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DUKE POWER

September 15, 1994

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 370/94-03
Problem Investigation Process No.: 2-M94-0989

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 370/94-03 concerning a missed Technical Specifications surveillance. 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

TLP/bcb

Attachment

xc: Mr. S.D. Ebnetter
Administrator, Region II
U.S. Nuclear Regulatory Commission
101 Marietta St., NW, Suite 2900
Atlanta, GA 30323

INPO Records Center
Suite 1500
1100 Circle 75 Parkway
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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 05000370
S PDR

Handwritten initials, possibly 'JEP' or similar, with a vertical line through them.

bxc: B.L. Walsh
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M.E. Patrick (ONS)
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Plant Operations Review Committee

LICENSEE EVENT REPORT (LER)

FACILITY NAME(1)

McGuire Nuclear Station, Unit 2

DOCKET
NUMBER(2)

05000 370

PAGE(3)

1 OF 4

TITLE(4) Failure To Perform A Technical Specifications Required Surveillance 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)
08	15	94	94	03	00	09	15	94	N/A	05000

OPERATING MODE(9)	1	THIS REPORT IS SUBMITTED PURSUANT TO REQUIREMENTS OF 10CFR (Check one or more of the following)(11)								
		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)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)		
		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)(ix)				

LICENSEE CONTACT FOR THIS LER(12)

NAME

Rickey J. Deese, Manager

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 15, 1994, Diesel Generator (D/G) room sump pump 2B2, associated with the 2B D/G was
made inoperable for maintenance. After the maintenance activities were complete, the pump
was returned to its normal alignment to allow functional testing. The Control Room Senior
Reactor Operator (CRSRO) declared the 2B2 D/G room sump pump operable based upon the pump
being returned to normal alignment. However, an operability test had not been performed. On
August 16, 1994, at 0553, the night shift CRSRO declared 2B3 D/G room sump pump inoperable
for maintenance. During the turnover process, the day shift Work Control Center Senior
Reactor Operator (WCCSRO) realized that the retest had not been performed on the 2B2 D/G room
sump pump, and that the 2B3 D/G room sump pump was inoperable. With both of the safety
related D/G room sump pumps inoperable, the D/G is inoperable. Inoperability of a D/G
requires verification of the circuits which are supplying the unit with offsite power. This
required surveillance had not been performed. The WCCSRO took immediate action to return the
2B3 sump pump to operable status and to perform the required offsite power verification. The
required surveillance was performed and the 2B3 sump pump was returned to service by 0735.
Corrective actions for this event include counseling of the CRSRO. Unit 2 was in mode 1
(Power Operation), at 100% power at the time of the event.

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EVALUATION:

Description of Event

On August 15, 1994, with Unit 2 operating in mode 1 (Power Operation) at 100% power, Operations (OPS) personnel removed the 2B2 Diesel Generator (D/G) [EIIIS:DG] room sump pump [EIIIS:P] from service for a coupling inspection in accordance with Work Order (WO) 94026627. Removal of this D/G room sump pump from service, as documented on Removal and Restoration (R&R) sheet 24-223 did not impact the operability of the D/G. Therefore, the pump maintenance activity was logged in the Technical Specifications Action Items Log (TSAIL) by the Control Room Senior Reactor Operator (CRSRO) as an item for tracking. The maintenance inspection was completed on the day shift of August 15. Mechanical Maintenance personnel returned to the Work Control Center (WCC) to notify the WCC Senior Reactor Operator (WCCSRO) that the sump pump maintenance was complete and that the functional test could be performed. The WCCSRO dispatched OPS personnel to place the sump pump into a normal alignment. The WCCSRO also had the Shift Work Manager (SWM) schedule a retest of the D/G room sump pump for the day shift of August 16, 1994.

The OPS non-licensed operator (NLO) who realigned the system placed the completed copy of R&R sheet 24-223 into the in box of the CRSRO. At approximately 1700, on August 15, the CRSRO cleared the TSAIL entry for the 2B2 D/G room sump pump. The CRSRO did not verify the status of the work order associated with the 2B2 sump pump.

On the night shift of August 16, 1994, preparations were made to remove the 2B3 D/G room sump pump from service for a coupling inspection in accordance with WO 94026632. Removal and restoration sheet 24-226 was prepared for this work. The night shift CRSRO logged the 2B3 sump pump inoperable in the TSAIL at 0553. However, since the WO task associated with the 2B2 sump pump retest had not been performed, the 2B2 sump pump was still inoperable. With both safety related sump pumps inoperable, the D/G is inoperable.

Technical Specification 3.8.1.1, Electrical Power Systems, A.C, Sources Operating, requires two operable D/Gs. The action statement of 3.8.1.1 requires that with one of the D/Gs inoperable, demonstrate the operability of the A.C. offsite sources by performing a surveillance to verify the correct breaker alignments and indicated power availability. This surveillance is required to be performed within one hour, and once per eight hours thereafter until the D/G is returned to operable status. Therefore, with the 2B D/G inoperable, the required Offsite power verification should have been performed by 0653 on August 16, 1994.

The WCCSRO who came on duty for the daylight shift of August 16, 1994, at approximately 0700, realized during the turnover that the 2B D/G was inoperable due to the inoperability of both safety related sump pumps and declared the 2B D/G inoperable. Immediate action was taken by the WCCSRO to return the 2B D/G to an operable condition. Work had not begun on the 2B3 D/G room sump pump, so the pump was restored to normal alignment. The 2B D/G was returned to operable status at 0735, on August 16, 1994. The WCCSRO contacted the Control Room personnel to inform them of the missed TS surveillance. The CRSRO directed the Unit 2 Reactor Operator to perform the required TS surveillance. The Surveillance of offsite power sources was performed with no discrepancies. Subsequent retesting of the 2B2 D/G sump pump was also performed satisfactorily with no discrepancies.

Conclusion

The cause of this missed surveillance was an Improper Work Practice on the part of the CRSRO. The failure of the dayshift CRSRO to verify that all work associated with 2B2 sump pump was complete prior to removing the sump pump from the TSAIL resulted in the D/G being

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made inoperable unknowingly. The night shift personnel made the D/G inoperable without knowing that this was happening since the SROs depend upon the status of equipment, as recorded in the TSAIL, to determine the operability. Since the entry for the 2B2 sump pump had been cleared, the night shift did not know that removal of the 2B3 sump pump would result in the B D/G being inoperable.

A search of the Problem Identification Process (PIP) database for the preceding 24 months revealed 3 reportable events which involve a failure to perform a TS required surveillance due to Improper Work Practices. Licensee Event Report (LER) 369/93-07, documents a failure to perform a surveillance of the Solid State Protection system on a staggered test basis. The Improper Work Practice was due to the failure to adequately verify the computer program that schedules the staggered tests. Licensee Event Report 370/94-01, documents a failure to perform an offsite power verification when a D/G was made inoperable. This was due to the failure of the CRSRO to initiate the required verification. Licensee Event Report 370/94-02, documents a failure to perform a Reactor Coolant system Chemistry sample within the required time frame. This was due to the failure of the Chemistry personnel to verify that the automatic sampling equipment was actually performing the required analysis. Licensee Event Reports 369/93-07 and 370/94-02 involve substantially different Improper Work Practices and are not related to this event. However, LER 369/94-01 involves the same TS required surveillance being missed, and the same job function. Therefore, this event is considered recurring. However, the prior event involved action that was not performed when the D/G was purposely made inoperable. In the event described in this report the D/G was made inoperable unknowingly. Therefore, the corrective actions of the previous event would not have prevented this occurrence.

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

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

CORRECTIVE ACTIONS:

- Immediate:**
- 1) Operations personnel declared the 2B D/G inoperable.
 - 2) Operations personnel realigned the 2B3 sump pump, restoring the 2B D/G to operable status.
 - 3) Operations personnel performed the verification of offsite power sources in accordance with TS 3.8.1.1, action d.
- Subsequent:**
- 1) Operations management have counseled the involved CRSRO to ensure adherence to written expectations for removing items from the TSAIL.
- Planned:**
- 1) Operations will communicate the details of this event to all licensed operators to ensure that personnel who perform the duties of CRSRO are aware of the need to fully verify the operability of equipment prior to removing equipment from the TSAIL.

SAFETY ANALYSIS:

The D/G was declared inoperable due to both sump pumps being technically inoperable. However, this inoperability would not have kept the D/G from performing its intended function. The 2B2 sump pump was aligned for normal operation, and awaiting a retest to prove operability. The retest was subsequently performed satisfactorily with no

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discrepancies. Therefore, the 2B2 sump pump would have functioned properly if needed. The 2B3 sump pump was not in a normal alignment, but no work had been performed prior to the discovery of the missed surveillance. The WCCSRO directed personnel to restore the 2B3 pump to normal alignment, which was accomplished within approximately 20 minutes.

The surveillance that was missed is used to verify the alignment of offsite power systems which are supplying the emergency busses. At no time was the alignment of offsite power less than the requirements of the TS. Various Control Room alarms and status lights are used to notify personnel of incorrect breaker alignments. This event becomes reportable only due to the fact that the alignment verification is required to be performed within one hour. The elapsed time from the 2B D/G becoming inoperable until the D/G was returned to operable status was 102 min. Therefore, this event is considered to not be significant.

The health and safety of the public and McGuire personnel were unaffected by this event.