REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8706240132 DOC. DATE: 87/06/19 NOTARIZED: NO DOCKET #
FACIL: 50-323 Diablo Canyon Nuclear Power Plant, Unit 2, Pacific Ga 05000323
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SHIFFER, J. D. Pacific Gas & Electric Co.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-010-00: on 870222, missed surveillance on intermediate range nuclear instrument occurred. Caused by personnel error in that preventive maint & test scheduler sys incorrectly updated. SCheduler sys put into place. W/870619 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 5
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

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	AEOD/DOA	1	1	AEOD/DSP/ROAB	2	2
	AEOD/DSP/TPAB	1	1	DEDRO	1	1
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	NRR/DOEA/EAB	1	1	NRR/DREP/RAB	1	1
	NRR/DREP/RPB	2	2	NRR/PMAS/ILRB	1	1
	NRR/PMAS/PTSB	1	1	REG FILE 02	1	1
	RES DEPY GI	1	1	RGN5 FILE 01	1	1
EXTERNAL:	EG&G GROH, M	5	5	H ST LOBBY WARD	1	1
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
DIABLO CANYON UNIT 2	0 5 0 0 0 3 2 3	1 OF 0 4

TITLE (4): MISSED SURVEILLANCE ON AN INTERMEDIATE RANGE NUCLEAR INSTRUMENT DUE TO AN ERROR IN UPDATING THE PREVENTIVE MAINTENANCE AND TEST SCHEDULER SYSTEM

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 5 0 0 0
0 2	2 2	8 7	8 7	0 1 0	0 0	0 6	1 9	8 7		0 5 0 0 0

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

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (11)

- [ ] 10 CFR 50.73(a)(2)(i)(B)
- [X] OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER AREA CODE
STEPHEN D. WILSON, REGULATORY COMPLIANCE ENGINEER	8 0 5 5 9 5 - 7 3 5 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)

- [ ] YES (If yes, complete EXPECTED SUBMISSION DATE)
- [X] NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

ABSTRACT (16)

On February 22, 1987, while in Mode 1 (Power Operation), the unit exceeded 10 percent power without a current channel calibration having been performed on intermediate range nuclear instrument (IRNI) N-35. This was contrary to the requirements of Technical Specification 4.3.1.1, Table 4-3.1, item 5.

The root cause of this event was personnel error (cognitive) in that the Preventive Maintenance and Test Scheduler (PMTS) system for tracking surveillance tests was incorrectly updated. This error caused personnel to be unaware that IRNI N-35 had exceeded its allowable surveillance interval. IRNI N-35 was calibrated on May 20, 1987, after discovery of the error by a Quality Assurance audit of Instrumentation and Controls (I&C) surveillance test records. The as-found condition of IRNI N-35 met all calibration acceptance criteria.

No further corrective action is necessary because a scheduler system for recurring tasks was put into place after the updating error of the PMTS system that caused this event.

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I. Initial Conditions

Unit 2 was in Mode 1 (Power Operation) at 10 percent power.

II. Description of Event

A. Event:

On February 22, 1987, while in Mode 1 (Power Operation), the unit exceeded 10 percent power without a current channel calibration having been performed on intermediate range nuclear instrument (IRNI) N-35 (IG)(DET). This was contrary to the requirements of Technical Specification (TS) 4.3.1.1, Table 4-3.1, item 5.

The last channel calibration of IRNI N-35 had been performed on March 19, 1985. The Preventive Maintenance and Test Scheduler (PMTS) system was incorrectly updated to show that the last channel calibration had been performed on July 27, 1985, when an analog channel operational test was performed on IRNI N-35. This caused I&C personnel to be unaware that on February 4, 1987, IRNI N-35 had exceeded the surveillance interval of TS 4.3.1.1, Table 4.3-1, item 5, including the allowable extension of TS 4.0.2. Unit conditions did not require IRNI N-35 to be operable until the transition from Mode 2 (Startup) to Mode 1 at greater than 10 percent power which occurred on February 22, March 6, and March 25, 1987. The unit operated at greater than 10 percent power from March 25, 1987, until April 3, 1987, when the unit refueling outage began.

IRNI N-35 was calibrated, after discovery of the error on May 20, 1987, by a Quality Assurance (QA) audit of Instrumentation and Controls (I&C) surveillance test records. The as-found condition of IRNI N-35 met all calibration acceptance criteria.

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

None

C. Dates for major occurrences:

1. March 19, 1985:	IRNI N-35 channel calibration performed.
2. July 27, 1985:	Analog channel operational test was performed on IRNI N-35, but the PMTS system was updated to show that a channel calibration had been performed on this date.

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3. February 4, 1987: The surveillance interval of TS 4.3.1.1, Table 4.3-1, item 5, with the allowable extension granted by TS 4.0.2, was exceeded.

4. February 22, 1987, March 6, 1987, and March 25, 1987: Event dates - The unit transitioned from Mode 2 (Startup) to Mode 1 at greater than 10 percent power on these dates with IRNI N-35 inoperable.

5. April 3, 1987: Unit shutdown for refueling.

6. May 20, 1987: Discovery date - Incorrect entry in the PMTS system was discovered, and the missed surveillance on IRNI N-35 was identified.

D. Other systems or secondary functions affected:

None

E. Method of discovery:

A QA audit of surveillance test records.

F. Operator actions:

None required

G. Safety system responses:

None

III. Cause of Event

A. Immediate cause:

The channel calibration on IRNI N-35 was not performed within the required surveillance interval due to incorrect dates recorded in the PMTS system.

B. Root cause:

Personnel error (cognitive) in that the PMTS files were incorrectly updated. This showed a lack of attention to detail, lack of secondary review, and a basic weakness of the programmatic methodology for reviewing and updating surveillance test recurring task files.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

IV. Analysis of Event

The redundant IRNI channel was operable at all times that IRNI N-35 was technically inoperable. The as-found data during the calibration of IRNI N-35, subsequent to the discovery of the event, were found to meet the calibration acceptance criteria. Thus, no adverse safety consequences or implications resulted from this event.

V. Corrective Actions

After the error was discovered in the PMTS system by a QA audit of I&C surveillance test records, IRNI N-35 was calibrated and the correct data was entered into the recurring task scheduler (RTS) system. To prevent missed surveillances, Administrative Procedure (AP) C-3S1, "Surveillance Testing and Inspection" was revised in May 1986 to provide a secondary review to prevent inadvertent errors in scheduling and data entry. The transfer of surveillance test scheduling information from the PMTS system to the RTS system was completed in September 1986. The RTS system incorporates the secondary reviews of the revised PMTS system and also provides accurate on-line information to surveillance test coordinators. Any future data entry errors should be prevented by the implementation of RTS. No further corrective action is deemed necessary at this time.

VI. Additional Information

A. Failed components:

None

B. Previous LERs on similar events:

LER 2-86-015: Missed surveillance of a radiation monitor due to an error in PMTS system file updating.

The event described in the current LER occurred due to an error made in 1985 before the implementation of the recurring task scheduler system described in LER 2-86-015. Therefore, the corrective action of LER 2-86-015 could not have prevented this event from occurring.

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PACIFIC GAS AND ELECTRIC COMPANY

PG&E

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JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

June 19, 1987

PGandE Letter No.: DCL-87-140

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

Re: Docket No. 50-323, OL-DPR-82
Diablo Canyon Unit 2
Licensee Event Report 2-87-010-00
Missed Surveillance on an Intermediate Range Nuclear Instrument Due to an Error in Updating the Preventive Maintenance and Test Scheduler System

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(i)(B), PGandE is submitting the enclosed Licensee Event Report 2-87-010-00 concerning a missed surveillance on an intermediate range nuclear instrument due to an error in updating the Preventive Maintenance and Test Scheduler System.

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
J. B. Martin
M. M. Mendonca
P. P. Narbut
B. Norton
CPUC
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