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RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 86-024-00:on 860104, missed surveillance on PORV

discharge temp channel due to personnel error.

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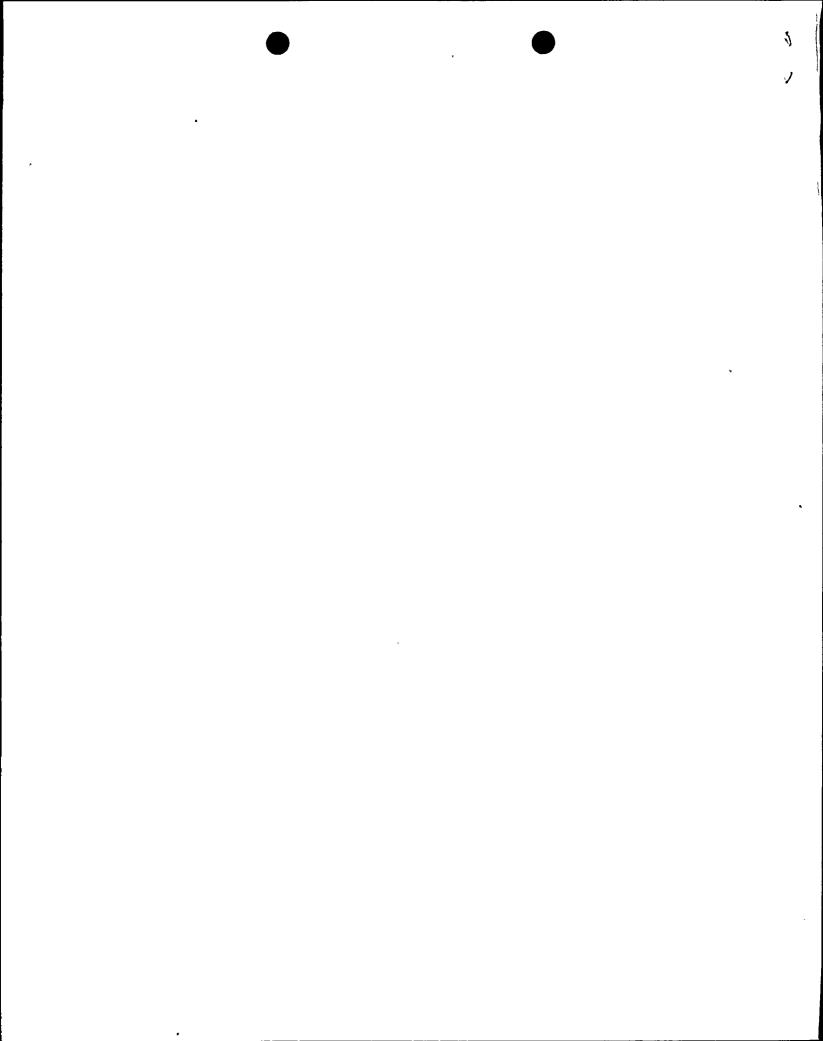
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Pacific Gas and Electric Company

77 Beale Street*
San Francisco, CA 94106
415/972-7000
TWX 910-372-6587

James D. Shiffer Vice President Nuclear Power Generation

May 24, 1989

PG&E Letter No. DCL-89-144



D.

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk 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 1-86-024-00
Missed Surveillance on PORV Discharge Temperature Channel due to Personnel Error

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i)(B), PG&E is submitting the enclosed Licensee Event Report (LER) concerning a missed surveillance on PORV discharge temperature channel due to personnel error.

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.

J. D. Shiffer

c: J. B. Martin
M. M. Mendonca
P. P. Narbut

H. Rood

B. H. Vogler

CPUC

Diablo Distribution

INPO

Enclosure

DCO-89-TN-NO50

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On January 4, 1986, for Unit 1 and December 11, 1986, for Unit 2, the surveillance interval for Technical Specification (TS) 4.3.3.6, item 13, including the 25 percent extension allowed by TS 4.0.2, was exceeded. These events were discovered on April 28, 1989 during a review of the preventive maintenance overdue report. It was discovered that a surveillance calibration test procedure was not issued for temperature channel TE-463, PORV Common Discharge Header Temperature. Upon discovery, the Shift Foreman for each unit was notified and TE-463 was declared inoperable for both units at 1230 PDT April 28, 1989.

These events were caused by personnel error, cognitive, in that plant personnel reviewing the TS changes for required surveillances failed to identify TE-463 as being applicable to TS 4.3.3.6, item 13. A surveillance calibration test procedure was issued, and performed on TE-463 on May 3, 1989 for Unit 1 and May 2, 1989 for Unit 2, and the affected instruments were declared operable.

To preclude recurrence, an independent review of the TS and the Surveillance Test Procedures will be performed to ensure all required surveillances are identified, proceduralized, and are being performed.

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ABSTRACT (16)

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U.S NUCLEAR REGULATORY COMMISSION
APPROVED OMS NO 3150-0104
EXPRES \$23108

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I. <u>Initial Conditions</u>

Unit 1 and Unit 2 operated at various modes and at various power levels while this condition existed.

II. Description of Event

None

A. Event:

On January 4, 1986, for Unit 1 and December 11, 1986, for Unit 2, the surveillance interval for Technical Specification (TS) 4.3.3.6, item 13, including the 25 percent extension allowed by TS 4.0.2, was exceeded. These events were discovered on April 28, 1989 during a review of the preventive maintenance overdue report. It was discovered that a surveillance calibration test procedure was not issued for temperature channel TE-463, PORV Common Discharge Header Temperature(AB)(TI). Upon discovery, the Shift Foreman for each unit was notified and TE-463 was declared inoperable for both units at 1230 PDT April 28, 1989.

The requirement to perform a channel calibration at least once every 18 months was added to the Combined Units 1 and 2 TS. The Combined Units 1 and 2 TS were issued with the Full Power Operating License for Unit 2 on August 26, 1985. During this time period, Unit 1 was in the final stages of the startup test program, and achieved initial commercial operation. Unit 2 had received a low power license, and was in the process of achieving initial criticality. Plant departments conducted a review of the Combined TS and compared them to surveillance test procedures to ensure all required surveillances were proceduralized. However, this review did not identify that a separate calibration procedure was required for TE-463.

B. Inoperable structures, components, or systems that contributed to the event:

C. Dates and approximate times for major occurrences:

1. August 26, 1985: Combined TS issued

Combined TS issued with a new 18 month

surveillance requirement.

2. January 4, 1986: Event date for Unit 1. TE-463 calibration

surveillance test not performed in

accordance with TS.

3. December 11, 1986: Event date for Unit 2. TE-463 calibration

surveillance test not performed in

accordance with TS.

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LICENSEE FORT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION
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- 4. April 28, 1989, at 1230 PDT: Discovery Date. TE-463 for both units declared inoperable.
- 5. May 2, 1989:

Surveillance test was performed on Unit 2,

6. May 3, 1989:

Surveillance test was performed on Unit 1.

D. Other systems or secondary functions affected:

None

E. Method of discovery:

These events were discovered by an I&C Engineer during the routine review of overdue preventive maintenance activities.

F. Operator actions:

Upon notification of the problem, the Shift Foreman of each unit declared TE-463 for each unit inoperable, entering TS action statement 3.3.3.6.a.

G. Safety system responses:

None

III. Cause of event:

A. Immediate cause:

The cause of this event was failure to perform an adequate review of the TS changes by plant departments.

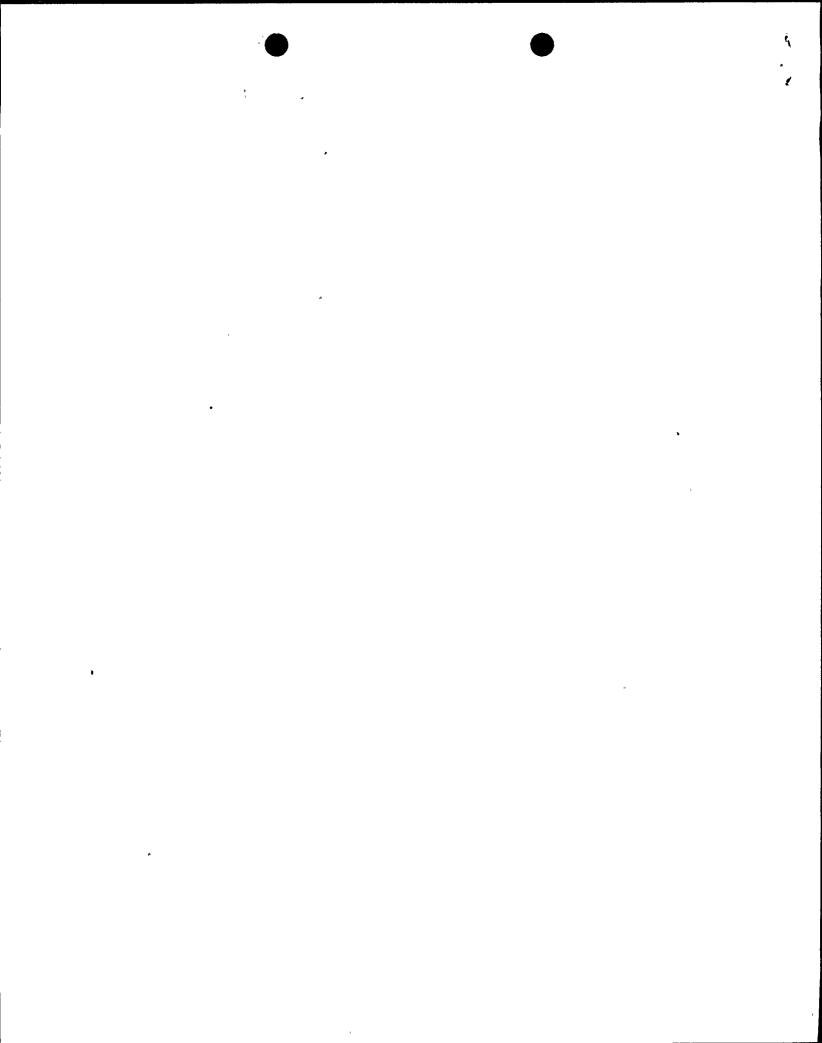
B. Root cause:

Personnel error, cognitive, in that personnel responsible for identifying equipment after the issuance of the combined TS requiring surveillance tests failed to identify that TE-463 required a surveillance calibration test procedure.

IV. Analysis of Event:

The PORV tailpipe temperature indicator, TE-463, provides additional indication of a PORV that is not fully closed. The calibration check performed May 3, 1989 for Unit 1 and May 2, 1989 for Unit 2, confirmed TE-463 to be within calibration limits

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U.S. MUCLEAR REGULATORY COMMISSION
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and fully functional. A review of maintenance history records disclosed that TE-463 was not removed from service for any time greater than the seven days allowed by TS 3.3.3.6.a.

Therefore, for both units, TE-463 was calibrated and with the exception of maintenance, was fully functional throughout the period of this event, and would have performed its intended safety function.

Thus, the health and safety of the public were not affected by this event.

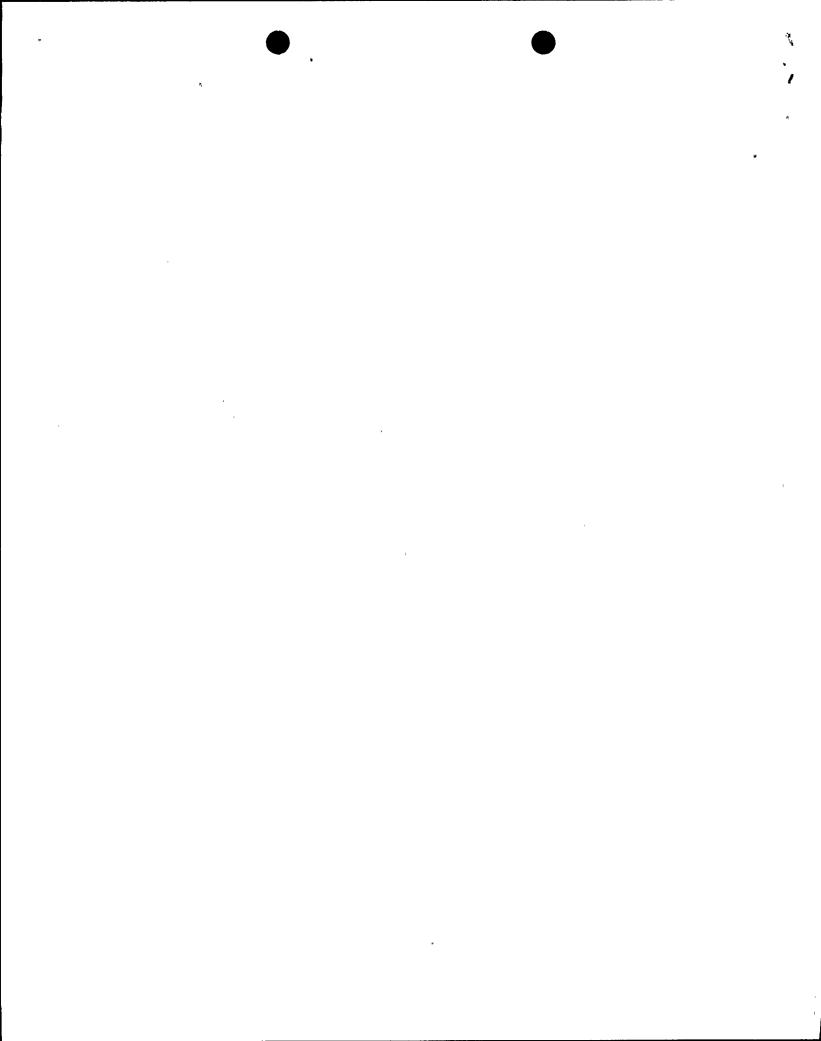
V. Corrective Actions:

- A. Immediate Corrective Actions
 - 1. A surveillance calibration test procedure was issued and performed on TE-463 on May 3, 1989 for Unit 1 and May 2, 1989 for Unit 2, and the affected instruments were declared operable. STP I-83C, "Calibration of Pressurizer PORV Temperature Channel 463," was added to the Recurring Task Scheduler, and AP C-3S1, "Surveillance Testing and Inspection," Attachment 6.3 and 6.4 of the Master Markup was modified to include the surveillance requirement.
- B. Corrective Actions to Prevent Recurrence:
 - 1. An independent review of the TS and the Surveillance Test Procedures will be performed to ensure all required surveillances are identified, proceduralized, and are being performed.
 - 2. PG&E Quality Assurance will conduct an audit of the recent license amendments to ensure that all new and revised regulatory requirements requiring surveillances are identified, implemented in procedures, and are performed when required.
 - 3. AP C-3S1, "Surveillance Testing and Inspection" and AP A-55, "Technical Specification Change Process," will be revised to provide further guidance regarding the responsibility for updating AP C-3S1 due to license amendments.

VI. Additional Information:

.A. Failed components:

None



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B. Previous LERs on similar events:

LER 2-88-026-00 concerned the failure to perform a surveillance test on the reactor vessel head vent valves in accordance with TS 4.0.5. This event was caused by personnel error, in that, engineering and operations personnel reviewing the test requirements for the reactor vessel head vent valves concluded that the surveillance frequency requirements of TS 4.4.11 met the IST Program requirements. Corrective actions included revising the Recurring Task Scheduler and the applicable STP. Since that event involved a different TS surveillance requirement, and occurred after this event, the corrective actions taken for LER 2-88-026-00 would not have prevented this occurrence.

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