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DATE: December 6, 1996

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

Subject: McGuire Nuclear Station, Unit 1 and 2
Docket No. 50-369
Licensee Event Report 369/96-07, Revision 0
Problem Investigation Process No.: 1-M96-3218

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 369/96-07 regarding a Mode Related Missed Technical Specification Surveillance on Containment Integrity Due To A Technical Inaccuracy. 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,

T.C. McMeekin

JWP/bcb

Attachment

cc: Mr. S.D. Ebneter
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U.S. Nuclear Regulatory Commission
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Atlanta, GA 30323

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Suite 1500
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U.S. Nuclear Regulatory Commission
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Mr. Scott Shaeffer
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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION

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

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.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
McGuire Nuclear Station Unit 1	05000 369	1 of 4

TITLE (4)
Mode Related Missed Technical Specification Surveillance on Containment Integrity Due To A Technical Inaccuracy

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(S)
											N/A	05000
11	07	96	96	-	007	-	0	12	06	96		05000

OPERATING MODE (9)	4	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (Check one or more of the following) (11)					
POWER LEVEL (10)	0	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 (Specify in Abstract below and in Text, NRC Form 366A)		
		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)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
J. W. Pitesa	(704)	875-4788

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 fifteen single-space typewritten lines) (16)

Unit Status: Mode 4 (Hot Shutdown) at 0 percent power.

Event Description:

Between November 6, 1996, at 2200, and November 7, 1996, at 0200, a decision was made to not perform the Cold Shutdown Containment Integrity Surveillance prior to entry into Mode 4. This decision was based on information obtained after reviewing the Preventative Maintenance/Periodic Testing (PM/PT) database and determining that the surveillance was within the proper interval. The PM/PT surveillance frequency was indicated as 18 months and the date last performed was January 18, 1996. The next due date for the surveillance was indicated as July 21, 1997. The surveillance frequency was incorrect in that the Technical Specification (T/S) 4.6.1.1 requires the "Containment Integrity to be verified during each Cold Shutdown except that such verification need not be performed more often than once per 92 days".

Event Cause:

This event is assigned a cause of Written Communication, Technical Inaccuracies, in that the PM/PT database contained incorrect information with regards to the surveillance frequency.

Corrective Action:

The PM/PT database has been corrected. Additionally, a T/S Surveillance Quality Improvement Team (QIT) has been formed to review all aspects (scheduling, execution, updating of surveillance program and process control)of the Operations T/S surveillance process, identify areas for improvement, and implement corrective actions.

EVALUATION:

Description of Event

Unit 1 was in Mode 4 (Hot Shutdown) at 0 percent power at the time of the event.

- On October 31,1996, a decision was made to shutdown Units 1 and 2 per Technical Specification (T/S) 3.8.2. following the failure of Vital Battery Bank EVCC to meet the performance test requirements.

- Operations (OPS) Test Group personnel, as required by Operations Management Procedure (OMP 9-5), Operations Periodic Test Program, generated a list of Periodic Tests (PT) that are required to be performed prior to mode change. This list identified PTs that were within their respective surveillance interval and others which needed to be performed.

- Also on October 31, the OPS Test Group personnel distributed the list to the day shift Control Room Senior Reactor Operator (CRSRO), Work Control SRO and the Work Process Manager.

- The PT list was reviewed by the day shift CRSRO on October 31, and placed on a clip board in the Control Room to ensure all required PTs were performed at the appropriate time prior to mode change.

- Unit 1 entered Mode 5 (Cold Shutdown) on November 1, 1996 at 0730.

- On November 4, 1996, "C" shift (night shift) CRSRO reviewed the list and the Cold Shutdown Containment Integrity PT procedure PT/1/A/4200/02B. He attempted to verify the PT completion status but did not find any documentation to indicate completion (mode 4 checklist step for the PT was not signed off).

- At that time, the Shift Work Manager (SWM) got involved and contacted the PT Coordinator (Test Group Supervisor) to check on the status The telephone conversation led the SWM and the CRSRO to believe that the PT Coordinator would be responsible for the PT.

- On November 6, 1996, while reviewing the PT list with the PT Coordinator, the WCSRO asked whether the Containment Integrity PT needed to be performed. The PT Coordinator reviewed the PM/PT database.

- The PM/PT database indicated that the PT was last performed on January 18, 1996, the next due date to be July 21, 1997, and the surveillance frequency to be 18 months.

- The PT Coordinator concluded that the PT did not need to be performed and informed the WCSRO that it was within the surveillance.interval.

- Believing the surveillance requirements to be met, the PT Coordinator signed off the Mode 4 checklist step for the PT.

- Unit 1 entered Mode 4 at 0352 on November 7, 1996.

Conclusion

This event did not result in any uncontrolled releases of radioactive material, personnel injuries, or radiation overexposures. The event is not Nuclear Plant Reliability Data System (NPRDS) reportable.

This event is assigned a cause of Written Communications, Technical Inaccuracies. The decision to not perform the PT was based on erroneous information in that the PM/PT database incorrectly listed the surveillance frequency to be 18 months. The PM/PT database is an acceptable source of information per station management.

Although inadequacies in the PT Surveillance Process were a contributing factor to this event, the root cause for not performing the PT was based on incorrect information obtained from the PM/PT database.

A review of the Problem Investigation Process (PIP) and Operating Experience (OEDB) databases for the past 24 months revealed one reportable event associated with a T/S surveillance.

- LER 369/94-10 documented a failure to perform T/S required surveillances due to testing not being specified.
- While the testing not performed was also a missed containment integrity verification, the causes of the events are different.
- The corrective actions for that event would not have prevented this event from occurring.

This event is not considered to be recurring.

CORRECTIVE ACTION:

Immediate:

1. PT/1/A/4200/02/B was performed to achieve compliance with T/S 4.6.1.1

Subsequent:

1. The incorrect information with regard to the surveillance frequency in the PM/PT database has been changed.

Planned:

1. Additional procedural guidance will be developed to ensure adequate review of Mode related T/S surveillances prior to mode change.

2. A T/S Surveillance Quality Improvement Team (QIT) will review all aspects (scheduling, execution, updating of surveillance program and process control)of the Operations T/S surveillance process and will implement appropriate changes.

3. If a required shutdown were to occur before the changes are proceduralized, additional management oversight will be provided to ensure that T/S surveillances are met prior to each mode change.

SAFETY ANALYSIS:

Based on this analysis, this event is not considered to be significant. At no time were the health and safety of the public or plant personnel affected as a result of this event.

T/Ss require that certain penetrations required to maintain Primary Containment Integrity be verified closed during each Cold Shutdown but need not be verified more ofter than once per ninety-two days. Unit 1 entered mode 4 prior to completing the surveillance as required, and therefore was not in compliance with T/Ss. The failure to perform the surveillance in no way affected the ability of any Safety Related equipment to perform its design function. The past and present operability of all affected equipment was subsequently verified by performing the required surveillance. Therefore, this incident had no effect on the safety of the Unit.