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DUKE POWER

April 16, 1990

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

Subject: McGuire Nuclear Station Unit 2
Docket No. 50-370
Licensee Event Report 370/90-02

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report 370/90-02 concerning a missed Technical Specification surveillance of the Ice Condenser intermediate deck doors. 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,

Tony L. McConnell

T.L. McConnell

DVE/ADJ/cbl

Attachment

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MC-815-04
(20)

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) McGuire Nuclear Station, Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 3 7 0 1 OF 0 5										PAGE (3) 1 OF 0 5							
TITLE (4) A Seven Day Technical Specification Surveillance Of The Ice Condenser Intermediate Deck Doors Was Missed Because Of An Inappropriate 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	N/A						DOCKET NUMBER (5)												
0	3	1	6	9	0	9	0	0	0	2	0	0	0	4	1	6	9	0	0 5 0 0 0 0 1 1								
OPERATING MODE (9)		1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																							
POWER LEVEL (10)		1 0 0		20.402(b)						20.406(e)						50.73(a)(2)(iv)						73.71(b)					
				20.406(a)(1)(i)						50.38(c)(1)						50.73(a)(2)(v)						73.71(c)					
				20.406(a)(1)(ii)						50.38(c)(2)						50.73(a)(2)(vi)						OTHER (Specify in Abstract below and in Text, NRC Form 366A)					
				20.406(a)(1)(iii)						X 50.73(a)(2)(i)						50.73(a)(2)(vii)(A)											
				20.406(a)(1)(iv)						50.73(a)(2)(ii)						50.73(a)(2)(vii)(B)											
				20.406(a)(1)(v)						50.73(a)(2)(iii)						50.73(a)(2)(ix)											
LICENSEE CONTACT FOR THIS LER (12)																											
NAME										TELEPHONE NUMBER																	
Alan Sipe, Chairman, McGuire Safety Review Group										AREA CODE 7 0 4 8 7 5 - 4 1 8 3																	
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC																	
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 March 16, 1990, at 1215, the Unit 2 Ice Condenser was declared inoperable after Operations personnel discovered that a Technical Specification Surveillance was missed. This was discovered when the Operations Manager was discussing the pending surveillance work load with Operations personnel. The surveillance was successfully performed and the Ice Condenser was declared operable at 1300. The seven day surveillance was normally performed on Tuesdays and was scheduled for March 13, 1990. On March 13, Operations personnel were prevented from entering the Reactor Building because of in-progress Annulus Ventilation (VE) system testing. Operations personnel were prevented from entering the Reactor Building again on March 14 and 15, because of concerns that an entry would degrade the VE system. The fact that this was a seven day surveillance with a maximum of a forty-two hour grace period was not identified to Operations Management. On March 15, the fact that the surveillance was missed was not recognized by Operations personnel. This event is assigned a cause of Inappropriate Action because of failure to adhere to policies, directives, or management procedures. Unit 2 was in Mode 1 (Power Operation), at 100 percent power, at the time of this event. Appropriate Operations personnel will read and review applicable directives and management procedures to ensure an understanding of their role and responsibilities.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/86

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McGuire Nuclear Station, Unit 2	0 5 0 0 0 3 7 0 9 0	—	0 0 2	— 0 0	0 2	OF 0 5

TEXT (If more space is required, use additional NRC Form 366A's) (17)

EVALUATION:

Background

The primary function of the Ice Condenser [EIIS:BC] (NF) system is the absorption of thermal energy released abruptly in the event of a Loss-Of-Coolant Accident (LOCA) for the purpose of limiting the initial peak pressure in Containment. A secondary function of the NF system is the further absorption of energy after the initial incident causing the Containment pressure to be reduced to and held at a lower level for a period of time.

Technical Specification (TS) 3.6.5.3 specifies that the Ice Condenser inlet doors [EIIS:DR], intermediate deck doors, and the top deck doors shall be closed and operable. These conditions are applicable in Mode 1 (Power Operation), Mode 2 (Startup), Mode 3 (Hot Standby), and Mode 4 (Hot Shutdown). TS Action Statement B for this TS specifies that with one or more ice condenser doors inoperable (not capable of opening automatically), restore all doors to operable status within 1 hour or be in Hot Standby within 6 hours and in Hot Shutdown within the following 6 hours and in Cold Shutdown within the following 30 hours.

TS 3.6.5.4 specifies that the Inlet Door Position Monitoring System shall be operable in Mode 1, Mode 2, Mode 3, and Mode 4. TS Action Statement specifies that with the Inlet Door Position Monitoring System inoperable, restore it to an operable status within 48 hours or be in at least Hot Shutdown within the next 6 hours and in Cold Shutdown within the following 30 hours.

TS 4.6.3.2a requires that each Ice Condenser intermediate deck door shall be verified closed and free of frost accumulation by a visual inspection at least once per 7 days. This requirement is documented by procedure PT/2/A/4200/14A, Ice Condenser Intermediate Deck Door and Monitoring System Inspection.

TS 4.6.5.4a requires that a channel check be performed once per 7 days on the Inlet Door Position Monitoring System. This requirement is also documented by procedure PT/2/A/4200/14A, Ice Condenser Intermediate Deck Door and Monitoring System Inspection.

TS 4.0.2 requires that each surveillance shall be performed within the specified time interval with a maximum allowable extension not to exceed 25 percent of the surveillance interval.

A weekly preventative maintenance visual inspection of the Ice Condenser is performed by Maintenance or Instrumentation and Electrical personnel to inspect the Air Handling Units [EIIS:AHU] (AHUs) for the condition of the drive belts, fan and bearings, glycol leaks, drain pans for ice overflow and coil for excessive frost buildup.

Description of Event

On March 6, 1990, Operations (OPS) personnel performed the required seven day surveillance on the Unit 2 NF intermediate deck doors using procedure

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

PT/2/A/4200/14A, Ice Condenser Intermediate Deck Door and Monitoring System Inspection. The intermediate deck doors were documented as being closed and free of any frost accumulation.

On March 12, 1990, Instrumentation and Electrical (IAE) personnel performed a weekly preventative maintenance inspection on the Unit 2 NF AHUs using Work Request (WR) 03880B. Intermediate deck door examination is not part of this inspection nor the responsibility of IAE personnel. However, IAE personnel are normally aware of frost accumulations on the intermediate deck doors while in the area performing the AHU inspection. IAE personnel interviewed who performed this inspection could not recall identifying any conditions that may have interfered with the intermediate deck door operation.

On the morning of March 13, 1990, OPS personnel prepared to perform the Unit 2 NF intermediate deck door surveillance. Shift Manager A was contacted for permission to enter the Reactor Building. Shift Manager A prevented Reactor Building entry because Annulus Ventilation System [EIIS:VD] (VE) TS Surveillance testing was in progress and the access doors were sealed. OPS personnel identified the delay to their supervisor. OPS Supervisor A contacted Unit Coordinator A. Unit Coordinator A confirmed the need to delay the NF surveillance because of VE TS surveillance testing. The late date for performance of the NF surveillance was not discussed.

On the morning of March 14, 1990, OPS personnel contacted Unit Coordinator A about performing the NF intermediate deck door surveillance. The surveillance was again delayed because removal of the door seal and entry into the Reactor Building may have degraded the VE system. The fact that the surveillance was beyond the 7 day frequency although not exceeding the allowable grace (42 hours), was not discussed. No notifications of entering the TS surveillance grace period were made.

On the morning of March 15, 1990, OPS personnel again contacted Unit Coordinator A about performing the NF intermediate deck door surveillance. The surveillance was again delayed because of concerns that entry into the Reactor Building may have degraded the VE system. The discussion then changed from the NF surveillance to a pending 2B Diesel Generator [EIIS:DG] TS surveillance. None of the personnel involved recognized nor discussed the fact that the NF surveillance was missed, beyond the frequency and allowable grace period. No notifications of a missed TS surveillance were made.

On March 16, 1990, the OPS Manager A discovered that the NF intermediate deck door TS surveillance was missed. The discovery was made while discussing pending surveillance testing with OPS personnel and Shift Manager B. The Control Room [EIIS:NA] Shift Supervisor was notified. The NF system was declared inoperable at 1215. Compliance personnel, NRC, and the Superintendent of Operations were also notified of the missed TS surveillance. OPS personnel performed the surveillance using PT/2/A/4200/14A, Ice Condenser Intermediate Deck Door and Monitoring System Inspection. The intermediate doors were documented as being closed and free of any frost accumulation. Also, the NF inlet door position monitoring system was documented as being operable. The NF system was declared operable at 1300.

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TEXT (If more space is required, use additional NRC Form 306A's) (17)

Conclusion

This event is assigned a cause of Inappropriate Action because of failure to adhere to policies, directives, or management procedures. Directions and instructions on notification of station management for TS surveillances that fall into grace periods are provided in Station Directives 3.2.0 and 3.2.1 and Operations Management Procedure 1-4. During this event OPS Supervisor A failed to notify the Control Room Shift Supervisor, OPS Support Manager, and Unit Operating Manager that the TS surveillance had fallen into a grace period.

OPS Supervisor A developed a mind set that Unit Coordinator A inherently recognized the need to perform the NF surveillance within the required frequency. This mind set included the assumption that Unit Coordinator A would then share in ensuring the surveillance completion. OPS Supervisor A regarded Unit Coordinator A's position as one of knowledge, authority, and responsibility because Unit Coordinator A held an active Senior Reactor Operator License and was functioning as Unit Manager. OPS Supervisor A's ultimate responsibility to ensure timely surveillance completion was obscured by his mind set. OPS Supervisor A stated he was not tired nor distracted or interrupted by other activities at the time of this event.

A review of the Operating Experience Program (OEP) Data Base for the previous twenty-four months revealed one event, LER 370/89-14 that involved a TS violation with a cause of Inappropriate Action because of failure to adhere to policies, directives, or management procedures. LER 370/89-14 involved different equipment, administrative controls, and personnel actions. Therefore, this event is not considered recurring.

A review of the OEP Data Base for the previous twenty-four months revealed nine events, LERs 369/88-23, 369/89-03, 369/89-11, 369/89-14, 369/89-16, 370/89-08, 370/89-12, 370/89-13, and 369/90-05 that identified missed TS surveillances. Also, in-progress LERs 369/90-03 and 370/90-03 involve missed TS surveillances. There is no single commonality between these events. The problem with missed TS surveillances in general is considered to be recurring.

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

There were no personnel injuries, radiation overexposures, or uncontrolled releases of radioactive material as a result of this event.

CORRECTIVE ACTIONS:

- Immediate:
- 1) Operations personnel declared the NF system inoperable at 1215.
 - 2) Operations personnel successfully completed the TS surveillance.
 - 3) Operations personnel declared the NF system operable at 1300.

Subsequent: Operations personnel reviewed this event with personnel involved.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

- Planned:
- 1) Appropriate Operations personnel will read and review applicable Station Directives and Operations Management procedures to ensure all personnel understand their roles and responsibilities.
 - 2) Operations personnel will cover this event with Operations Staff personnel and Shift Supervisors to ensure awareness by Operations personnel.
 - 3) Operations personnel will evaluate adding weekly surveillances to the PMPTLOOK Computer Program used to monitor and track periodic station testing.

SAFETY ANALYSIS:

During this event, the ability of the NF system to perform as designed was not impaired. The late surveillance of the NF intermediate doors and monitoring system verified that the system was in an operable condition during this event.

Between March 13, 1990 and March 16, 1990, no event occurred which would have challenged the NF system.

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