Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

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April 8, 1993

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

Subject: Docket No. 50-362
30-Day Report
Licensee Event Report No. 93-002
San Onofre Nuclear Generating Station, Unit 3

Pursuant to 10 CFR 50.73(d), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving a missed Technical Specification required daily surveillance. Neither the health nor the safety of plant personnel or the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely,

Raymond Waldo for
R. Krieger

Enclosure: LER No. 93-002

cc: J. B. Martin (Regional Administrator, USNRC Region V)
C. W. Caldwell (USNRC Senior Resident Inspector, Units 1, 2 and 3)
M. B. Fields, NRC Project Manager, San Onofre Units 2 & 3
Institute of Nuclear Power Operations (INPO)

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LICENSEE EVENT REPORT (LER)

Facility Name (1)	Docket Number (2)	Page (3)
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Title (4)

MISSED DAILY TECHNICAL SPECIFICATION SURVEILLANCE

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)
				---	---				NONE	0 5 0 0 0
0 3	0 9	9 3	9 3	0 0 2	0 0	0 4	0 3	9 3		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)			
1	___ 20.402(b)	___ 20.405(c)	___ 50.73(a)(2)(iv)	___ 73.71(b)
POWER LEVEL (10)	___ 20.405(a)(1)(i)	___ 50.36(c)(1)	___ 50.73(a)(2)(v)	___ 73.71(c)
1 0 0	___ 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
R. W. Krieger, Station Manager	AREA CODE 7 1 4 3 6 8 - 6 2 5 5

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)

At approximately 0700 on March 9, 1993, with Unit 3 in Mode 1 at 100% power, it was discovered that a Technical Specification (TS) surveillance required to be performed at least once per 24-hours had not been performed. The surveillance was subsequently performed at 0740 on March 9, 1993. The interval between completed surveillances was 3 hours and 10 minutes greater than the TS surveillance interval plus the allowable extension permitted by TS 4.0.2.

The cause of the event was an error by control room operators. The Assistant Control Operator (ACO) became distracted by other control room activities and failed to perform SO23-3-3.26 as scheduled. The Control Operator (CO) and the Control Room Supervisor (CRS) review all completed surveillances and check them against a list of required surveillances on a Technical Specification Surveillance Control Sheet (TSSCS). The CO initials the TSSCS indicating completion of each surveillance. Due to lack of verification by the CO and assumptions made by the CRS during the review process, the discrepancy was not identified.

As a corrective action, the personnel involved in this event have been counseled. In addition: 1) refresher training will be conducted for all licensed operators to emphasize management expectations with regard to performance and review of surveillances and 2) a change will be implemented to the TSSCS such that the operator actually performing the surveillance will now initial for completion.

There was no safety significance to this event since the delinquent performance of SO23-3-3.26 demonstrated that applicable TS components met their associated TS requirements and therefore remained operable.

Plant: San Onofre Nuclear Generating Station
Unit: Three
Reactor Vendor: Combustion Engineering
Event Date: March 9, 1993
Time: 0430

A. CONDITIONS AT THE TIME OF THE EVENT:

Mode: 1, Power Operation
Power Level: 100%

B. BACKGROUND INFORMATION:

Technical Specifications (TS):

TS 4.0.2 requires that each surveillance requirement be performed within the specified surveillance interval with a maximum allowable extension not to exceed 25% of the surveillance interval.

TS 4.0.3 specifies that the failure to perform a surveillance requirement within the allowed surveillance interval, defined by TS 4.0.2, shall constitute noncompliance with the Operability requirements for a Limiting Condition for Operation.

TSs 4.1.2.8.b and 4.5.4.b require that the temperature of each Refueling Water Storage Tank (RWST) be verified at least once per 24 hours when the outside air temperature is less than 40 degrees F or greater than 100 degrees F. TSs 4.1.2.8.b and 4.5.4.b are applicable in Modes 1 through 4.

TS 4.3.3.10.a requires that each channel of the loose-part detection system be demonstrated operable by performing a channel check at least once per 24 hours. TS 4.3.3.10.a is applicable in Modes 1 and 2.

TS 4.6.1.5 requires that the containment arithmetical average temperature (at any four of five containment elevations) be determined to be less than 120 degrees F at least once per 24 hours. TS 4.6.1.5 is applicable in Modes 1 through 4.

TS 4.1.3.6 requires in part, that the accumulated time during which the regulating Control Element Assembly (CEA) groups are inserted beyond the Long Term Steady State Insertion Limits but within the Transient Insertion Limits be determined at least once per 24 hours. TS 4.1.3.6 is applicable in Mode 1 and in Mode 2 with Keff > 1.

TS 4.1.3.7 requires in part, that the accumulated time during which the part length CEA groups are inserted beyond the Long Term Steady State Insertion Limits but within the Transient Insertion Limits be determined at least once per 24 hours. TS 4.1.3.7 is applicable in Mode 1 > 20% power.

Surveillance Operating Instruction SO23-3-3.26:

Surveillance Operating Instruction SO23-3-3.26, "Once A Day Surveillance (Modes 1 - 4)," is performed by Operations personnel to satisfy (in part) all the above TS 24-hour surveillance requirements. SO23-3-3.26 is normally performed by the Assistant Control Operator (ACO)(utility, licensed) and verified completed by the Control Operator (CO)(utility, licensed). The CO then makes an entry in the log indicating completion of the surveillance. The Control Room Supervisor (CRS)(utility, licensed) subsequently reviews the surveillance to ensure compliance with acceptance criteria.

Administrative Controls:

Surveillances are tracked by the computerized Operations Surveillance Tracking and Scheduling Program (OSTSP). The OSTSP is updated daily and provides control room personnel (utility, licensed) with a list of TS surveillances which are required to be performed and specifies the time period in which each surveillance should be performed. This list of surveillances to be performed is called a Technical Specification Surveillance Control Sheet (TSSCS) and is located in a binder on the CO's desk in the Control Room. The TSSCS contains blanks for the CO to initial indicating completion of each surveillance listed. The TSSCS also contains a blank for the CRS to initial for conducting a review of the TSSCS for completion of required surveillances.

C. DESCRIPTION OF EVENT:

1. Event:

At approximately 0700 on Tuesday, February 9, 1993, with Unit 3 in Mode 1 at 100% power, it was discovered that the daily Technical Specification (TS) surveillance SO23-3-3.26, Attachment 1A had not been performed the previous night. The Day Shift Control Operator (CO) was notified and action was immediately initiated to perform the TS required surveillance. At 0740 the operators completed satisfactory performance of SO23-3-3.26, Attachment 1A.

The 25% extension allowed by TS 4.0.2 had expired at 0430 on February 9. The interval between completed surveillances exceeded the allowed 25% extension by 3 hours and 10 minutes.

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

Not applicable.

3. Sequence of Events:

Date/Time	Description
3/7 2230	SO23-3-3.26, Attachment 1A is completed satisfactorily.
3/9 0430	TS allowed 25% extension expires.

3/9 0700 An administrative review finds no documentation that would indicate completion of SO23-3-3.26, Attachment 1A.

3/9 0740 SO23-3-3.26 Attachment 1A is completed satisfactorily.

4. Method of Discovery:

The delinquent once-a-day surveillance was identified by the surveillance coordinator (utility, non-licensed) while reviewing completed documentation prior to updating the computerized OSTSP.

5. Personnel Actions and Analysis of Actions:

Not Applicable

6. Safety System Responses:

Not applicable:

D. CAUSE OF THE EVENT:

1. Immediate Cause:

The ACO was standing watch for the first time as a qualified ACO. The CO, who has assigned responsibility to perform the surveillance, delegated this responsibility to the ACO. However, the ACO failed to complete the assigned daily surveillance. Although properly trained in performance of the surveillance, the ACO was not familiar with the shift routine or managements expectations of performance in completing the routine surveillances. This lack of familiarity with shift routine allowed the ACO to become distracted and was a contributing cause of the ACO not completing the surveillance. The CO failed to adequately follow-up on the delegated work such that the omission of the surveillance would be identified. The CO then signed off the TSSCS based on a recollection of those completed surveillances he had reviewed.

2. Intermediate Cause:

The CRS initialed the TSSCS in error, indicating all surveillance requirements were satisfied, without performing a completed documentation check.

3. Root Cause:

The root cause of the ACO not performing the surveillance is the use of a tracking tool (TSSCS) that did not reflect the actual shift work practices for accomplishing assigned surveillances. The CO initials for completion of work that is delegated to the ACO rather than having the ACO initial the TSSCS.

A contributing cause to this event was failure of the CO and CRS to recognize the potential impact on shift routine from assignment of a newly qualified ACO, including the increased potential for error. As a result, they did not compensate by conducting a more detailed review of the ACOs work actions. Had either the CO or CRS completed their required review of the tracking sheet vs the completed hard copies of the surveillances correctly, the misced surveillance would have been discovered.

E. CORRECTIVE ACTIONS:

1. Corrective Actions Taken:

   a. SO23-3-3.26, Attachment 1A was completed satisfactorily.

   b. Those personnel involved have been counseled as to the proper methods for performance of surveillances and completion of their associated administrative duties.

2. Planned Corrective Actions:

   a. The TSSCS will be changed to require the person actually performing the surveillance to initial for completion on the TSSCS.

   b. Refresher training for all licensed operators will be conducted to reiterate and reemphasize management expectations regarding performance and review of surveillances.

F. SAFETY SIGNIFICANCE OF THE EVENT:

There was no safety significance to this event since the delinquent performance of the once-a-day surveillance demonstrated that the RWST Temperature, loose-part detection system, containment air temperature, and CEA insertion limits met their associated TS requirements and therefore remained operable.

G. ADDITIONAL INFORMATION:

1. Component Failure Information:

   Not applicable.

2. Previous LERs for Similar Events:

   LER 3-91-004, (Docket No. 50-362) reported an occurrence involving delinquent TS surveillances required to be performed at least once per 24-hours. The cause was attributed to an error by control room personnel. Corrective actions included 1) appropriate disciplinary actions and 2) reviewing the event with appropriate operations personnel. This previous LER occurred in part because of a recent change in shift schedules to 12

hour shifts and the resulting rescheduling of surveillance performance times. The new scheduled time to complete the daily surveillance was prior to 2400. This was not recognized by control room personnel, and they performed the surveillance at the old scheduled time (0505). Thus, corrective actions for the previous event were related to the recognition of changes in surveillance scheduling and could not have prevented this event.