

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR: 8906210154      DOC. DATE: 89/06/13      NOTARIZED: NO      DOCKET #  
 FACIL: 50-361 San Onofre Nuclear Station, Unit 2, Southern California      05000361  
 AUTH. NAME      AUTHOR AFFILIATION  
 MORGAN, H.E.      Southern California Edison Co.  
 RECIP. NAME      RECIPIENT AFFILIATION

SUBJECT: LER 89-008-00: on 890519, control room isolation sys Train A  
 inadvertent actuation due to operator error.      W/8      ltr.

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*Southern California Edison Company*

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

H. E. MORGAN  
STATION MANAGER

TELEPHONE  
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June 13, 1989

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

Subject: Docket No. 50-361  
30-Day Report  
Licensee Event Report No. 89-008  
San Onofre Nuclear Generating Station, Units 2 and 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 spurious actuation of the Control Room Isolation System. 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 or the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely,

*H E Morgan*

Enclosure: LER No. 89-008

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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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

Title (4) **CONTROL ROOM ISOLATION SYSTEM TRAIN A INADVERTENT ACTUATION DUE TO OPERATOR ERROR**

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
Month	Day	Year	Year	/// Sequential ///	/// Revision ///	Month	Day	Year	Facility Names	Docket Number(s)		
0   5	1   9	8   9	8   9	---	0   0   8	---	0   0	0   6	1   3	8   9	SONGS, UNIT 3	0   5   0   0   0   3   6   2

OPERATING MODE (9) **5**

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 checked="" 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 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 **H. E. Morgan, Station Manager** TELEPHONE NUMBER **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)

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)

At 1155 on 5/19/89, with Unit 2 in Mode 5 and Unit 3 at 100% power, a Control Room Isolation System (CRIS) Train A actuation occurred when power was inadvertently removed from radiation monitor 2RI-7824. The control room radiation levels were verified to be normal through observation of Train B radiation instrumentation. CRIS Train A was reset and the ventilation lineup returned to normal at 1220. All CRIS Train A components were verified to have actuated as required. There is no safety significance to this event since radiation levels remained normal, and Train B CRIS and Control Room Emergency Air Cleanup System remained operable throughout the event.

The actuation was caused by operator error. It was intended that the monitor be bypassed to support a routine filter change. The operator manipulated the power transfer switch, which is used to select either Unit 2 or 3 as the monitor power source, instead of the bypass switch, which is used to disconnect the monitor from its actuation circuitry. This misoperation was caused by the operator: 1) misreading the labels on the key operated power transfer and bypass switches as well as on the respective keys, and 2) inadequately considering the purpose of keyed switches and the results of manipulating the switch.

As corrective action the operator has received appropriate disciplinary action and has reviewed this event. In addition, this event has been reviewed with appropriate operations personnel with emphasis placed on the purpose of keyed switches and the need for confirming administratively controlled manipulations prior to performing them.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

SAN ONOFRE NUCLEAR GENERATION STATION	DOCKET NUMBER	LER NUMBER	PAGE
UNIT 2	05000361	89-008-00	2 OF 4

Plant: San Onofre Nuclear Generating Station  
Units: Two and Three  
Reactor Vendor: Combustion Engineering  
Event Date: 05-19-89  
Time: 1155

A. CONDITIONS AT TIME OF THE EVENT:

Mode: Unit 2 - Mode 5, Cold Shutdown  
Unit 3 - Mode 1, 100% Reactor Power

B. BACKGROUND INFORMATION:

The Control Room Isolation System (CRIS) and associated Control Room Emergency Air Cleanup System (CREACUS) [VI] consist of two independent trains of radiation monitors (RI-7824 (Train A) and RI-7825 (Train B)) [RIT], emergency ventilation supply (EVS) units (A-206 and A-207) [AHU], emergency air conditioning (EAC) units (E-418 and E-419) [ACU], cabinet area emergency air cooling units (E-423, E-424, E-426, and E-427) [ACU], and associated emergency isolation dampers [BDMP]. Each radiation monitor is comprised of a particulate/iodine channel and a noble gas channel. Upon receipt of either a high radiation or instrument failure signal, the dampers operate to direct outside air through the EVS and EAC units, both of which contain filtration units [FLT], thus providing purified and cooled air to the control room and minimizing exposure to personnel.

C. DESCRIPTION OF THE EVENT:

1. Event:

At 1155 on 5/19/89, with Unit 2 in Mode 5 and Unit 3 at 100% power, a CRIS Train A actuation occurred when power was inadvertently removed from radiation monitor 2RI-7824. The control room radiation levels were verified to be normal through observation of Train B radiation instrumentation. CRIS Train A was reset and the ventilation lineup returned to normal at 1220. All CRIS Train A components were verified to have actuated as required. There is no safety significance to this event since radiation levels remained normal, and Train B CRIS and CREACUS remained operable throughout the event.

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

None.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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3. Sequence of Events:

<u>TIME</u>	<u>ACTION</u>
1155	CRIS Train A actuation occurred.
1220	After verifying that the actuation was inadvertent, CRIS Train A was reset and the control room ventilation lineup returned to normal.

4. Method of Discovery:

Control room indications and alarms alerted the operators (utility, licensed) of the CRIS Train A actuation.

5. Personnel Actions and Analysis of Actions:

The operators responded properly to the CRIS Train A actuation by: 1) verifying each CRIS Train A component actuated as required, and 2) verifying control room radiation levels were normal prior to resetting CRIS and returning the ventilation lineup to normal.

6. Safety System Responses:

All CRIS Train A components were verified to have actuated as required.

D. CAUSE OF THE EVENT:

1. Immediate Cause:

When the monitor power supply was inadvertently transferred from Unit 3 to Unit 2, the "break before make" characteristics of the transfer switch caused power to be briefly removed from 2RI-7824. The actuation relay was deenergized, resulting in the CRIS actuation. It was intended that the monitor be bypassed to support changing its filter.

2. Root Cause:

The cause of this event was cognitive operator error. The operator (utility, licensed) manipulated the power transfer switch instead of the bypass switch. This misoperation was caused by the operator: 1) misreading the labels on the key operated power transfer and bypass switches as well as on their keys, and 2) inadequately considering the purpose of keyed switches and the results of manipulating the switch.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

SAN ONOFRE NUCLEAR GENERATION STATION  
UNIT 2

DOCKET NUMBER  
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E. CORRECTIVE ACTIONS:

1. Corrective Actions Taken:

- a. The operator has received appropriate disciplinary action and has reviewed this event.
- b. This event has been reviewed with appropriate operations personnel with emphasis placed on the purpose of keyed switches and the need for confirming administratively controlled manipulations prior to performing them.

2. Planned Corrective Actions:

None.

F. SAFETY SIGNIFICANCE OF THE EVENT:

There is no safety significance to this event since radiation levels remained normal, and Train B CRIS and CREACUS remained operable throughout the event.

G. ADDITIONAL INFORMATION:

1. Component Failure Information:

Not applicable.

2. Previous LERs for Similar Events:

None.

3. Results of NPRDS Search:

Not applicable.