



Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

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December 12, 1991

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

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 91-017
San Onofre Nuclear Generating Station, Unit 2

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 Reactor Coolant System chemistry surveillance analyses for Units 2 and 3. Since this occurrence involves similar systems, causes, and corrective actions applicable to Units 2 and 3, a single report for Unit 2 is being submitted in accordance with NUREG-1022. Neither the health nor the safety of plant personnel or the public was affected by this occurrence or condition.

If you require any additional information, please so advise.

Sincerely,

Enclosure: LER No. 91-017

cc: C. W. Caldwell (USNRC Senior Resident Inspector, Units 1, 2 and 3)

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

Institute of Nuclear Power Operations (INPO)

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LICENSEE EVENT REPORT (LER)

Facility Name (1) SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2	Docket Number (2) 0 5 0 0 0 3 6 1	Page (3) 1 of 0 4
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Title (4)
DELINQUENT REACTOR COOLANT SYSTEM SURVEILLANCE SAMPLE

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 Name	Docket Number(s)	
11	12	91	91	0 1 7	0 0	11	12	91	SAN ONOFRE, UNIT 3	0 5 0 0 0 3 6 2	

OPERATING MODE (9) 5

POWER LEVEL (10) 0 | 0 | 0

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

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> Other (Specify in Abstract below and in text)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

Name: R. W. Krieger, Station Manager

TELEPHONE NUMBER: AREA CODE 7 | 1 | 4 | 3 | 6 | 8 | 1 | 6 | 2 | 5 | 5

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS
//////				//////					//////
//////				//////					//////
//////				//////					//////

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

Expected Submission Date (15)

Month	Day	Year

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

On 11/13/91, it was determined that the Unit 2 and Unit 3 Reactor Coolant System samples obtained on 11/11/91, had not been analyzed for fluoride within the time required by Technical Specification (TS) 3/4.4.6, "Reactor Coolant System Chemistry." The analyses were required to be completed on 11/12/91 at 0223 and 0250 for Unit 2 and Unit 3, respectively. The fluoride analyses were subsequently completed at approximately 1100 on 11/12/91.

The root cause of this event was determined to be a cognitive personnel error. A Nuclear Chemistry Technician foreman (utility, non-licensed) had incorrectly deferred completion of the analysis without recognizing that the surveillance interval (including the extension allowed by TS 4.0.2) would be exceeded. In addition, difficulties were encountered in the use of the fluoride analysis equipment which contributed to the delay.

Corrective actions include 1) reviewing this event with appropriate Chemistry personnel, and 2) providing refresher training with respect to TS sampling and analysis requirements to appropriate Chemistry personnel.

There was no safety significance to this event since subsequent sample results were within the TS limits.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

SAN ONOFRE NUCLEAR GENERATION STATION	DOCKET NUMBER	LER NUMBER	PAGE
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Plant: San Onofre Nuclear Generating Station
 Units: Two and Three
 Reactor Vendor: Combustion Engineering
 Event Date: 11-12-91
 Time: 0223

A. CONDITIONS AT TIME OF THE EVENT:

Unit 2 Mode: 5, Cold Shutdown
 Unit 3 Mode: 1, Power Operation

B. BACKGROUND INFORMATION:

Technical Specification (TS) Requirement:

TS 3/4.4.6, "Reactor Coolant System Chemistry," Surveillance 4.4.5 requires the Reactor Coolant System (RCS) [AB] to be analyzed for chloride and fluoride at least once per 72 hours. Maintaining chemistry within the TS limits for chloride and fluoride provides adequate corrosion protection to ensure the structural integrity of the RCS over the life of the plant.

C. DESCRIPTION OF THE EVENT:

i. Event:

On 11/13/91, it was determined that the Unit 2 and Unit 3 RCS samples obtained on 11/11/91, had not been analyzed for fluoride within the time required by the TS. The RCS samples were analyzed for chloride on 11/11/91 by approximately 2000, within the time allowed by TSs (plus extension permitted by TS 4.0.2). However, the Units 2 and 3 fluoride sample analyses, which were required to have been performed by 0223 and 0250, respectively, were not completed until approximately 1100 on 11/12/91.

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

Not applicable.

3. Sequence of Events:

<u>DATE</u>	<u>TIME</u>	<u>ACTION</u>
11/8	0823	Unit 2 chloride/fluoride analysis completed, thus starting the next 72 hour sample/analysis interval.
	0850	Unit 3 chloride/fluoride analysis completed.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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3. Sequence of Events (cont'd):

<u>DATE</u>	<u>TIME</u>	<u>ACTION</u>
11/11	0830	Unit 2 chloride/fluoride samples taken.
	0845	Unit 3 chloride/fluoride sample taken.
11/11	-2000	Completed Unit 2 and Unit 3 chloride analyses within the TS allowed time.
11/12	0223	End of Unit 2 surveillance period including allowed extension.
	0250	End of Unit 3 allowed surveillance period including allowed extension.
	-1100	Completed Unit 2 and Unit 3 fluoride analyses.

4. Method of Discovery:

On 11/13/91, during a review of the activities associated with the RCS chloride/fluoride analyses of 11/11/91, Chemistry personnel noted that the fluoride analyses completed on 11/12/91 had exceeded the TS surveillance frequency.

5. Personnel Actions and Analysis of Actions:

Not applicable.

6. Safety System Responses:

Not applicable.

D. CAUSE OF THE EVENT:

The cause of this event was determined to have resulted from a cognitive personnel error (utility, non-licensed). A Nuclear Chemistry Technician (NCT) foreman incorrectly authorized deferral of the completion of the fluoride analysis without recognizing that the TS surveillance interval would be exceeded. The NCT involved also did not recognize the TS implications. Difficulties encountered in the use of the fluoride analysis equipment contributed to the event in that attempts to resolve the problems diverted the focus and attention of responsible chemistry personnel away from the time constraints.

LICENSEE EVENT REPORT , TEXT CONTINUATION

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E. CORRECTIVE ACTIONS:

1. Corrective Actions Taken:

The fluoride analyses were completed at approximately 1100 on 11/12/91.

2. Planned Corrective Actions:

- a. This event will be reviewed with the appropriate Chemistry personnel.
- b. All appropriate Chemistry personnel will receive refresher training on SONGS TS sampling and analysis requirements.

F. SAFETY SIGNIFICANCE OF THE EVENT:

There was no safety significance to this event since subsequent sample results were within the TS limits.

G. ADDITIONAL INFORMATION:

1. Component Failure Information:

Not applicable.

2. Previous LERs for Similar Events:

The following LERs addressed either delinquent or missed surveillances involving chemistry activities:

Docket No. 50-206

86-003, 86-006, 88-007, 89-009, 89-027, 89-033,
90-003, 91-005, 91-006

Docket No. 50-361

86-028, 87-030, 88-018, 90-013

Docket No. 50-362

86-004, 86-007, 88-001, 88-010

Since the event being reported in this LER resulted from a cognitive personnel error, the corrective actions implemented as a result of the previous events could not have prevented this missed surveillance.