



Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128

SAN CLEMENTE, CALIFORNIA 92074-0128

R. W. KRIEGER
STATION MANAGER

October 29, 1992

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

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 92-011
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 the Units 2 and 3 Fire Protection System. Since this occurrence involves similar systems, cause, 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.

If you require any additional information, please so advise.

Sincerely,

Enclosure: LER No. 92-011

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 1	Page (3) 1 of 0 1
Title (4) FIRE PROTECTION SYSTEM IMPAIRMENT COMPENSATORY ACTIONS NOT PERFORMED IN ACCORDANCE WITH TECHNICAL SPECIFICATIONS DUE TO COGNITIVE PERSONNEL ERR ²			

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)
1 0	0 5	9 2	9 2	0 1 1	0 0	1 0	2 9	9 2	SONGS UNIT 3	0 5 0 0 0 3 6 2

OPERATING MODE (9) POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)	
//////	20.402(b)	20.405(c)
//////	20.405(a)(1)(i)	50.36(c)(1)
//////	20.405(a)(1)(ii)	50.36(c)(2)
//////	20.405(a)(1)(iii)	X 50.73(a)(2)(i)
//////	20.405(a)(1)(iv)	50.73(a)(2)(ii)
//////	20.405(a)(1)(v)	50.73(a)(2)(iii)
//////		50.73(a)(2)(iv)
//////		50.73(a)(2)(v)
//////		50.73(a)(2)(vi)
//////		50.73(a)(2)(vii)(A)
//////		50.73(a)(2)(vii)(B)
//////		50.73(a)(2)(x)
		73.71(b)
		73.71(c)
		Other (Specify in Abstract below and in text)

LICENSEE CONTACT FOR THIS LER (12)

Name R. W. Krieger, Station Manager	TELEPHONE NUMBER AREA CODE 7 1 4 3 6 8 - 6 2 5 5
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	////////	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	////////
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SUPPLEMENTAL REPORT EXPECTED (14)

Expected Submission Date (15)	Month	Day	Year
Yes (if yes, complete EXPECTED SUBMISSION DATE) <input type="checkbox"/>			
NO <input checked="" type="checkbox"/>			

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

At approximately 1300 on 10/7/92 it was discovered that fire protection system [KP] impairment compensatory actions initiated on 10/5/92 at 2400, with Unit 2 in Mode 1 at 100% power and Unit 3 in Mode 1 at 100% power, had not been completed in accordance with Technical Specification (TS) 3.7.8.3, "Plant Systems- Fire Hose Stations." TS 3.7.8.3 requires, in part, that "With one or more of the fire hose stations shown in Table 3.7-6 inoperable . . . a [compensatory] fire hose shall be stored in an area easily accessible to the unprotected area. Signs identifying the purpose and location of the fire hose shall be mounted above the [compensatory] hose and at the inoperable hose station." All requirements of the TS were met, with the exception of the signs which were not posted.

The fire system impairment compensatory actions were initiated in support of planned maintenance activities on the Units 2 and 3 Fire Suppression System. Fourteen fire hose stations were inoperable during the 3-day maintenance activity. Upon completion of the maintenance activity, during removal of the impairment compensatory actions, it was discovered by Fire Department personnel that the required signs had not been posted.

The cause of this event was cognitive personnel error by the two Fire Department officers who activated the impairment compensatory actions when they failed to post the signs required by TS 3.7.8.3 and by the Fire Protection Impairment Procedure. The two Fire Department officers involved in this event have received counseling. In addition, this event will be reviewed by appropriate Fire Protection personnel.

There was no safety significance to this event since backup water sources had been established in accordance with the action requirements of TS 3.7.8.3 and these operable water sources were available to Fire Department personnel, should the need have arisen. In addition, rather than a brigade, San Onofre has a fully certified Fire Department to handle any fire-related events onsite. These personnel are routinely briefed on the status of fire protection systems and would have been aware of the impairments. In addition, Fire Department trucks have redundant hoses which likely would have been used in the event of a fire.