

Commonwealth Edison

Zion Generating Station 101 Shiloh Blvd. Zion, Illinois 60099 Telephone 708 / 746-2084

January 27, 1994

U. S. Nuclear Regulatory Commission Document Control Desk Washington. DC 20555

Dear Sir;

The enclosed Licensee Event Report number 93-004-00. Docket No. 50-304/DPR-048 from Zion Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(i)(B), which requires a 30 day written report when any operation or condition occurs that is prohibited by the plant's Technical Specifications.

Very truly yours.

E. A. Broccolo(/ Station Manager Zion Generating Station

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Enclosure: Licensee Event Report

cc: NRC Region III Administrator NRC Resident Inspector INPO Record Center CECo distribution List

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

On December 28, 1993, during review of Technical Staff Surveillance (TSS) 15.6.20V-P. "In Service Testing Valve Surveillance. Power Operated Valve Testing", it was noticed that the stroke time from July 29, 1993. for valve 2MOV-CSD002 [BE], had increased by 26.3% compared to the previous stroke time. The ASME code requires that the test frequency be increased to monthly whenever the stroke time of the valve increases by 25% or more. The required increased testing was not performed in August or Semptember.

The cause of the missed surveillances was personnel error. The IST coordinator failed to identify the 25% increase in stroke time, and thus did not place the valve on increased surveillance contrary to the requirements of ISS 15.6.20V-P, step 4.4.

The Safety Analysis maximum stroke time limit was not exceeded during the surveillance. The safety significance of this event was minimal.

Corrective actions include reviewing this event with the appropriate personnel to stress attention to detail, review of the 1993 IST program surveillances for additional deficiencies, revision of the IST procedure, and increased review of the program until the new program is instituted.

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A. CONDITION PRIOR TO EVENT

MODE 0 - Defueled RX Power 0% RCS [AB] Temperature/ Pressure _____ F ____psig

B. DESCRIPTION OF EVENT

On July 29. 1993, valve 2MOV-CS0002 [BE] was stroked in accordance with Periodic Test (PT) 6A-ST. "Containment Spray Pump A System Tests and Checks". The valve stroked in 60.5 seconds, which was less than the 65 second maximum stroke time. Once the PT was completed, it was forwarded to the Operating Engineers for their review and then on to the IST Coordinator for review per Technical Staff Surveillance (TSS) 15.6.20V-P. "In Service Testing Valve Surveillance, Power Operated Valve Testing". During the IST Coordinator's review, data was transferred from the PT to a graph for each valve in the PT which was covered under the IST program. As part of the review, the IST coordinator also calculated the percent increase in stroke time for each valve.

On December 28, 1993, during review of TSS 15.6.20V-P, it was noticed that the 60.5 second stroke time for valve 2MOV-CS0002 was 26.3% greater than the previous stroke time of 47.9 seconds on May 3, 1993. The IST program, as required by Technical Specifications 4.0.5, is based on the 1980 ASME Section XI code with the Winter 1981 Addenda. The code requires that test frequency be increased to monthly whenever the stroke time of a valve increases by 25% or more for valves with full-stroke times greater than 10 seconds. Unit 2 shut down in September for a planned outage, with the required testing due during August and September having been missed. This was a violation of Technical Specifications, 4.6.1.A.2, which requires that this valve be tested per Technical Specifications, 4.0.5.

Upon identification of this event, the IST coordinator began a review of the valve stroke data for the year of 1993.

C. APPARENT CAUSE OF EVENT

The cause of the missed surveillances was personnel error. The IST coordinator failed to identify the 25% increase in stroke time, and thus did not place the valve on increased surveillance contrary to the requirements of TSS 15.6.20V-P. step 4.4.

A contributing cause of the missed surveillance was procedural deficiency. TSS 15.6.20V-P required that the percent increase in stroke time be calculated but did not provide a worksheet or log sheet for documenting this value and the pass/fail of the trending acceptance criteria.

A contributing cause was management/QA deficiency. Technical deficiencies in the IST procedures were previously identified, but sufficient resources were not available to ensure that suitable priority was placed on performing the changes in a timely manner.

SAFETY ANALYSIS OF EVENT

The Safety Analysis maximum stroke time limit had not been exceeded during the surveillance. There was no increase in the significance of any accident on the health and safety of the public.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION														Form Rev 3.0												
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- This event has been reviewed with the Results Engineering Group in order to stress the importance of attention to detail and self-checking.
- The IST procedure is in the process of being completely revised to incorporate the noted deficiencies and meet the requirements of the Third 10 Year Interval. The Third 10 Year Interval program will be based on the 1989 revision of the ASME Section XI code. The new code does not have the increased frequency requirement based on the 25% increase of stroke time. In place of the increased frequency requirement will be an acceptance band on the stroke time of valves. This acceptance band will allow for identification of problem valves, at the time of valve stroke. ZMAP 01208 is tracking implementation of the third 10 Year Interval Program.
- The System Engineering/Results Engineering Group Leader will review TSS 15.6.20V-P and TSS 15.6.20P. "IST Pump Surveillance", on a bi-weekly basis until the new procedure is implemented. (304-180-93-00701)
- The 1993 IST program surveillances will be reviewed to determine if any other deficiencies exist. Other equipment which exceeded the trending acceptance criteria and was not previously identified will be documented. Any corrective actions will be
- Valve 2MOV-CS0002 will be retested per the applicable section of PT 6A-ST prior to startup of Unit 2. Operations will be informed that General Operating Procedure (GOP) 0. "Plant Startup Documentation Requirements". must require that the applicable section of PT 6A-ST be performed. (304-180-93-00703)
- System Engineering/Results Engineering Group has hired a contractor to coordinate
- PT-13A, "ISI Increased Testing Frequency Program for Valves", has been performed, increasing the surveillance frequency of 2MOV-CS0002 from quarterly to monthly until corrective actions or evaluation have been performed on the valve.

A Nuclear Tracking System database search was performed on the subject containing "CS0002". "In Service Test". "Stroke Time". "Surveillance" or "Missed Surveillance" and no similar events were located.