

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8707300478 DOC. DATE: 87/07/27 NOTARIZED: NO DOCKET #
 FACIL: 50-361 San Onofre Nuclear Station, Unit 2, Southern Californ 05000361
 AUTH. NAME AUTHOR AFFILIATION
 MORGAN, H. E. Southern California Edison Co.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-006-00 on 870626, while performing surveillance of
 ECCS circuit breaker alignments, two ECCS circuit breakers
 valves found closed. Caused by failure to identify error
 during review of alignment. Valves opened. W/870727 ltr.

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 TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: ELD Chandler 1cy. 05000361

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	ID CODE/NAME		LTTR	ENCL		ID CODE/NAME		LTTR	ENCL
	PD5 LA		1	1		PD5 PD		1	1
	ROOD, H		1	1					
INTERNAL:	ACRS MICHELSON		1	1		ACRS MOELLER		2	2
	AEOD/DOA		1	1		AEOD/DSP/NAS		1	1
	AEOD/DSP/ROAB		2	2		AEOD/DSP/TPAB		1	1
	DEDRO		1	1		NRR/DEST/ADE		1	0
	NRR/DEST/ADS		1	0		NRR/DEST/CEB		1	1
	NRR/DEST/ELB		1	1		NRR/DEST/ICSB		1	1
	NRR/DEST/MEB		1	1		NRR/DEST/MTB		1	1
	NRR/DEST/PSB		1	1		NRR/DEST/RSB		1	1
	NRR/DEST/SGB		1	1		NRR/DLPQ/HFB		1	1
	NRR/DLPQ/QAB		1	1		NRR/DOEA/EAB		1	1
	NRR/DREP/RAB		1	1		NRR/DREP/RPB		2	2
	NRR/PMAS/ILRB		1	1		NRR/PMAS/PTSB		1	1
	REG FILE 02		1	1		RES DEPY GI		1	1
	RES TELFORD, J		1	1		RES/DE/EIB		1	1
	RGN5 FILE 01		1	1					
EXTERNAL:	EG&G GROH, M		5	5		H ST LOBBY WARD		1	1
	LPDR		1	1		NRC PDR		1	1
	NSIC HARRIS, J		1	1		NSIC MAYS, G		1	1
NOTES:			1	1					

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2										DOCKET NUMBER (2) 0 5 0 0 0 3 6 1				PAGE (3) 1 OF 0 3		
TITLE (4) MISPOSITIONED EMERGENCY CORE COOLING SYSTEM VALVE CIRCUIT BREAKERS																
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)						
MONTH	DAY	YEAR	YEAR	SEQ. NUMBER	REV. NUMBER	MONTH	DAY	YEAR	FACILITY NAMES				DOCKET NUMBER(S)			
0 6	2 6	8 7	8 7	0 0 6	0 0	0 7	2 7	8 7					0 5 0 0 0			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)														
1		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)		
POWER LEVEL (10)		0 9 1				20.405(a)(1)(i)				50.36(c)(1)				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 H. E. MORGAN, STATION MANAGER										TELEPHONE NUMBER 7 1 4 3 6 8 - 6 2 4 1						
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NFRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NFRDS						
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO				
Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																
<p>On 6/26/87, at 0325, with Unit 2 at 91% power, while performing the shiftly surveillance of Emergency Core Cooling System (ECCS) circuit breaker (CB) alignments required by Technical Specification (TS) 4.5.2.a, CBs for two ECCS valves were found closed contrary to the TS surveillance requirement. The two CBs were promptly opened. The associated valves, however, were in the required position and there was no functional impairment of the ECCS. Therefore, there was no impact on the health and safety of plant personnel or the public as a result of this event.</p> <p>Investigation revealed that these valves were properly removed from service for maintenance at 0625, on 6/25/87. Upon restoration to service, the two CBs were closed in accordance with an incorrectly specified "return to service" (RTS) alignment. At 1200, the ECCS components were declared operable based on completion of the RTS alignment. Performance of the TS surveillance on the following shift failed to determine that the CBs were closed. As noted above, the circuit breakers were opened at 0325 on 6/26/87.</p> <p>The condition resulted from erroneously specifying the RTS alignment, as well as, failure to identify the error during the review and approval of the RTS alignment. Failure of the next shiftly surveillance to identify the open CBs was due to use of an improper surveillance technique. Personnel have been disciplined as appropriate, and the use of proper surveillance techniques has been re-emphasized to all operations personnel. The review and approval process for RTS alignments will be enhanced. Signs will be posted adjacent to applicable CBs indicating that the breaker must be open when the ECCS and its subsystems are required to be operable in accordance with the TS.</p>																

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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On June 26, 1987, at 0325, with Unit 2 in Mode 1 at 91% power, while conducting a 12-hour interval surveillance of Emergency Core Cooling System (ECCS) (EIIS System Code B0) required by Technical Specification Surveillance Requirement 4.5.2.a, the operating power circuit breakers (EIIS Component Code 52) for valves (EIIS Component Code V) HV-0396 (Shutdown Cooling System Heat Exchanger Bypass Flow Control) and HV-8162 (Low Pressure Safety Injection Pump P-015 Miniflow Isolation) were found to be closed. This is contrary to the Technical Specification requirement. The two breakers were promptly opened. The associated valves HV-0396 and HV-8162, however, remained in the required "closed" and "open" positions, respectively, and the functional capability of the ECCS was, therefore, not impaired by the circuit breakers being closed.

Investigation of this occurrence revealed that certain Train A ECCS components (including the two valves) were removed from service on June 25, 1987, at 0625 for preventive maintenance. Later that morning, the affected components were re-aligned in accordance with the "return to service" alignments specified on the work authorization form. The return to service alignment incorrectly specified that the circuit breakers for valves HV-0392 and HV-8162 be closed. Non-licensed equipment operators, therefore, closed the breakers when directed to restore the ECCS Train to service.

At 1200 on June 25, 1987, the affected ECCS was declared operable based on completion of the alignments specified by the work authorization.

At 1910 on June 25, 1987, the swing shift completed the shiftly surveillance and failed to determine that the two circuit breakers were closed. As noted above, the following shift, in performing the same surveillance procedure, determined that the breakers were in the incorrect position. The breakers were correctly aligned at 0325 on June 26, 1987.

Investigation revealed that specification of valve power supply circuit breaker positions on the work authorization form "return to service" alignment was in error. The on-shift Senior Reactor Operator authorizing performance of the "return to service" alignment did not recognize that the breaker positions for two of the valves was incorrectly specified.

The operator performing the shiftly valve and breaker alignment verification on the shift immediately following the closing of the two valve circuit breakers did not observe the incorrect breaker position indication due to using an improper surveillance technique. Contrary to checking each breaker position individually as required, the operator visually surveyed the breaker panel.

Operations personnel responsible for preparation of valve and breaker "removed from service" and "return to service" alignments on work authorization record forms have been appropriately disciplined. The work authorization record form, and its process for preparation, review and approval, is intended to require that "return to service" equipment alignments be consistent with applicable operating instructions for the equipment involved.

Recent internal audits of the work authorization form and its process had previously indicated that the layout and structure of the form should be improved. Previously planned changes to the work authorization form will simplify and re-structure the form, including the requirement that "return to service" equipment alignments be consistent with applicable operating instructions for the equipment involved.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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The operator who failed to detect the incorrect alignment while performing the surveillance has been disciplined. Use of proper surveillance techniques has been re-emphasized to all operations personnel.

In addition, signs will be posted adjacent to applicable ECCS circuit breakers indicating that they must be open in specified modes when the associated ECCS and subsystems are required to be operable. Similar signs will also be posted adjacent to other circuit breakers which are required by Technical Specifications to be open when the associated component is be operable.

Since the ECCS subsystem remained capable of performing its safety function throughout the period the two valve circuit breakers were misaligned, there was no impact on the health and safety of plant personnel or the public as a result of this event.

Southern California Edison Company

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July 27, 1987

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

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 87-006
San Onofre Nuclear Generating Station, Unit 2

Pursuant to 10 CFR 50.73(a)(2)(i), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving the Emergency Core Cooling System. Neither the health and safety of plant personnel nor the health and safety of the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely,

HE Morgan

Enclosure: LER No. 87-006

cc: F. R. Huey (USNRC Senior Resident Inspector, Units 1, 2 and 3)
J. B. Martin (Regional Administrator, USNRC Region V)
Institute of Nuclear Power Operations (INPO)

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