuated by the relay are included in the appropriate procedure.
 - 2) Site Management personnel will review this LER with all Qualified Reviewers emphasizing their responsibility to assure procedure changes are implemented accurately.

SAFETY ANALYSIS:

This event had minimal safety significance. Valve 1NM200B is a one inch Kerotest valve. The slave relay for this valve was successfully tested on August 10, 1994. This test verified that during the time period the slave relay test for this valve was not being performed, (September 10, 1991, through August 10, 1994) the contacts would have operated as required. Chemistry personnel stopped using the sample line associated with this valve in March of 1989. Since that time the normal state for the valve has been the closed position. Since valve 1NM200B is a containment isolation valve, the required position for an Engineered Safety Features (ESF) actuation signal is closed. The valve has been successfully tested during the ESF test performed during refueling outages. In addition to these tests, the master relays have been checked on a monthly basis verifying that the slave relay for this valve would receive a signal. The slave relay for valve 1NM200B has been checked on a quarterly basis. These checks included operability verification of the relay and all associated components except valve 1NM200B.

At no time were the health and safety of the public or plant personnel affected by this event.