REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8810240436 DOC. DATE: 88/10/18 NOTARIZED: NO DOCKET #
FACIL: 50-362 San Onofre Nuclear Station, Unit 3, Southern Californ 05000362
AUTH. NAME AUTHOR AFFILIATION
MORGAN, H. E. Southern California Edison Co.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-009-00: on 880915, delinquent surveillance of radiation effluent monitor due to personnel error.

W/8 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 6
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD5 LA	1	1	PD5 PD	1	1
	HICKMAN, D	1	1			
INTERNAL:	ACRS MICHELSON	1	1	ACRS MOELLER	2	2
	ACRS WYLIE	1	1	AEOD/DOA	1	1
	AEOD/DSP/NAS	1	1	AEOD/DSP/ROAB	2	2
	AEOD/DSP/TPAB	1	1	ARM/DCTS/DAB	1	1
	DEDRO	1	1	NRR/DEST/ADS 7E	1	0
	NRR/DEST/CEB 8H	1	1	NRR/DEST/ESB 8D	1	1
	NRR/DEST/ICSB 7	1	1	NRR/DEST/MEB 9H	1	1
	NRR/DEST/MTB 9H	1	1	NRR/DEST/PSB 8D	1	1
	NRR/DEST/RSB 8E	1	1	NRR/DEST/SGB 8D	1	1
	NRR/DLPQ/HFB 10	1	1	NRR/DLPQ/QAB 10	1	1
	NRR/DOEA/EAB 11	1	1	NRR/DREP/RAB 10	1	1
	NRR/DREP/RPB 10	2	2	NRR/DRIS/SIB 9A	1	1
	NUDOCS-ABSTRACT	1	1	REG FILE 02	1	1
	RES TELFORD, J	1	1	RES/DSIR/EIB	1	1
	RES/DSR DEPY	1	1	RES/DSR/PRAB	1	1
	RGN5 FILE 01	1	1			
EXTERNAL:	EG&G WILLIAMS, S	4	4	FORD BLDG HOY, A	1	1
	H ST LOBBY WARD	1	1	LPDR	1	1
	NRC PDR	1	1	NSIC HARRIS, J	1	1
	NSIC MAYS, G	1	1			

TOTAL NUMBER OF COPIES REQUIRED: LTTR 47 ENCL 46

A/B/4

LICENSEE EVENT REPORT (LER)

Facility Name (1)	Docket Number (2)	Page (3)
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 3	0 5 0 0 0 3 6 2	1 of 0 5

Title (4)

DELINQUENT SURVEILLANCE OF RADIATION EFFLUENT MONITOR DUE TO PERSONNEL ERROR

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
Month	Day	Year	Year	/// Sequential Number	/// Revision Number	Month	Day	Year	Facility Names	Docket Number(s)
0 9	1 5	8 8	8 8	--- 0 0 9	--- 0 0	1 0	1 8	8 8	NONE	0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 0 0

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

___ 20.402(b)	___ 20.405(c)	___ 50.73(a)(2)(iv)	___ 73.71(b)		
___ 20.405(a)(1)(i)	___ 50.36(c)(1)	___ 50.73(a)(2)(v)	___ 73.71(c)		
___ 20.405(a)(1)(ii)	___ 50.36(c)(2)	___ 50.73(a)(2)(vii)	___ Other (Specify in Abstract below and in text)		
___ 20.405(a)(1)(iii)	X 50.73(a)(2)(i)	___ 50.73(a)(2)(viii)(A)			
___ 20.405(a)(1)(iv)	___ 50.73(a)(2)(ii)	___ 50.73(a)(2)(viii)(B)			
___ 20.405(a)(1)(v)	___ 50.73(a)(2)(iii)	___ 50.73(a)(2)(x)			

LICENSEE CONTACT FOR THIS LER (12)

Name	TELEPHONE NUMBER
H. E. Morgan, Station Manager	AREA CODE 7 1 4 3 6 8 - 6 2 4 1

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)

	Expected Submission Date (15)	Month	Day	Year
___ Yes (If yes, complete EXPECTED SUBMISSION DATE) XX NO				

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

On 9/18/88 at 0320, with Unit 3 at 100% power, during a routine surveillance of the Radiation Monitoring System by the common Control Room Operator (CRO), it was discovered that the daily channel check for the condenser air ejector wide range effluent radiation monitor 3RT-7870 had not been performed on 9/15/88, 9/16/88, and 9/17/88. The surveillance is required by Technical Specifications 4.3.3.1 and 4.3.3.9. The CRO immediately informed the Operations Supervisor (SOS) and the channel check of the monitor was satisfactorily completed. There was no safety significance to this event since the channel check demonstrated that the monitor continued to be operable.

The cause of this event was a cognitive personnel error. The CRO mistakenly concluded that an "out-of-service" sticker, which was attached to the control room panel and addressed a flow meter associated with the radiation monitor, applied to 3RT-7870. He similarly erred in reviewing the "list of inoperable equipment", which also referred to the flow meter rather than the radiation monitor being out-of-service. Since the surveillance is not required on out-of-service equipment, it was not performed. Additionally, the SOS did not perform an adequate review of the completed surveillances, resulting in an oversight of the error made by the CRO. This event has been discussed with the CRO and SOS involved, and will be reviewed with all appropriate operations personnel.

IE22
1/1

Plant: San Onofre Nuclear Generating Station
Unit: Three
Reactor Vendor: Combustion Engineering
Event Date: 09-15-88

A. CONDITIONS AT TIME OF THE EVENT:

Mode: 1, Power Operation

B. BACKGROUND INFORMATION:

The Condenser Evacuation System (EIIS System Code SH) releases gases to the environment during normal power operation and postulated accidents. The release path is provided with a normal range radiation monitor (EIIS Component Code RIT), 3RT-7818; and a wide range radiation monitor, 3RT-7870. The monitors provide alarm, indication, and recording to assist the operator in the early detection and trending of leakage from the primary to secondary system and then to the environment.

The wide range monitor indication spans the narrow range providing a backup during normal operation. The monitors measure activity (counts per minute or micro curies per second) and flow rate (cubic feet per minute or cubic centimeters per second) to calculate an output of micro curies per cubic centimeter. A substitute flow rate may be entered into the calculator if the flow meter is unavailable.

Technical Specification 4.3.3.1 and 4.3.3.9 require that the wide range Condenser Evacuation System Noble Gas Effluent Radiation Monitor be demonstrated operable by performing a channel check daily. Plant procedures require that the channel check be performed by a Control Room Operator (CRO) (utility-licensed) and the results approved by the Senior Reactor Operator - Operations Supervisor (SOS) (utility-licensed). This surveillance is normally performed on the midnight to 0700 shift. The surveillance procedure specifies how the channel check is to be performed and properly addresses actions to take if the flow meter or the monitor is out-of-service. The operator is required to determine the status of the monitor and select the appropriate portion of the surveillance procedure. The SOS is required to review the completed surveillance procedure.

C. DESCRIPTION OF THE EVENT:

1. Event:

On 9/18/88 at 0320, with Unit 3 at 100% power, during a routine surveillance of the Radiation Monitoring System, it was discovered that the daily channel check for the condenser air ejector wide range effluent radiation monitor 3RT-7870 had not been performed on 9/15/88, 9/16/88, and 9/17/88. The CRO immediately informed the SOS and the surveillance was satisfactorily completed.

2. Inoperable Structures, Systems or Components that Contributed to the Event:

None.

3. Sequence of Events:

DATE	TIME	ACTION
9/14/88	0327	Channel check of 3RT-7870 satisfactorily performed.
9/15/88 thru 9/17/88		Channel check of 3RT-7870 not performed.
9/18/88	0320	Missed channel check discovered. Satisfactory check immediately performed.

4. Method of Discovery:

The missed channel checks were discovered by the CRO while performing a routine surveillance of the Radiation Monitoring System.

5. Personnel Actions and Analysis of Actions:

Upon identification of the missed channel checks, the CRO immediately informed the SOS and satisfactorily performed a check.

6. Safety System Responses:

Not applicable.

D. CAUSE OF THE EVENT:

1. Immediate Cause:

The CRO responsible for the surveillance erroneously determined that radiation monitor 3RT-7870 was out-of-service. Thus, according to procedure, a channel check was concluded not to be applicable on 9/15/88, 9/16/88 and 9/17/88.

2. Root Cause:

The cause of this event was cognitive personnel error. The CRO mistakenly concluded that an "out-of-service" sticker, which addressed a flow meter associated with the radiation monitor and attached to the control room panel, applied to 3RT-7870. He similarly erred in reviewing the "list of inoperable equipment", which also referred to the flow meter rather than the radiation monitor being out-of-service. Since the surveillance is not required on out-of-service equipment, it was not performed. Additionally, the SOS did not perform an adequate review of the completed surveillance, resulting in an oversight of the error made by the CRO.

E. CORRECTIVE ACTIONS:

1. Corrective Actions Taken:

   a. The condenser air ejector wide range gas monitor channel check was satisfactorily performed on 9/18/88.

   b. This event has been discussed with the CRO and SOS involved.

   c. Procedural, administrative, and human factor controls associated with this event have been reviewed and were found to be adequate.

2. Planned Corrective Actions:

   This event will be reviewed with all appropriate operations personnel.

F. SAFETY SIGNIFICANCE OF THE EVENT:

There was no safety significance to this event since subsequent performance of the channel check of 3RT-7870 demonstrated that the monitor continued to be operable.

G. ADDITIONAL INFORMATION:

1. Component Failure Information:

   Not applicable.

2. Previous LERs on Similar Events:

   a. An inoperable air ejector radiation monitor 2RT-7870 due to an improper system valve alignment was reported in LER 86-026 (Docket No. 50-361). The misalignment was caused by an incorrect reference to a step within the Chemistry procedure. The procedure was revised to reference the correct step.

      In this case (LER 3-88-009), the system was aligned properly for operation without a flow detector, and the Operations procedure was correctly written. However, an equipment status list was misunderstood by the CRO.

   b. A missed surveillance on containment purge and stack wide range airborne monitor 3RT-7865 due to a procedural omission was reported in LER 87-007 (Docket No. 50-362). The procedure was revised to reinstate the omitted actions.

      In this case (LER 3-88-009), the procedure correctly detailed how the channel check was to be performed when either the flow meter or the monitor is out-of-service. However, the status of the monitor was misunderstood and the incorrect portion of the surveillance procedure was selected.

3. Results of NPRDS Search:

   Not applicable.

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

H. E. MORGAN
STATION MANAGER

TELEPHONE
(714) 368-6241

October 18, 1988

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Subject: Docket No. 50-362
30-Day Report
Licensee Event Report No. 88-009
San Onofre Nuclear Generating Station, Unit 3

Pursuant to 10 CFR 50.73(a)(2)(i)(B), this submittal provides the required 30-day written Licensee Event Report (LER) for a condition involving a delinquent surveillance of a radiation effluent monitor. Neither the health and safety of plant personnel or the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely,

HEMorgan

Enclosure: LER No. 88-009

cc: F. R. Huey (USNRC Senior Resident Inspector, Units 1, 2 and 3)

J. B. Martin (Regional Administrator, USNRC Region V)

Institute of Nuclear Power Operations (INPO)

IE22
1/1