

# ACCELERATED DISTRIBUTION DEMONSTRATION SYSTEM

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8804060246      DOC. DATE: 88/03/31      NOTARIZED: NO      DOCKET #  
 FACIL: 50-362 San Onofre Nuclear Station, Unit 3, Southern Californ      05000362  
 AUTH. NAME      AUTHOR AFFILIATION  
 MORGAN, H.E.      Southern California Edison Co.  
 RECIP. NAME      RECIPIENT AFFILIATION

SUBJECT: LER 88-003-00: on 880224, delinquent inservice test of containment emergency cooling subsystem valve.

w/8      ltr.

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

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LICENSEE EVENT REPORT (LER)

|   |  |  |  |  |  |  |  |  |                            |  |  |
|---|--|--|--|--|--|--|--|--|----------------------------|--|--|
| Facility Name (1)<br>SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 3  |  |  |  |  |  | Docket Number (2)<br>0   5   0   0   0   3   6   2 |  |  | Page (3)<br>1   of   0   6 |  |  |
| Title (4)<br>DELINQUENT INSERVICE TEST (IST) OF CONTAINMENT EMERGENCY COOLING SUBSYSTEM VALVE DUE TO INADEQUATE ADMINISTRATIVE CONTROLS |  |  |  |  |  |  |  |  |                            |  |  |

| 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 |                               | Docket Number(s)  |  |  |
| 0   2          | 2   4 | 8   8 | 8   8          | 0   0   3         | 0   0           | 0   3 | 3   1           | 8   8 | NONE           |                               | 0   5   0   0   0 |  |  |

|                               |           |  |                  |                   |                  |                 |           |             |                |                 |                  |                 |                |                  |                      |                      |                |          |          |   |
|-------------------------------|-----------|--|------------------|-------------------|------------------|-----------------|-----------|-------------|----------------|-----------------|------------------|-----------------|----------------|------------------|----------------------|----------------------|----------------|----------|----------|---|
| OPERATING MODE (9)<br>1       |           | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11) |                  |                   |                  |                 |           |             |                |                 |                  |                 |                |                  |                      |                      |                |          |          |   |
| POWER LEVEL (10)<br>1   0   0 | 20.402(b) | 20.405(a)(1)(i)  | 20.405(a)(1)(ii) | 20.405(a)(1)(iii) | 20.405(a)(1)(iv) | 20.405(a)(1)(v) | 20.405(c) | 50.36(c)(1) | 50.73(a)(2)(i) | 50.73(a)(2)(ii) | 50.73(a)(2)(iii) | 50.73(a)(2)(iv) | 50.73(a)(2)(v) | 50.73(a)(2)(vii) | 50.73(a)(2)(viii)(A) | 50.73(a)(2)(viii)(B) | 50.73(a)(2)(x) | 73.71(b) | 73.71(c) | Other (Specify in Abstract below and in text) |

LICENSEE CONTACT FOR THIS LER (12)

|                                       |  |
|---------------------------------------|--|
| Name<br>H. E. Morgan, Station Manager | TELEPHONE NUMBER<br>AREA CODE<br>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 NPRDS | CAUSE  | SYSTEM | COMPONENT | MANUFACTURER | REPORTABLE TO NPRDS |
|--------|--------|-----------|--------------|---------------------|--------|--------|-----------|--------------|---------------------|
| ////// | ////// | //////    | //////       | //////              | ////// | ////// | //////    | //////       | //////              |
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SUPPLEMENTAL REPORT EXPECTED (14)

|  |  |                               |       |     |      |
|--|--|-------------------------------|-------|-----|------|
| <input type="checkbox"/> Yes (If yes, complete EXPECTED SUBMISSION DATE) | <input checked="" type="checkbox"/> NO | Expected Submission Date (15) | Month | Day | Year |
|--|--|-------------------------------|-------|-----|------|

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On 3/1/88, with Unit 3 in Mode 1 at 100% power, during a supplemental review of IST surveillance records, it was discovered that Containment Emergency Cooling Subsystem (CCS) valve HV-6370 had exceeded the time period for completing the quarterly (92-day) stroke test required by Technical Specification (TS) 4.6.3.5, including the 25% extension permitted by TS 4.0.2. The valve was last tested on 11/1/87, and was scheduled to be tested on 1/31/88. The 25% extension expired on 2/24/88. There was no safety significance to this event since subsequent IST of HV-6370 on 3/2/88 demonstrated that the valve remained operable.

Because a Caution Tag was attached to the actuation switch for HV-6370 at the time the IST surveillance checklist was performed for the CCS valves, the Control Room Operator (CO) did not stroke the valve. Contrary to procedures: 1) the CO annotated the Comments Section of the checklist with the Caution Tag number and failed to initiate an Equipment Deficiency Mode Restraint (EDMR) form used to track this type of incomplete test; and 2) the SRO Operations Supervisor (CRS), due to an oversight, reviewed and approved the checklist results without resolving this comment as required by the program. The root cause of these errors is the lack of clear procedural guidance for dealing with surveillance checklist items which cannot be performed as scheduled.

This event has been reviewed with the CRS and CO involved. Appropriate surveillance operating instructions will be revised to provide additional and explicit administrative controls for dealing with surveillance checklist items which cannot be performed as scheduled. Upon completion of the above procedure revisions, all Units 2 and 3 licensed Operators will receive on-the-job training on the administrative requirements for dealing with surveillance steps which are not performed.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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Plant: San Onofre Nuclear Generating Station  
 Unit: Three  
 Reactor Vendor: Combustion Engineering  
 Event Date: 02-24-88

A. CONDITIONS AT TIME OF THE EVENT:

Mode: 1  
 Reactor Power: 100%

B. BACKGROUND INFORMATION:

The Containment Emergency Cooling Subsystem (CCS) (EIIS System Code BK), which contains four emergency cooling units (ECU) (two for each train), is designed to remove sufficient heat energy from containment atmosphere, following a Loss of Coolant Accident (LOCA) or Main steam Line Break (MSLB), to maintain containment atmospheric pressure below design limits. The Component Cooling Water (CCW) System (EIIS System Code CC) removes heat from the Containment ECUs. CCW for each of the ECUs passes through its supply containment isolation valve (HV-6366, 6368, 6370 or 6372) (EIIS Component Code ISV), through the cooling coil and out through its return containment isolation valve (HV-6367, 6369, 6371 or 6373) to the CCW System. The Containment ECUs automatically start and CCW isolation valves open upon receipt of a Containment Cooling Actuation Signal (CCAS) (EIIS System Code JE).

Technical Specification (TS) Surveillance Requirement 4.6.3.5 requires quarterly Inservice Tests (IST) be performed for the CCW isolation valves. Surveillance Operating Instruction (SOI) S023-3-3.30, "Inservice Valve Testing, Quarterly", Attachment 12 checklist, contains the CCW isolation valves to the Containment ECUs.

Operations Division Procedure S0123-0-20, "Use of Procedures", specifies how to deal with procedural sign-off/initial steps that are not performed. One method permitted is to enter "A/C" (Alternately Controlled) in the sign-off space and reference the alternately controlling document in the Comments Section of the Attachment. Limiting Condition for Operation Action Requirement (LCOAR) or Equipment Deficiency Mode Restraint (EDMR) tracking forms are acceptable documents which track the actions to be taken for instances when the surveillance schedule can not be met.

S0123-0-20 and S023-3-3.30 specifically state that the SRO Operations Supervisor reviewing the attachment for completeness should not sign the "Reviewed By" block until all comments have been resolved.

SOI S023-3-3.0, "Operations Surveillance Program Requirements", specifies the SRO Operations Supervisor as having responsibility for reviewing the completeness, accuracy and results of surveillance testing, reporting schedule deviations to the Surveillance Coordinator, and initiating appropriate tracking documentation (e.g. EDMR), if applicable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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C. DESCRIPTION OF THE EVENT:

1. Event:

On March 1, 1988, with Unit 3 in Mode 1 at 100% power, during a supplemental review of IST surveillance records, it was discovered that CCS valve HV-6370 had exceeded the time period for completing the quarterly (92-day) stroke test required by TS 4.6.3.5, including the 25% extension permitted by TS 4.0.2. The valve was last tested on November 1, 1987, and was scheduled to be tested on January 31, 1988. The 25% extension expired on February 24, 1988.

Because a Caution Tag was attached to the actuation switch for HV-6370 at the time the IST surveillance checklist was performed for the CCS valves, the licensed Control Room Operator (CO) did not stroke the valve. Contrary to administrative controls, the CO annotated the Comments Section of the checklist with the Caution Tag number, which is not an acceptable alternately controlling document, and failed to initiate an EDMR form used to track this type of incomplete test.

Investigation determined that the Caution Tag had been placed on HV-6370 to advise the operators not to use HV-6370 for flow balancing due to a possible water hammer. On March 2, 1988, after it was determined that the concern for a potential water hammer was not valid, the Caution Tag was removed and a satisfactory IST of HV-6370 was performed. The bases for the concern described on the Caution Tag could not be identified.

2. Inoperable Structures, Systems or Components that Contributed to the Event:

None.

3. Sequence of Events:

| DATE    | ACTION   |
|---------|--|
| 11/1/87 | Quarterly IST of CCS valves satisfactorily completed.                      |
| 1/31/88 | Quarterly IST of CCS valves performed, HV-6370 not tested.                 |
| 2/24/88 | The 25% extension permitted by Technical Specification 4.0.2 exceeded.     |
| 3/1/88  | Missed IST of HV-6370 discovered. Purpose of caution tag investigated.     |
| 3/2/88  | Caution tag removed from HV-6370. IST of HV-6370 satisfactorily performed. |

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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4. Method of Discovery:

The missed IST was discovered while conducting a supplemental review of IST surveillance results by the Surveillance Coordinator.

5. Personnel Actions and Analysis of Actions:

Upon identification of the missed IST, Operations management investigated the basis for the caution tag prior to operating HV-6370. After it was determined that the caution tag was not required, the tag was removed and HV-6370 was properly tested.

6. Safety System Responses:

Not applicable.

D. CAUSE OF THE EVENT:

1. Immediate Cause(s):

- a. Contrary to S0123-0-20, the CO completing the checklist failed to either test HV-6370 or follow administrative procedures for dealing with steps which are not performed. Consequently, an EDMR was not initiated which would have flagged the requirement to complete the test.
- b. Contrary to S0123-0-20, the responsible SRO Operations Supervisor (CRS) failed to resolve the comment associated with HV-6370 prior to approving the surveillance checklist.

2. Intermediate Cause(s):

- a. The procedural error by the CO was due to a lack of clear understanding of the need to strictly apply the administrative requirements for completing procedural steps to Technical Specification surveillance checklists.
- b. The procedural error by the CRS has been attributed to an administrative oversight during the review of the checklist for completeness. This individual was fully cognizant of the requirements for initiating proper tracking documents and to notify the Surveillance Coordinator when scheduled surveillances are not performed. Because the review failed to identify the need to resolve the comment for HV-6370, these required actions were not taken. A review of recent IST records was performed and no other missed surveillances were found.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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3. Root Cause:

The root cause of the procedural errors described above is the lack of clear administrative controls. Although administrative procedure S0123-0-20 address several methods of dealing with procedural sign-off steps which cannot be completed, the Units 2 and 3 surveillance program implementation procedure S023-3-3.0 fails to provide clear guidance on what actions are expected of the CO and CRS when a surveillance checklist item cannot be completed. Unlike S023-3-3.0, the Unit 1 surveillance program implementing procedure provides explicit actions to be taken, including the initiation of a unique tracking form and the placement of "test required" stickers, when a surveillance checklist item cannot be performed. The instructions contained in S023-3-3.0 are not sufficiently prescriptive to prevent errors such as those described above.

E. CORRECTIVE ACTIONS:

1. Corrective Actions Taken:

- a. A satisfactory IST of HV-6370 was performed on 3/2/88.
- b. This event has been reviewed with the CRS and the CO involved.

2. Planned Corrective Actions:

- a. The Acceptance Criteria section of all valve IST surveillance test procedures will be revised to explicitly require the initiation of an EDMR for each valve that cannot be tested as scheduled during performance of the entire checklist.
- b. SOI S023-3-3.0 will be revised to provide additional and explicit administrative controls for dealing with surveillance checklist items which cannot be performed as scheduled.
- c. Upon completion of the above procedure revisions, all Units 2 and 3 licensed Operators will receive on-the-job training on the administrative requirements for dealing with surveillance steps which are not performed.

F. SAFETY SIGNIFICANCE OF THE EVENT:

There were no safety consequences resulting from this event since subsequent stroke testing of HV-6370 demonstrated that the valve remained operable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

|   |                           |                         |                |
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G. ADDITIONAL INFORMATION:

1. Component Failure Information:

Not applicable.

2. Previous LERs on Similar Events:

A delinquent IST quarterly surveillance on Unit 1 No. 2 Diesel Generator valves was reported in LER 86-001, Docket No. 50-206. The valves were not tested during the scheduled surveillance since the No. 2 Diesel Generator was removed from service for maintenance at that time. Administrative procedures for surveillance implementation requires a tracking form to be completed identifying equipment which could not be tested during performance of a surveillance procedure. Contrary to this procedure, the responsible individual failed to identify the need for this form during the review and closure of the quarterly IST valve procedure. As corrective action, administrative procedures for Unit 1 were revised to clarify requirements for the tracking form and to increase the frequency of audits. This corrective action was not applied to Units 2 and 3 since it was determined that administrative controls were sufficient to prevent occurrence. However, these controls were not designed to overcome multiple personnel errors.

3. Results of NPRDS Search:

Not applicable.



**Southern California Edison Company**

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H. E. MORGAN  
STATION MANAGER

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March 31, 1988

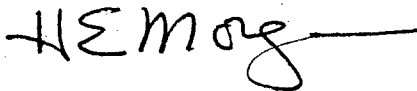
U. S. Nuclear Regulatory Commission  
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Washington, D.C. 20555

Subject: Docket No. 50-362  
30-Day Report  
Licensee Event Report No. 88-003  
San Onofre Nuclear Generating Station, Unit 3

Pursuant to 10 CFR 50.73(a)(2)(i)(B), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving a delinquent Inservice Test of a Containment Emergency Cooling Subsystem valve. 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,



Enclosure: LER No. 88-003

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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