

NRC FORM 366
(4-95)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 04/30/98

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), 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.

FACILITY NAME (1)

Grand Gulf Nuclear Station, Unit 1

DOCKET NUMBER (2)

05000-416

PAGE (3)

1 of 3

TITLE (4)

Voluntary Report / Routine Maintenance Renders High Pressure Core Spray EDG Inoperable

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
01	26	96	96	002	00	02	26	96	N/A	05000
									FACILITY NAME	DOCKET NUMBER
									N/A	05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more) (11)			
POWER LEVEL (10)	100	20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(2)(i)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.405(a)(1)(ii)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	X OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 365A Voluntary Report
20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)			

LICENSEE CONTACT FOR THIS LER (12)

NAME

Riley Ruffin / Licensing Specialist

TELEPHONE NUMBER (Include Area Code)

601-437-2167

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)

YES (If yes, complete EXPECTED SUBMISSION DATE)	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i. e., approximately 15 single-spaced typewritten lines) (16)

On January 26, 1996, plant personnel were performing a weekly prelube on division 3 emergency diesel generator. During the prelube, an oil leak was observed from a lube oil strainer. The leak was reworked and satisfactorily leak-checked. A review of this condition revealed that on January 19 a planned maintenance activity had rendered the diesel inoperable. Plant personnel concluded that the diesel may not have been able to perform its intended function. On January 19, maintenance personnel attempted to obtain an oil sample from the division 3 emergency diesel generator. In the first attempt, an inappropriate sample point was used to obtain the oil sample. As a result of the use of this point, the scavenger strainer cover became unseated which provided a flow path for the oil. The instructions which were used did not give specific locations to obtain the oil sample. Additionally, the expectations of management were not met in that personnel involved did not inform the first line supervision of the attempt to get the sample from the wrong location.

The work task that is used to obtain the oil samples from EDG 13 has been revised to incorporate specific locations to obtain samples. The personnel involved was counseled by maintenance management. As a part of the close-out for the quality deficiency which is herein described, the expectations of mechanical maintenance management will be conveyed to appropriate personnel to heighten their awareness of this incident.

Even though the diesel was inoperable, the supported system was still fully capable of performing its intended function. The outage times for other systems which are required for safety were reviewed. It was determined that none of the outage times were in excess of the allowed times specified in GGNS technical specifications. This incident constitutes a condition that may have resulted in the failure of the Division 3 EDG unit. Therefore this report is being submitted to fulfill the commitment identified in 7.7.2.2 of the GGNS UFSAR Appendix 16B.

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

A. Reportable Occurrence

During the performance of a weekly prelube for Division 3 Emergency Diesel Generator (EDG 13) [EK], plant personnel identified an oil leak from an oil strainer. A small amount of oil wept from the strainer. As a result of this condition EDG 13 was declared inoperable.

A review of previous maintenance revealed that a maintenance activity had caused the oil leak to develop, thus placing the EDG in a potentially inoperable condition. Plant Operating personnel were unaware of this condition. Therefore, the Technical Specification required actions were not administratively pursued and documented for an inoperable EDG within the specified time limits. However, by virtue of equipment and plant status, the plant remained in compliance with GGNS Technical Specifications. This condition is being reported via a voluntary report.

Additionally, this report also serves as notification of the valid failure of EDG 13.

B. Initial Conditions

The plant was in OPERATIONAL CONDITION 1 with reactor power indicating approximately 100 percent. Reactor pressure was approximately 1030 psig at the time of discovery.

C. Description of Occurrence

On January 26, 1996, at approximately 0100 hours, plant personnel were in the process of prelubing EDG 13. Upon opening the prelube valves, personnel observed lube oil leaking from the scavenger strainer. Only a small amount of oil wept from the strainer. However, it was concluded that EDG 13 may not have been able to perform its intended function and was declared inoperable. The appropriate Technical Specification actions were taken as a result of this condition. A repetitive task was issued to check the strainer assembly.

Maintenance personnel determined that the closure device for the strainer compartment was not fully tightened and allowed the strainer cover to unseat. The unseated cover permitted oil to leak out of the strainer when pressurized. The strainer cover was removed and the associated O-ring was inspected. Maintenance personnel reinstalled the cover and ensured that it was properly resealed. A leak check was satisfactorily performed following the activity and EDG 13 was returned to the operable status 35 minutes after discovery of the condition.

An investigation of the condition revealed that the EDG had been potentially rendered inoperable due to a maintenance activity that occurred on January 19, 1996. On this day Maintenance personnel obtained an oil sample from both engines of EDG 13. The sample is normally obtained from lube oil strainer D026 ("A" or "B" depending on the engine). However, during this evolution, Maintenance personnel attempted to obtain the sample from scavenger strainer D027A. When attempting to reclose the strainer compartment, the cover was not properly seated. This resulted in a leakage path around the O-ring seal. Therefore, it was concluded that the EDG may have been inoperable since January 19.

This incident constitutes a condition that may have resulted in the failure of the Division 3 EDG unit. Therefore this report is being submitted to fulfill the commitment identified in 7.7.2.2 of the GGNS UFSAR Appendix 16B.

D. Apparent Cause

As a part of the GGNS Lubricating Oil Sample Program, lube oil samples are taken from various components for analyses. Samples are taken from EDG 13 on a monthly frequency. Guidance for this process is given by a General Maintenance Instruction. The instruction gives generic directions and does not give details for oil samples from specific components. The associated work instructions also only gave generic guidance. Therefore personnel's familiarity with the normal method of obtaining samples was relied on to ensure that the sample was taken from the appropriate point.

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A major factor which contributed to the inoperability of EDG 13 was the fact that the personnel involved did not meet the expectations of management which was to inform first line supervision that an oil sample had been attempted from the wrong location. Therefore on-shift management was unaware of the condition.

E. Corrective Actions

The work task that is used to obtain the oil samples from EDG 13 has been revised to incorporate specific locations to obtain samples.

The personnel involved was counseled by maintenance management.

As a part of the close-out for the quality deficiency which is herein described, the expectations of mechanical maintenance management will be conveyed to appropriate personnel to heighten their awareness of this incident.

F. Safety Assessment

This condition existed for a period of 6 days, 16 hours and 35 minutes. Even though the EDG is assumed not to perform its intended function, its supported system was fully functional during the entire evolution. Each of the other divisional EDGs was also operable. This was not a condition which would have caused a failure of the other two divisional EDGs. Offsite power was being supplied to all its respective circuits.

The 72 hour Allowed Outage Time for EDG 13 was exceeded; however, there are special provisions for EDG 13 in LCO 3.8.1. For outage times which would exceed the 72 hour limit, it allows the plant to administratively declare the High Pressure Core Spray system [BG] inoperable. This allows an additional 14 days of allowed out of service time if RCIC [BN] and other ECCS system are operable.

A review of the equipment that was removed from service during this time revealed that on January 22 and 24 Low Pressure Coolant Injection [BO] divisions 1 and 2, respectively were removed from service. However, the outage times were well within the 72 hour allowed outage time of Technical Specification 3.5.1 for this condition.

Considering this review, it is concluded that although specific actions were not administratively pursued, the status of plant equipment during the existence of this condition did not compromise the ability of the plant to mitigate the consequences of an accident. The health and safety of the public were not in jeopardy at any time during this condition.

This failure of EDG 13 is the first failure out of the last 100 valid tests.

G. Additional Information

Energy Industry Identification System (EIIIS) codes are identified in the text within brackets [].