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February 23, 2000

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

Subject: Oconee Nuclear Station  
Docket Nos. 50-287  
Licensee Event Report 287/2000-02, Revision 0  
Problem Investigation Process No.: O-99-4936

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a)(1) and (d), attached is Licensee Event Report 287/2000-02, Revision 0, concerning operation prohibited by Technical Specifications due to a missed surveillance.

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,



W. R. McCollum, Jr.

Attachment

IE22

Document Control Desk

Date: February 23, 2000

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cc: Mr. Luis A. Reyes  
Administrator, Region II  
U.S. Nuclear Regulatory Commission  
61 Forsyth Street, S. W., Suite 23T85  
Atlanta, GA 30303

Mr. D. E. LaBarge  
U.S. Nuclear Regulatory Commission  
Office of Nuclear Reactor Regulation  
Washington, D.C. 20555

INPO Records Center  
700 Galleria Parkway, NW  
Atlanta, GA 30339-5957

Mr. M. C. Shannon  
NRC Senior Resident Inspector  
Oconee Nuclear Station

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the 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. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

# LICENSEE EVENT REPORT (LER)

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

<b>FACILITY NAME (1)</b> Oconee Nuclear Station, Unit 3	<b>DOCKET NUMBER (2)</b> 05000 - 287	<b>PAGE (3)</b> 1 OF 4
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**TITLE (4)**  
Missed Surveillance due to Incorrect Interpretation of Requirements

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
5	09	99	2000	- 02	- 00	2	23	00		05000
									FACILITY NAME	DOCKET NUMBER
										05000

<b>OPERATING MODE (9)</b> 1	<b>THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)</b>									
<b>POWER LEVEL (10)</b> 100%	20.2201(b)	20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)(B)	50.73(a)(2)(viii)					
	20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)	50.73(a)(2)(x)					
	20.2203(a)(2)(i)	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)						
	20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)						
	20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)						
					<b>OTHER</b> Specify in Abstract below or in NRC Form 366A					

**LICENSEE CONTACT FOR THIS LER (12)**

<b>NAME</b> L.E. Nicholson, Regulatory Compliance Manager	<b>TELEPHONE NUMBER (Include Area Code)</b> (864) 885-3292
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**COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)**

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

**SUPPLEMENTAL REPORT EXPECTED (14)**

<b>YES</b> (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/> <b>NO</b>	<b>EXPECTED SUBMISSION DATE (15)</b>	MONTH	DAY	YEAR

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

Improved Technical Specification (ITS) Surveillance Requirement (SR) 3.5.3.1 was added when Oconee converted to ITS on March 27, 1999. Position verification of the Oconee Unit 3 Decay Heat Removal (LPI) Heat Exchanger (HX) Bypass valves 3LP-92 and 3LP-93 were not included in the original scope of this surveillance based primarily on an assessment of common industry practices.

Based on subsequent industry experience, Duke Energy conservatively decided to incorporate these valves into the SR verification program. The valves were added to the appropriate procedure and were found in their proper position when initially verified on November 3, 1999.

An evaluation concluded on January 24, 2000, that these valves should have been included in the original scope of SR 3.5.3.1, so the initial position verification should have occurred on or before May 9, 1999. Unit 3 was operated in Mode 1 at 100% power during the period of March 27, 1999 to November 3, 1999, except for a 3-day reduction to Mode 3 in May, 1999. There are no equivalent valves on Unit 1 or 2.

This event is considered to have no significance with respect to the health and safety of the public.

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Oconee Nuclear Station, Unit 3	05000-287	2000	02	00	2	OF	4

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

EVALUATION:

BACKGROUND

This report addresses operation prohibited by Technical Specifications due to a missed surveillance. This event is reportable per 10CFR 50.73 (a) (2) (i) (B).

The Low Pressure Injection (LPI) [EIIS:BP] System provides normal decay heat removal in Modes 5 and 6, Emergency Core Cooling System low pressure safety injection, and long term emergency decay heat removal following a Loss of Coolant Accident (LOCA). LPI includes two separate trains, each composed of one pump, one heat exchanger, associated piping, valves, and instrumentation.

Valves 3LP-92 and 3LP-93 allow LPI flow to by-pass the Decay Heat Coolers for LPI Train A and Train B, respectively. They are air-operated valves that fail closed on loss of instrument air and are operated from the control room. These valves may be procedurally opened during certain outage configurations, but are typically maintained closed by procedure while the LPI system is in ES stand-by alignment. 3LP-92 and 3LP-93 are unique to the Unit 3 LPI system, with no comparable counterpart on the other two Oconee units.

Prior to this event Unit 3 was operating at 100% power with no safety systems or components out of service that would have contributed to this event.

EVENT DESCRIPTION

In 1999, Oconee Nuclear Station converted from Current Technical Specifications (CTS) to Improved Technical Specifications (ITS). ITS implementation became effective on March 27, 1999. There were several new provisions that existed in the Improved Standardized Technical Specifications (ISTS) that were incorporated into ITS.

One such provision was a new surveillance requirement (SR) to verify certain valve positions every 31 days. Specifically, ITS SR 3.5.3.1 established a requirement to:

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

"Verify each LPI manual and non-automatic power operated valve in the flow path, that is not locked, sealed, or otherwise secured in position, is in the correct position."

During the ITS implementation process, Oconee conducted an informal survey of industry peers. Given the wide range of industry interpretations associated with defining flow path valves, Oconee concluded that the LPI decay heat cooler by-pass valves (3LP-92 and 3LP-93) did not need to be included in Periodic Test procedure PT/3/A/0115/011, "ITS Flow Path Verification." This test verifies that each subject valve is in the correct position.

Based on subsequent industry experience, Oconee began a specific review to reevaluate including 3LP-92 and 3LP-93 in the surveillance program. Oconee conservatively decided to amend the SR program to include verification of 3LP-92 and 3LP-93 and the valves were verified in their correct position on November 3, 1999. Oconee continued to evaluate if the inclusion should be considered a voluntary enhancement to the SR program, or a reportable omission. On January 24, 2000, Oconee determined this problem to be reportable under Technical Specification Prohibited Operation or Condition as a missed surveillance since these valves had not been included in the surveillances initially. The initial position verification should have occurred on or before May 9, 1999.

**CAUSAL FACTORS**

The root cause of this event was an incorrect interpretation of the requirements of ITS SR 3.5.3.1. This interpretation was based primarily on industry practices at facilities that had already implemented similar requirements.

There have been no previous Oconee LERs relative to implementing new surveillance requirements associated with the conversion to Improved Technical Specifications.

**CORRECTIVE ACTIONS**

Immediate:

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

1. 3LP-92 and 3LP-93 were added to surveillance procedure PT/3/A/0115/011, "ITS Flow Path Verification," and verified to be in their proper positions.

Subsequent:

None

Planned:

None

There are no NRC Commitment items contained in this LER.

**SAFETY ANALYSIS**

On November 3, 1999, both valves were found in the closed position, as specified for the Engineered Safeguards stand-by alignment. Prior to November 3, 1999, these valves remained subject to the configuration controls that had been in place prior to conversion to ITS.

During unit start up, the LPI system valves are all aligned per procedure and verified to be in the proper position. Manipulation of these valves is governed by procedures. It is reasonable to expect that any misposition would be discovered through monitoring of plant parameters, and the recovery would not be time critical. The valves are operated from the control room. Therefore, there was no actual impact on the health and safety of the public due to this event.

**ADDITIONAL INFORMATION**

There were no releases of radioactive materials, radiation exposures or personnel injuries associated with this event.

This event is not considered reportable under the Equipment Performance and Information Exchange (EPIX) program.