

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) DIABLO CANYON UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 2 7 5	PAGE (3) 1 OF 0 1 4
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TITLE (4)
MISSED SURVEILLANCE ON BIT RECIRCULATION CHECK VALVE 8912

EVENT DATE (5)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 3	0 3	8 4	8 4	0 3 6	0 1	0 3	1 0	8 6	DIABLO CANYON UNIT 2		0 5 0 0 0 3 2 3
									0 5 0 0 0		

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

OPERATING MODE (9) 3	20.402(b)	20.405(e)	80.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 0 0 0	20.405(a)(1)(i)	80.38(e)(1)	80.73(a)(2)(v)	73.71(e)
	20.405(a)(1)(ii)	80.38(e)(2)	80.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 80.73(a)(2)(i)	80.73(a)(2)(vii)(A)	
	20.405(a)(1)(iv)	80.73(a)(2)(ii)	80.73(a)(2)(vii)(B)	
	20.405(a)(1)(v)	80.73(a)(2)(iii)	80.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME DAVID P. SISK, REGULATORY COMPLIANCE ENGINEER	TELEPHONE NUMBER 8 0 5 5 9 5 1 - 7 3 5 1
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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

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (16)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (18)

On March 3, 1984, for Unit 1 and on July 25, 1985, for Unit 2, initial entry to Mode 3 (Hot Standby) was made without the boron injection tank (BIT) recirculation check valve 8912 for either unit meeting the ASME Section XI stroke testing requirements as required by Technical Specifications (T.S.) 4.0.4. and 4.0.5. Check valve 8912 was initially demonstrated to "stroke to the fully closed position" for Unit 1 on January 14, 1986, and for Unit 2 on October 30, 1985. This event was discovered on January 6, 1986, by plant engineers performing an internal engineering review of the Inservice Testing (IST) Program.

This event was caused by a procedure deficiency. This valve was being tested during the performance of Surveillance Test Procedure (STP) P-14B to verify the valve to be in the fully opened position. However, the IST Program referenced STP P-14B as meeting the requirement to stroke to the fully closed position. Plant engineers failed to identify the need to stroke this check valve closed during the development of STP P-14B.

To prevent recurrence, STP M-16B will be revised to include the testing of check valve 8912 in the fully closed position for both units. The IST Program submitted for both units will be revised to reference STP M-16B as the STP implementing the requirements of ASME Section XI for check valve 8912. This event has been reviewed with all applicable personnel.

LER 1-85-036-00 reported a similar event.
0739S/0042K

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FACILITY NAME (1) DIABLO CANYON UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 2 7 5	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (// more space is required, use additional NRC Form 365A's) (17)

I. Initial Conditions

Both units were in Mode 4 (Hot Shutdown) prior to initial entry to Mode 3 (Hot Standby) and operated in Mode 1 (Power Operation) to Mode 5 (Cold Shutdown) prior to satisfactorily meeting the ASME Section XI surveillance requirement for check valve 8912 (BQ)(V).

II. Description of Event

A. Event

On March 3, 1984, for Unit 1 and on July 25, 1985, for Unit 2, initial entry to Mode 3 (Hot Standby) was made without the boron injection tank (BQ)(BIT) recirculation check valve 8912 for either unit meeting the ASME Section XI stroke testing requirements as required by Technical Specifications (T.S.) 4.0.4. and 4.0.5. Check valve 8912 was initially demonstrated to "stroke to the fully closed position" for Unit 1 on January 14, 1986, and for Unit 2 on October 30, 1985.

This event was discovered on January 5, 1986, by plant engineers while performing an internal engineering review of the Inservice Testing (ISI) Program. The engineers found that no specific procedure stroke tested the valve to the closed position on a quarterly basis.

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

None

C. Dates for major occurrences.

1. March 3, 1984: Event Date - Initial entry of Unit 1 to Mode 3.
2. July 25, 1985: Event Date - Initial entry of Unit 2 to Mode 3.
3. October 30, 1985: For Unit 2, during a slave relay test from the plant solid state protection system, check valve 8912 was stroke tested to the fully closed position as well, thereby meeting the ASME Section XI stroke test requirements.
4. January 6, 1986: Discovery Date
5. January 14, 1986: Unit 1 check valve 8912 was stroke tested to the fully closed position to assure operability and meet the ASME Section XI stroke test requirements.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (if more space is required, use additional NRC Form 366A's) (17)

D. Other system or secondary functions affected:

None

E. Method of discovery:

Plant engineers, conducting an internal engineering review of the IST Program as part of the corrective action for LER 1-85-036, discovered that the procedure designated in the IST Program did not meet the ASME Section XI requirement for stroke testing check valve 8912.

F. Operator actions:

None

G. Safety system responses:

None

III. Cause of Event

A. Immediate cause:

This event was caused by a procedure deficiency. An ASME Section XI testing requirement was omitted from STP P-14B.

B. Root cause:

Plant engineering personnel developing STPs to meet the IST Program requirements failed to include the requirement to stroke test check valve 8912 to the closed position in an STP.

IV. Analysis of Event

Operation of check valve 8912 is required for the isolation of the BIT recirculation system during a safety injection actuation.

The successful completion of the stroke test performed on October 30, 1984 and January 14, 1986, indicates that check valve 8912 was operable during the event period and capable of performing its intended safety function with no adverse consequences to the plant or the health and safety of the public.

In addition, redundant air-operated isolation valve 8911 was operable and capable of performing its intended function during this event.

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V. Corrective Actions

1. For both Unit 1 and Unit 2, STP M-16B will be revised to include the stroke testing of check valve 8912 to the fully closed position.
2. The IST Program for both units will be revised to show STP M-16B as the STP implementing the requirements of ASME Section XI for check valve 8912.
3. All applicable engineering personnel have reviewed this event to emphasize the importance of meeting ASME Section XI surveillance requirements and that in the development of STPs, all requirements are incorporated.

VI. Additional Information

A. Failed components:

None

B. Previous LERs on similar events:

LER 1-85-036-00 - Safety Injection and Charging Pump Suction Crosstie Valves Missed Surveillances. The missed surveillances were discovered during review of surveillance test procedures. The IST Program revision had not been incorporated in the STP. The master Surveillance Schedule is in the process of being reviewed to assure compliance with the IST Program. Review of the Master Surveillance Schedule resulted in the discovery of the event being reported in this LER.

PACIFIC GAS AND ELECTRIC COMPANY

PG&E

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JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

March 10, 1986

PGandE Letter No. DCL-86-063

Document Control Desk
U.S. Nuclear Regulatory Commission
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 1-84-036-01
Missed Surveillance on BIT Recirculation Check Valve 8912

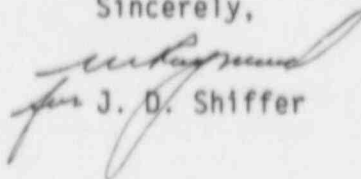
Gentlemen:

Pursuant to 10 CFR 50.73 (a)(2)(i), PGandE is submitting the enclosed revision to Licensee Event Report 1-84-036-00 concerning missed surveillances on BIT Recirculation Check Valve 8912. This revision is being submitted to provide additional information on the event.

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,


for J. D. Shiffer

Enclosure

cc: L. J. Chandler
R. T. Dodds
J. B. Martin
B. Norton
H. E. Schierling
CPUC
Diablo Distribution
INPO

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