REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8709110271 DOC. DATE: 87/09/04 NOTARIZED: NO DOCKET #
FACIL: 50-361 San Onofre Nuclear Station, Unit 2, Southern Californ 05000361
AUTH. NAME AUTHOR AFFILIATION
MORGAN, H. E. Southern California Edison Co.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-012-00: on 870808, control room emergency air cleanup sys inadvertently actuated during 31-day functional test of control room isolation sys radiation monitor. Caused by employee error. Employee counseled. W/8870904 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 4
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: ELD Chandler 1cy. 05000361

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD5 LA	1	1	PD5 PD	1	1
	ROOD, H	1	1			
INTERNAL:	ACRS MICHELSON	1	1	ACRS MOELLER	2	2
	AEOD/DOA	1	1	AEOD/DSP/NAS	1	1
	AEOD/DSP/ROAB	2	2	AEOD/DSP/TPAB	1	1
	DEDRO	1	1	NRR/DEST/ADS	1	0
	NRR/DEST/CEB	1	1	NRR/DEST/ELB	1	1
	NRR/DEST/ICSB	1	1	NRR/DEST/MEB	1	1
	NRR/DEST/MTB	1	1	NRR/DEST/PSB	1	1
	NRR/DEST/RSB	1	1	NRR/DEST/SGB	1	1
	NRR/DLPQ/HFB	1	1	NRR/DLPQ/QAB	1	1
	NRR/DOEA/EAB	1	1	NRR/DREP/RAB	1	1
	NRR/DREP/RPB	2	2	NRR/PMAS/ILRB	1	1
	REG FILE 02	1	1	RES DEPY GI	1	1
	RES TELFORD, J	1	1	RES/DE/EIB	1	1
	RGN5 FILE 01	1	1			
EXTERNAL:	EG&G GROH, M	5	5	H ST LOBBY WARD	1	1
	LPDR	1	1	NRC PDR	1	1
	NSIC HARRIS, J	1	1	NSIC MAYS, G	1	1
NOTES:		1	1			

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NRC Form 366
(9/83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2	0 5 0 0 0 3 6 1	1 OF 0 2

TITLE (4)
CONTROL ROOM ISOLATION SYSTEM (CRIS) INADVERTENT ACTUATION DURING FUNCTIONAL TESTING

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQ. NUMBER	REV. NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 8	0 8	8 7	8 7	0 1 2	0 0	0 9	0 4	8 7	SONGS, UNIT 3	0 5 0 0 0 3 6 2
										0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	0 9 5

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

20.402(b)	20.405(c)	X 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, NRC Form 366A)	
20.405(a)(1)(iii)	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)	X NO				

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

On August 8, 1987, at 1957, with Unit 2 at 95% power and Unit 3 at 100% power, the Control Room Emergency Air Cleanup System (CREACUS) was inadvertently actuated while performing the 31-day functional test on Control Room Isolation System (CRIS) Train B Radiation Monitor.

The cause of the CRIS actuation was the failure of the technician to place the monitor back in "Alarm Defeat" prior to releasing the "Reset/Bypass" switch. Recognizing this error, the technician immediately reset the CRIS and returned the monitor to "Alarm Defeat".

CREACUS components operated according to design with the exception of Control Room Cabinet Area Emergency Cooling Unit E-423, which did not start. E-423 was subsequently started and stopped by using its Control Room handswitch and also by manually initiating CRIS Train B. It was concluded that the fan failure was associated with the immediate resetting of CRIS by the technician.

The technician involved was counseled and all other technicians involved with radiation monitor testing were briefed on the event. A similar inadvertent actuation of CRIS during performance of the same functional test occurred previously and was reported in LER 84-077. A design change that will install a keylock switch for the bypass function and a spring-loaded switch for the reset function, thereby simplifying the manipulations required by the surveillance procedure, is currently being implemented on all Engineered Safety Features Actuation System radiation monitors in both Units 2 and 3.

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On August 8, 1987, at 1957, with Unit 2 at 95% power and Unit 3 at 100% power, the Control Room Emergency Air Cleanup System (CREACUS) (EIIS System Code VI) was inadvertently actuated while performing the 31-day functional test on Control Room Isolation System (CRIS) Train B Radiation Monitor 2/3 RE-7825B (EIIS Component Code RIT).

The technician reported to the Control Room that the cause of the CRIS actuation was his failure to place 2/3 RE 7825 B back in "Alarm Defeat" prior to releasing the "Reset/Bypass" switch (EIIS Component Code HS), and recognizing this error, he had immediately reset the CRIS and returned the monitor to "Alarm Defeat".

CREACUS components operated according to design with the exception of Control Room Cabinet Area Emergency Cooling Unit E-423 (EIIS Component Code FAN), which did not start. The proper operation of E-423 was verified by manually starting and stopping the fan using its Control Room handswitch and also verifying that it would start by manually initiating CRIS Train B. It was concluded that the fan failure was associated with the immediate resetting of CRIS by the technician.

CRIS was reset and CREACUS was returned to the stand-by mode at 2007.

A similar inadvertent actuation of CRIS during performance of the same functional test occurred previously and was reported in LER 84-077 (Docket No. 50-361). A design change that will install a keylock switch for the bypass function and a spring-loaded switch for the reset function, thereby simplifying the manipulations required by the surveillance procedure, is currently being implemented on all ESFAS (Engineered Safety Features Actuation System) radiation monitors in both Units 2 and 3.

The technician involved was counseled and all other technicians involved with radiation monitor surveillances were briefed on the event.

There are no reasonable or credible circumstances which could have increased the severity of the event. The health and safety of the public or plant personnel was not affected.

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

H. E. MORGAN
STATION MANAGER

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September 4, 1987

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

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 87-012
San Onofre Nuclear Generating Station, Units 2 and 3

Pursuant to 10 CFR 50.73(a)(2)(iv), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving an actuation of the Control Room Isolation System (CRIS). Since this event involved shared systems between Units 2 and 3, a single report is being submitted in accordance with NUREG-1022. Neither the health and safety of plant personnel nor the health and safety of the public was affected by this event.

If you require any additional information, please so advise.

Sincerely,

HEMorg

Enclosure: LER No. 87-012

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)

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