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PG&E Letter DCL-03-164

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Docket No. 50-275, OL-DPR-80
Diablo Canyon Unit 1
Licensee Event Report 1-2003-001-00
Technical Specification 3.8.1, Action B.1, Not Met Due to Personnel Error

Dear Commissioners and Staff:

In accordance with 10 CFR 50.73(a)(2)(i)(B), PG&E is submitting the enclosed licensee event report regarding Technical Specification 3.8.1, "AC Sources – Operating," Action B.1, not met due to personnel error.

This event did not adversely affect the health and safety of the public.

Sincerely,

David H. Oatley

smg/2246/N0002172
Enclosure
cc/enc: Bruce S. Mallett
David L. Proulx
Girija S. Shukla
Diablo Distribution
INPO

IE22

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Diablo Canyon Unit 1	0 5 0 0 0 2 7 5	1 OF 6

TITLE (4)

Technical Specification 3.8.1, Action B.1, Not Met Due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	09	2003	2003	- 0 0 1 -	0 0	12	04	2003		

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR: (11)	
1	X	10 CFR 50.73(a)(2)(i)(B)
POWER LEVEL (10)		OTHER
1 0 0	(SPECIFY IN ABSTRACT BELOW AND IN TEXT, NRC FORM 366A)	

LICENSEE CONTACT FOR THIS LER (12)

	TELEPHONE NUMBER	
	AREA CODE	
Lawrence M. Parker – Senior Regulatory Services Engineer	805	545-3386

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MON	DAY	YR
[ ] YES (If yes, complete EXPECTED SUBMISSION DATE)	[X]NO				

ABSTRACT (Limit to 1400 spaces. i.e., approximately 15 single-spaced typewritten lines.) (16)

On October 9, 2003, with Unit 1 in Mode 1 (Power Operation) at 100 percent power, Technical Specification (TS) 3.8.1, "AC Sources – Operating," Action B.1, was not met when operators failed to perform an offsite circuit check within one hour upon declaring an emergency diesel generator inoperable to support exhaust stack slide bearing replacement. After the shift turnover briefing following completion of the slide bearing replacement, the unit shift foreman (SFM) determined that the conditional surveillance had been required and concluded two independent circuits between the off-site transmission network and the on-site distribution system were operable.

The root cause of the event was personnel error. The Unit 1 SFM did not recognize the necessity to perform the conditional surveillance nor did he adequately communicate the change in plant status with the control room crew. Additionally, recent changes in the work control process placed work authorization responsibilities with the work control shift foreman, including the responsibility to communicate changes in plant status to the Unit 1 SFM.

Corrective actions to prevent recurrence include briefing all operating crews on effective control room communication and modifying the TS tracking module to require a sign-off that any required conditional surveillances are being implemented upon declaring equipment inoperable.

I. Plant Conditions

Unit 1 was in Mode 1 (Power Operation) at 100 percent power at the time of discovery.

II. Description of Problem

A. Background

Diablo Canyon Power Plant (DCPP) has three emergency diesel generators (DGs) [EK][DG] per unit, which supply power to the three 4.16 kV vital AC buses whenever power is either unavailable or voltage degrades below the point at which required loads would become inoperable. The DGs automatically start on a safety injection (SI) signal, degraded or loss of voltage on the associated vital bus, or undervoltage on the 230 kV startup power system.

After a DG has started, if the vital bus is deenergized, it will automatically supply power to its associated bus. If the vital bus is not deenergized, the DG will continue to run, but not connect to its respective vital bus.

Technical Specification (TS) 3.8.1, "AC Sources – Operating," Action B.1, requires performance of Surveillance Requirement (SR) 3.8.1.1 within one hour of declaring a DG inoperable and once every eight hours thereafter. SR 3.8.1.1 involves verifying correct breaker alignment and indicated power availability for each required offsite circuit.

Surveillance Test Procedure (STP) I-1C, "Routine Weekly Checks Required by Licenses," Attachment 12.4, is used to document the verification of the operability of the independent circuits between the off-site transmission network and the on-site distribution system in accordance with SR 3.8.1.1.

B. Event Description

On October 9, 2003, at 0835 PST, DG 1-3 was declared inoperable to replace degraded exhaust stack slide bearings. Since replacement of the degraded slide bearings could potentially place the exhaust stacks in an unanalyzed condition, the work control shift foreman (WCSFM) declared the DG inoperable, though the DG was not cleared for the work nor taken to manual control. Therefore, although inoperable, DG 1-3 was available for all automatic and manual starts.

On October 9, 2003, at 1609 PST, after completion of the DG exhaust stack slide bearing maintenance, the WCSFM updated the tracking documentation and declared DG 1-3 operable.

On October 9, 2003, at approximately 1730 PDT, during the shift turnover briefing, the Unit 1 SFM reviewed the work performed during the shift. After the briefing, the control operator inquired if SR 3.8.1.1 was required. The SFM concluded that the surveillance had been required and informed the shift manager. A visual check indicated that two independent circuits between the off-site transmission network and the on-site distribution system were operable and the SFM concluded there was no reason to believe that they had been inoperable during the shift. However, the SFM did not perform SR 3.8.1.1, since at the time of discovery, all three Unit 1 DGs were operable.

C. Status of Inoperable Structures, Systems, or Components that Contributed to the Event

None.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

The failure to perform the conditional surveillance was discovered by utility licensed operators in the control room during a review of the day's work at the shift turnover.

F. Operator Actions

DG 1-3 had been declared operable prior to the time operators discovered the conditional surveillance had not been performed within the required completion time. A visual check indicated that two independent circuits between the off-site transmission network and the on-site distribution system were operable, and operators concluded there was no reason to believe that they had been inoperable during the shift. Since all three Unit 1 DGs were operable at the time of discovery, SR 3.8.1.1 was not performed.

G. Safety System Responses

None.

III. Cause of the Problem

A. Root Cause

The root cause of this event was personnel error. Ineffective communication between the WCSFM, the SFM, and the control operator resulted in the SFM not recognizing the necessity to perform the conditional surveillance and the control operator believing DG 1-3 was operable. In addition, changes to the work control process, which became effective on September 1, 2003, shifted the responsibility of approving work from the SFM to outside the control room with the WCSFM. This change placed additional burden on both the WCSFM and the SFM to assure thorough and timely communication regarding changes in plant status and the need to implement required compensatory measures/surveillances.

B. Contributory Cause

Due to the nature of the work being performed on DG 1-3, it was declared inoperable administratively, but was not removed from service. Thus, it remained available for all automatic and manual starts. Had the DG been removed from service, additional cues to perform the conditional surveillance would have been evident.

IV. Assessment of Safety Consequences

There were no actual safety consequences involved in this event. Although DG 1-3 was declared inoperable to support the exhaust stack slide bearing replacement, it remained available. When the SFM realized that the conditional surveillance was required, a visual circuit check indicated that offsite circuits were available and that there was no reason to believe that they were unavailable during the period that DG 1-3 had been administratively declared inoperable.

Thus, the event did not adversely affect the health and safety of the public.

V. Corrective Actions

A. Immediate Corrective Actions

The SFM was counseled on senior reactor operator expectations associated with TS equipment operability and verification of required actions.

B. Corrective Actions to Prevent Recurrence

1. All operations crews will be briefed on effective control room communication.

2. For those TS Actions requiring conditional surveillances, DCPP's TS tracking module will be modified to require a sign-off that the conditional surveillance(s) are being implemented upon declaring equipment inoperable.

VI. Additional Information

A. Failed Components

None

B. Previous Similar Events

Similar events were reported in the following LERs:

LER 1-99-004-00, "Technical Specification 3.8.1.1c, Not Met Due to Personnel Error," reported a missed conditional surveillance required within 1 hour by TS 3.8.1.1, Action c, due to personnel error (cognitive) by a licensed SFM. The corrective actions consisted of counseling the SFM, procedural enhancements to assure the operators perform the TS conditional surveillances within required times, and incorporation of lessons learned into appropriate procedures.

LER 1-98-005-00, "Technical Specification 3.8.1.1, Action b., Not Met Due to Personnel Error," reported a missed conditional surveillance required within 1 hour by TS 3.8.1.1, Action b, due to personnel error (cognitive) by the two licensed SFM. The corrective action consisted of counseling the SFM, adding an annunciator note to identify the surveillance requirement when a DG is in manual mode, and requiring a log entry when a DG is placed in manual mode to document the observation of offsite power source status.

LER 1-97-014-00, "Technical Specification 3.8.1.1, Action b., Not Met Due to Personnel Error," reported a missed conditional surveillance required within 8 hours by TS 3.8.1.1, Action b, due to personnel error (cognitive) by the shift technical advisor (STA) and the SFM. The corrective actions consisted of counseling the STA and SFM and adding timing devices.

LER 2-97-001-00, "Technical Specification 3.8.1.1, Action b. Not Met Due to Personnel Error," reported a missed conditional surveillance required within 1 hour by TS 3.8.1.1, Action b, due to personnel error (cognitive) by the SFM. The corrective action consisted of counseling the SFM who reviewed the STP.