



**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

TPJ/sks

Enclosure: Licensee Event Report

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

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION											Form Rev 3.0											
FACILITY NAME (1)	DOCKET NUMBER (2)				LER NUMBER (6)						Page (3)											
					Year	///	Sequential	///	Revision													
					///	///	Number	///	Number													
Zion Unit 2	0	5	0	0	0	3	0	4	9	3	-	0	0	4	-	0	0	0	2	DF	0	13

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

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.

D. 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.

