

LICENSEE EVENT REPORT (LER)

FACILITY NAME ZION NUCLEAR POWER STATION UNIT	DOCKET NUMBER 0 5 0 0 0 2 9 5	PAGE 1 OF 0 3
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TITLE	1FCV-CS0002 was inoperable between January 15, 1997, and February 8, 1997, because of failing to verify that the acceptance criteria for the return to service of 1FCV-CS0002 was met.
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EVENT DATE			LER NUMBER			REPORT DATE			OTHER FACILITIES INVOLVED		
MONTH	DAY	YEAR	YEAR	SEQ.	REV.	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 1	1 4	9 7	9 7	- 0 0 9	- 0 0	0 5	1 4	9 7	ZION UNIT 2		0 5 0 0 0 3 0 4

OPERATING MODE	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (CHECK ONE OR MORE OF THE FOLLOWING)				
1	20.402(b)	20.405(e)	50.73(a)(2)(iv)	73.71(b)	
POWER LEVEL	20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)	
0 9 9	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	
NAME N.M. Brennan Reg. Assurance Ext. 2380	TELEPHONE NUMBER 8 4 7 7 4 6 - 2 0 8 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		

SUPPLEMENTAL REPORT EXPECTED						EXPECTED SUBMISSION DATE		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).

Operating personnel failed to meet Technical Specification(TS) 4.0.5 "Inservice Inspection Surveillance Requirements." During his review of PT-6B-ST "Containment Spray B Pump Tests and Checks," a Unit Supervisor(US) mis-interpreted the partially performed Technical Staff Group Procedure (TSGP) TSGP-31, "Setting minimum flow stops for FCV-CS0001, 2, 3" as meeting the operability requirements of 1FCV-CS0002. The US assumed that TSGP-31 had been completely performed, but did not review TSGP-31. Therefore 1FCV-CS0002 was inoperable between January 15 and February 8, 1997. On February 8, 1997, 1FCV-CS0002 was successfully "Fail Open" proven operable. Although not correctly documented, the valve was operated during the performance of TSGP-31 sufficiently to provide assurance that following maintenance to the valve, it would fail open. When first reviewed, it was considered that operability of the 1FCV-CS0002 had been shown during the maintenance activity and this event was not reportable. Upon further evaluation, it was determined on April 14, 1997, that because PT-6B-ST was not performed on 1FCV-CS0002, TS 4.0.5 requirements were violated. The Cause of this event is the practice which allows a single License Shift Supervisor to determine what sections of a prescribed Post Maintenance Test will be performed. A contributing cause of this event was the Unit Supervisor failing to verify that the acceptance criteria for the return to service of 1FCV-CS0002 was met. Corrective actions include 1)Unit Supervisor has been counselled. 2)This event will be covered in Licensed Operator current events training. 3)Deletion of a sections of prescribed Maintenance Test will require concurrence of two License Shift Supervisors. (NUREG Code 1022 code E)

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TEXT Energy Industry Identification System (EIIS) codes are identified in the text as [XX]

A. PLANT CONDITIONS PRIOR TO EVENT

Unit 1 MODE 1-power operations RX Power 99.6
RCS[AB]Temperature/Pressure 559 deg F/2235 PSIG

B. DESCRIPTION OF EVENT

On January 14, 1997, at 0501 hours the 1B Containment Spray (CS) [BE] pump was made inoperable to perform corrective maintenance. Part of the work package was the replacement of the valve actuator on 1FCV-CS0002 [BE] "CS Pump B Recirculation Flow Control Valve." The work package contained requirements to perform Technical Staff Group Procedure (TSGP) TSGP-31 "Setting Minimum Flow Stops for FCV-CS0001, 2, 3" and Periodic Test (PT) PT-6B-ST "Containment Spray B Pump Tests and Checks." Both of these tests contain sections to perform "Fail Open" tests on 1FCV-CS0002. TSGP-31 also contains a section that strokes 1FCV-CS0002 for setting minimum flow by removing the power from the supply air solenoid, thus failing 1FCV-CS0002 open. The "Fail Open" test is required to meet Inservice Test (IST) requirements of Technical Specification (TS) 4.0.5.

TSGP-31 and PT-6B-ST were started at 0200 hours. TSGP-31 was completed at 0615 hours. PT-6B-ST testing continued through the 0700 hours Operating Shift turnover and was completed at 0945 hours. The applicable section on TSGP-31 was not used to test the "Fail Open" requirements and was marked "N/A" because of PT-6B-ST was specified in the work package to be performed to prove operability. Interviews with the System Engineer indicated that he requested flow readings from the Unit 1 Nuclear Station Operator (NSO) while setting the mechanical stops, but this was not documented. 1FCV-CS0002 [BE] was failed open 10 times during the setting of the minimum flow stop. After test TSGP-31 was completed, the System Engineer performing the test notified the Unit One Unit Supervisor (US) and left the site.

The oncoming US, during his review of PT-6B-ST, mis-interpreted the multiple stroking of 1FCV-CS0002 performed in TSGP-31. The PT-6B-ST section that tests the "Fail Open" requirements of 1FCV-CS0002 was mistakenly marked "N/A" by the US. The US assumed that the entire TSGP-31 has been performed the preceding shift without verification. This resulted in 1FCV-CS0002 being returned to service without being proven operable. On February 8, 1997, 1FCV-CS0002 was successfully "Fail Open" tested and proven operable. Therefore, 1FCV-CS0002 was inoperable between January 15, 1997, and February 8, 1997. When first reviewed, it was considered that operability of the 1FCV-CS0002 "CS Pump B Recirculation Flow Control Valve" had been demonstrated during the maintenance activity and this event was not reportable. Upon further evaluation, it was determined on April 14, 1997, that because PT-6B-ST was not performed on 1FCV-CS0002, the event violated TS 4.0.5 requirements.

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C. CAUSE OF EVENT

The Cause of this event is the practice which allows a single License Shift Supervisor to determine what sections of a prescribed Post Maintenance Test will be performed. A contributing cause of this event was the Unit Supervisor failing to verify that the acceptance criteria for the return to service of 1FCV-CS0002 was met.

D. SAFETY ANALYSIS

Although not correctly documented, the valve was operated during the performance of TSGP-31, "Setting Minimum Flow Stops For FCV-CS0001,2,3," sufficiently to provide assurance that following maintenance the valve would fail open following a loss of instrument air. When adjusting the valve to meet its upper mechanical stop, the controller supplies zero current to the air supply solenoid which vents the control air from the valve actuator. This has the same effect as a loss of air. TSGP-31 step 7.2.13 records that at the upper mechanical stop the flow rate reads 145 gpm which is essentially full open. The valve came to this position by the engineer electrically opening the solenoid valve, venting the air from the actuator, and allowing the spring to force open the valve. The work performed replaced the valve diaphragm actuator. No work was performed on the actuation circuitry and therefore the actuation circuitry function was not affected. The safety significance of the event is minimal and the risk to the health and safety of the public was not affected.

E. CORRECTIVE ACTIONS

1. Unit Supervisor has been counselled.
2. This event will be covered in Licensed Operator current events training.
3. Plant procedures will be revised to require concurrence of two Licensed Shift Supervisors to delete sections of prescribed Post Maintenance Tests.

F. PREVIOUS EVENTS SEARCH AND ANALYSIS

A review of Zion's Nuclear Tracking System database has revealed a previous occurrence in which Licensed Shift Supervisors performed an inadequate review; refer to LERs 95-0006, 96-007 and 96-009. Zion Station has identified that problems exist in this area of surveillance compliance and is taking steps to eliminate this problem.

G. COMPONENT FAILURE DATA

None