

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) DIABLO CANYON, UNIT 1										DOCKET NUMBER (2) 0 5 0 0 0 2 7 5										PAGE (3) 1 OF 0 4																																		
TITLE (4) SAFETY INJECTION AND CHARGING PUMP SUCTION CROSSTIE VALVES MISSED SURVEILLANCES																																																						
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 NAMES DIABLO CANYON, UNIT 2													DOCKET NUMBER(S) 0 5 0 0 0 3 2 3														
0 8			1 4			8 5			8 5			0 3 6			0 0			1 2			1 9			8 5			0 5 0 0 0																											
OPERATING MODE (9) 1									THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)																																													
POWER LEVEL (10) 1 0 0									20.402(b)									20.406(c)									50.73(a)(2)(iv)									73.71(b)																		
									20.406(a)(1)(i)									50.36(c)(1)									50.73(a)(2)(v)									73.71(c)																		
									20.406(a)(1)(ii)									50.36(c)(2)									50.73(a)(2)(vi)									OTHER (Specify in Abstract below and in Text, NRC Form 366A)																		
									20.406(a)(1)(iii)									50.73(a)(2)(i)									50.73(a)(2)(vii)(A)																											
									20.406(a)(1)(iv)									50.73(a)(2)(ii)									50.73(a)(2)(vii)(B)																											
									20.406(a)(1)(v)									50.73(a)(2)(iii)									50.73(a)(2)(x)																											
LICENSEE CONTACT FOR THIS LER (12)																																																						
NAME RICHARD M. LUCKETT, REGULATORY COMPLIANCE ENGINEER																				TELEPHONE NUMBER 8 0 5 5 9 5 - 7 3 5 1																																		
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														
<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)

On November 19, 1985, with both units in Mode 1, plant engineers performing a review of surveillance test procedures discovered that the frequency for testing the safety injection and charging pump suction crosstie valves did not conform with the requirements of the Inservice Testing Program.

The Inservice Testing Program requires a quarterly test frequency. The Surveillance Test Procedure V-3L3, "Exercising Valves 8807A and 8807B, Safety Injection Charging Pump Suction Crosstie," specified a cold shutdown frequency. This discrepancy resulted in the surveillance test not being performed several times during the period from August 14, 1984, to November 9, 1985, as required by Technical Specification 4.0.5.

The cause of the discrepancy was personnel error in that the procedure was not updated to reflect a revision to the Inservice Testing Program. Upon discovery, an on-the-spot change was issued to revise the procedure to the correct frequency, and the test was performed.

Plant engineers will continue to review all related surveillance test procedures and the Master Surveillance Schedule to assure compliance with the Inservice Testing Program.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
DIABLO CANYON UNITS 1 AND 2	0 5 0 0 0 2 7 5	8 5	— 0 3 6	— 0 0	0 2	OF 0 4

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

I. Initial Conditions

The units were in Mode 1 (Power Operation) with Unit 1 at 100 percent power and Unit 2 at 40 percent power.

II. Description of Event

A. Event:

On November 19, 1985, plant engineers performing a review of surveillance test procedures discovered that the frequency for testing the safety injection and charging pump suction crosstie valves (8807A and B)(BQ) did not conform with the frequency requirement of the Inservice Testing Program.

The Inservice Testing Program requires a quarterly test frequency. The surveillance test procedure specified a cold shutdown frequency. This discrepancy resulted in the surveillance test on both Units 1 and 2 not being performed within the correct intervals as required by Technical Specification 4.0.5.

PGandE's original Inservice Testing Program was sent to the NRC Staff for review on September 28, 1981. Plant engineers developed or revised surveillance test procedures to reflect the content of this submittal. This original submittal specified a cold shutdown test frequency for the full stroke testing of valves 8807A and B in accordance with the test requirements of ASME Section XI, 1977 Edition (Summer 1978 Addenda), Article IWV-3412, which allows valves to be full-stroke exercised during cold shutdowns when they cannot be practically exercised during plant operation.

Subsequently, in February 1983, during an Inservice Testing Program working meeting between the NRC and their consultants and PGandE engineers, it was decided that valves 8807A and B could be exercised during plant operation with only minimal detrimental effect on operation. As a result of this working meeting, Revision 1 to the Inservice Testing Program was sent to the NRC Staff on May 10, 1983. This revised submittal specified a quarterly test frequency for valves 8807A and B. Upon submitting the revision to the Inservice Testing Program, plant engineers revised surveillance test procedures to reflect the changes made to the program. During this effort, Surveillance Test Procedure V-3L3, "Exercising Valves 8807A and 8807B, Safety Injection Charging Pump Suction Crosstie," was overlooked, and a change in the surveillance frequency was not made.

As a result of the failure to revise the frequency, several test intervals exceeded the 92-day frequency plus the 25 percent allowable extension. The test interval was exceeded seven times for Unit 1 between August 14, 1984, and September 26, 1985, and once for Unit 2 on November 9, 1985.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
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DIABLO CANYON UNITS 1 AND 2	0 5 0 0 0 2 7 5 8 5	—	0 3 6	—	0 0	0 3	OF 0 4

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

- Upon discovery during an ongoing review of surveillance test procedures, the procedure was immediately revised with an on-the-spot change and the test performed on Unit 2. Unit 1 valve testing was current and a test was not required.
- B. Inoperable structures, components, or systems that contributed to the event:
- None
- C. Dates and approximate times for major occurrences:
1. Revision 1 to Inservice Testing Program submitted to NRC:
May 10, 1983
 2. Event dates:
 - a. Surveillance missed on Unit 1 Trains A and B:
August 14, 1984; August 16, 1984; November 24, 1984;
January 4, 1985; April 9, 1985; September 3, 1985; and
September 26, 1985
 - b. Surveillance missed on Unit 2 Trains A and B: November 9, 1985
 3. Discovery date: November 19, 1985
- D. Other system or secondary functions affected:
- None
- E. Method of discovery:
- Plant engineers conducting surveillance test procedure review.
- F. Operator actions:
- None
- G. Safety system responses:
- None

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES 8/31/85

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DIABLO CANYON UNITS 1 AND 2	05000275	85	036	00	04	OF 04

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

III. Cause of Event

A. Immediate cause:

Incorrect test frequency on procedure.

B. Root cause:

This event was caused by personnel error (cognitive). Plant personnel failed to update procedure to reflect revision in the Inservice Testing Program.

IV. Analysis of Event

As demonstrated by the 11 successful completions of this surveillance test procedure for Unit 1 and 4 successful completions for Unit 2 during this time period, PGandE concluded that these valves were operable and capable of performing their intended safety function. Thus, no safety consequences or implications resulted from this event.

V. Corrective Actions

- A. Surveillance Test Procedure V-3L3 was revised to reflect the correct test frequency.
- B. The Master Surveillance Schedule was updated to reflect the correct test frequency.
- C. Plant engineers will continue review of all related surveillance test procedures and the Master Surveillance Schedule to assure compliance with the Inservice Testing Program. This review will be complete by January 15, 1986.

VI. Additional Information

A. Failed components:

None

B. Previous LERs on similar events:

LER 85-029-00, and Rev. 1 Containment Sump Level - Wide Range Missed Surveillances

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PACIFIC GAS AND ELECTRIC COMPANY

PG&E

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JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

December 19, 1985

PGandE Letter No.: DCL-85-368

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

Re: Docket No. 50-275, OL-DPR-80
Docket No. 50-323, OL-DPR-82
Diablo Canyon Units 1 and 2
Licensee Event Report 1-85-036-00
Safety Injection and Charging Pump Suction
Crosstie Valves Missed Surveillances

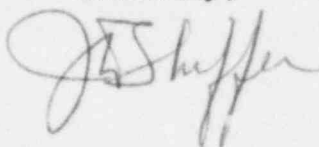
Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i), PGandE is submitting the enclosed Licensee Event Report concerning missed surveillances on safety injection and charging pump suction crosstie valves (8807A and B).

This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,



Enclosure

cc: L. J. Chandler
R. T. Dodds
J. B. Martin
B. Norton
H. E. Schierling
CPUC
Diablo Distribution
INPO

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