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DUKE POWER

June 13, 1995

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

Subject: Catawba Nuclear Station
Docket No. 50-413
LER 413/95-002

Gentlemen:

Attached is Licensee Event Report 413/95-002 concerning MISSED TECHNICAL SPECIFICATION SURVEILLANCE TEST DUE TO MANAGEMENT DIRECTIONS. This event was considered to be of no significance with respect to the health and safety of the public.

Very truly yours,

D. L. Rehn by [signature]

D. L. Rehn

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Attachments

xc: Mr. S. D. Ebneter
Regional Administrator, Region II
U. S. Nuclear Regulatory Commission
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Mr. R. E. Martin
U. S. Nuclear Regulatory Commission
Office of Nuclear Reactor Regulation
Washington, D.C. 20555

Mr. R. J. Freudenberger
NRC Resident Inspector
Catawba Nuclear Station

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NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

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)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Catawba Nuclear Station, Unit 1	05000 413	1 OF 4

TITLE (4)
Missed Technical Specification Surveillance Test Due To Management Directions

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
									N/A	05000
05	17	95	95	-- 002 --	00	06	13	95	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	1
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (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
	20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(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)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
D. P. Kimball, Safety Review Group Manager	(803) 831-3743

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 15 single-spaced typewritten lines) (16)

ABSTRACT

On May 17, 1995 at 1315 hours, Units 1 and 2 were in Mode 1, Power Operation at 100% power when Maintenance discovered that a Technical Specification (T/S) Surveillance interval had been exceeded. The Channel Calibration surveillance for 0ADLT5000, level transmitter for the Standby Shutdown Diesel (AD) System fuel oil tank, expired on April 25, 1995. This problem was discovered during planning of the predefined Work Order for 0ADLT5000 to be performed in June 1995. A Maintenance Supervisor found that the previous predefined Work Order was completed on February 3, 1994 by taking credit for a Channel Calibration that was performed on June 8, 1993. When the predefined Work Order was completed, the June 8, 1993 date should have been entered into the Work Management System rather than the February 3, 1994 date to ensure the next surveillance interval was not exceeded. The root cause of this event is Management Directions, policy guidance was not well defined. Maintenance personnel initiated a Work Order, performed a Channel Calibration, and returned the instrument to service. The instrument was found in calibration. Corrective actions taken include a review of Work Orders for similar problems (none were discovered) and communication to all Maintenance personnel the proper process for using corrective Work Orders to satisfy predefined Work Order requirements. Administrative guidelines will be revised to include this guidance.

BACKGROUND

The Standby Shutdown Diesel [EIIS:EK](AD) System provides an alternate and independent means to achieve and maintain hot standby conditions in the event of a postulated fire, sabotage event, or a total loss of all AC Power for one or both units. Within the Standby Shutdown Facility is a Control Station [EIIS:XIK] equipped with sufficient controls to control primary system volume and pressure, secondary system volume and pressure, and instrumentation to verify essential parameters. A Diesel Generator [EIIS:DG] rated at 700KW is provided for backup power in the event of a total loss of all AC power. Level indication for the Diesel Generator Main Fuel Oil Tank [EIIS:TK], 0ADLT5000, is provided to ensure adequate fuel oil exists to achieve and maintain hot standby conditions for 72 hours. 0ADLT5000 is required by Technical Specification (T/S) 3/4.7.13 to be demonstrated OPERABLE by the performance of a Channel Calibration at least once per eighteen months.

EVENT DESCRIPTION

June 8, 1993

Instrumentation and Electrical (IAE) technicians replaced faulty gauge and calibrated 0ADLT5000 under Corrective Work Order 93038531-01.

Note: This calibration date should have been used to schedule the next predefined Work Order to satisfy the 18 month Channel Calibration for this instrument.

February 3, 1994

IAE completed predefined Work Order 93064473-01. This Work Order is normally used to perform the 18 month Channel Calibrations for the AD System.

0ADLT5000 is part of the 18 month Channel Calibrations for the AD System. IAE referenced and took credit for the previous calibration performed under the corrective Work Order on June 8, 1993 to satisfy the predefined Work Order. The completion date for the Channel Calibration of 0ADLT5000 was entered into the Work Management System as February 3, 1994 instead of the actual Channel Calibration date of June 8, 1993.

April 25, 1995

The 18 month Channel Calibration interval and grace period for instrument device 0ADLT5000 expired.

May 17, 1995

During planning/scheduling of the predefined Work Order for the AD System instrumentation calibrations in June 1995, a Maintenance Supervisor discovered that 0ADLT5000 had not been calibrated within the required T/S frequency.

A Channel Calibration was performed on 0ADLT5000; the instrument was found to be within calibration setpoints.

CONCLUSION

The root cause of this event is Management Directions, policy guidance was not well defined. On February 3, 1994 IAE referenced and took credit for the Channel Calibration performed on June 8, 1993. This information was not entered into the Work Management System so that the due date for the next T/S Surveillance could be adjusted. No formal process was in place to ensure this action was taken. Maintenance management has established a formal process for using corrective Work Orders to satisfy predefined Work Order requirements and has communicated the process requirements to all Maintenance personnel. Administrative guidelines will be revised to include this process. In addition, a statistically acceptable (95/95 assurance criterion) sample of completed predefined Work Orders has been reviewed to ensure similar problems do not exist. No additional problems were discovered as a result of this review.

A review of reportable events for the past 36 months indicates that missed Technical Specification Surveillances is a recurring problem at Catawba. This problem was previously identified as recurring in Licensee Event Report (LER) 414/94-004, submitted on September 29, 1994 which documented a missed T/S Surveillance for a valve stroke time test (IWV). As a result, generic corrective actions were developed to address the recurring problem. This event is the only missed T/S Surveillance that has occurred at Catawba since LER 414/94-004. At this time, no additional generic corrective actions are deemed necessary.

An additional review of reportable events for the past 36 months was performed to determine if Technical Specifications violations due to Management Directions within IAE is recurring. No LERs were identified during this review, therefore this event is not recurring from this aspect.

CORRECTIVE ACTIONS

IMMEDIATE

1) A Channel Calibration was performed on 0ADLT5000; the instrument was found to be within calibration setpoints.

SUBSEQUENT

1) Maintenance management has established a formal process for using corrective Work Orders to satisfy predefined Work Order requirements. This process has been communicated to all Maintenance personnel.

2) A statistically acceptable (95/95 assurance criterion) sample of completed predefined Work Orders were reviewed to determine if similar problems existed. No additional problems were discovered.

PLANNED

1) Maintenance will revise administrative guidelines to include the proper process for using corrective Work Orders to satisfy predefined Work Order requirements.

SAFETY ANALYSIS

The Standby Shutdown Diesel System was technically inoperable from April 25, 1995 to May 17, 1995. Upon discovery that the Diesel Generator fuel oil tank level transmitter had exceeded its T/S Surveillance interval, a Work Order was initiated for the Channel Calibration and the instrument was found to be within calibration setpoints. The intended function of 0ADLT5000 is to ensure accurate indication of fuel oil tank level in order to support Diesel Generator operation for 72 hours. Since the as found condition of 0ADLT5000 was acceptable, the level instrument would have performed its intended function. Additionally, the significance of this event is reduced due to the short time period (approximately three weeks) of technical inoperability.

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