REGULATORY NFORMATION DISTRIBUTION SYMPEM (RIDS)

ACCESSION NBR: 8710080399 DOC. DATE: 87/09/29 NOTARIZED: NO DOCKET #
FACIL: 50-362 San Onofre Nuclear Station, Unit 3, Southern Californ 05000362

AUTH. NAME

AUTHOR AFFILIATION

MORGAN, H. E.

Southern California Edison Co.

RECIP. NAME

RECIPIENT AFFILIATION

SUBJECT: LER 87-015-00: on 870830, containment purge isolation sys actuated on instrument failure signal from containment airborne monitor. Caused by photomultiplier (PM) tube failure. PM tube replaced & tested satisfactory. W/8

ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 5

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CONTAINMENT PURGE ISOLATION SYSTEM ACTUATION DUE TO FAILURE OF AIRBORNE MONITOR 3RT-7807																														
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																														
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Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

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YES

On 8/30/87, at 0636, Containment Purge Isolation System (CPIS) Train "B" actuated on an instrument failure signal from Containment Airborne Monitor 3RT-7807 (Iodine Channel). There was no purge in progress; therefore, CPIS components did not actuate. At 1051, the failed monitor was removed from service, and CPIS was reset.

It was determined that the detector failed due to a failure of the photomultiplier (PM) tube. CPIS Train "B" was returned to operable status on 9/8/87, following completion of PM tube replacement and satisfactory functional testing of the monitor.

A calculation of the failure rate of the PM tubes at San Onofre and a review of vendor and industry data determined that the experienced failure rate is well within the expected failure rate typical for this equipment. Therefore, additional corrective action is not warranted at this time.

There was no safety significance to this event since, had a containment purge been in progress, the instrument failure would have resulted in CPIS performing its safety function, as designed.

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YEAR

EXPECTED SUBMISSION DATE (15)

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YES (If yes, complete EXPECTED SUBMISSION DATE)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

SAN ONOFRE NUCLEAR GENERATION STATION DOCKET NUMBER LER NUMBER PAGE 05000362 87-015-00 2 0F 4

Plant: San Onofre Nuclear Generating Station (SONGS)

Unit: 3

Reactor Vendor: Combustion Engineering

Event Date: 08-30-87

Time: 0636

A. Plant Conditions at Time of the Event:

Unit 3 was operating at 100% power. All containment purge valves were closed.

B. Background Information:

There are two independent Containment Purge Isolation System (CPIS) (EIIS System Code VA) trains. Each train is comprised of a containment airborne radiation monitor (EIIS Component Code RIT), an area radiation monitor and a set of purge isolation valves (EIIS Component Code ISV). Each train is actuated by either a remote manual push button, or by one of the monitors on high radiation, instrument failure or loss of power.

C. Description of the Event:

1. Event:

On 8/30/87, at 0636, Containment Purge Isolation System (CPIS) Train "B" actuated on an instrument failure signal from Containment Airborne Monitor 3RT-7807 (Iodine Channel). Because there was no purge in progress, only the logic circuit actuated, and there was no actuation of CPIS components. At 1051, the failed monitor was removed from service, and CPIS was reset.

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

3. Sequence of Events:

TIME	ACTION
8/30/87 at 0636	CPIS Train "B" actuated.
8/30/87 at 1051	Monitor 3RT-7807 removed from service and CPIS reset.
9/8/87 at 0836	Returned CPIS Train "B" to operable status following repair and testing of 3RT-7807.

Method of Discovery:

The failure of 3RT-7807 was indicated by Control Room annunciation of the CPIS actuation.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

SAN ONOFRE NUCLEAR GENERATION STATION	DOCKET NUMBER	LER NUMBER	PAGE
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UNIT 3	05000362	87-015-00	3 OF 4
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5. Personnel Actions and Analysis of Actions:

In accordance with established procedures, licensed operators verified that radiation levels inside containment were normal prior to resetting CPIS.

6. Safety System Responses:

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The containment purge valves were closed at the time of the actuation. Therefore, no safety system components actuated.

D. Cause of the Event:

1. Immediate Cause:

The iodine channel to monitor 3RT-7807 failed low resulting in a CPIS Train "B" actuation on an instrument failure signal.

2. Intermediate Cause:

Troubleshooting of 3RT-7807 revealed a failed detector photomultiplier (PM) tube. This has been determined to be a random failure.

Root Cause:

The failure rate for the PM tube, based on experience at SONGS Units 2 and 3, was calculated to be 7.8 failures per 10E+6 hours of service. A review of the failure rate of scintillation monitors established in IEEE Std. 500, Reliability Data, indicates a range from 20 to 33 failures per 10E+6 hours of service is typical for this equipment. The manufacturer of the PM tube has indicated that it has experienced a failure rate equivalent to approximately 38 failures per 10E+6 hours. Since the current failure rate of this type of equipment at SONGS is significantly less than the expected rate of failure, additional root cause evaluation is not required at this time.

We will continue to monitor this equipment in accordance with our root cause program.

E. Corrective Actions:

1. Corrective Actions Taken:

The monitor was repaired and a functional test was satisfactorily performed.

2. Planned Corrective Actions:

Additional corrective action is not warranted at this time.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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SAN ONOFRE NUCLEAR GENERATION STATION	DOCKET NUMBER	LER NUMBER	PAGE
UNIT 3	05000362	87-015-00	4 OF 4

F. Safety Significance of the Event:

There was no safety significance to this event since, had a containment purge been in progress, the instrument failure would have resulted in CPIS performing its safety function, as designed.

G. Additional Information:

1. Component Failure Information:

Monitor 3RT-7807 is supplied by Nuclear Measurements Corp. The PM tube is manufactured by EMI Electron Tubes, model number 9896B.

2. Previous LERs on Similar Events:

The following LERs reported CPIS actuations caused by instrument failures. None of these LERs involved detector PM tube failures.

<u>Docket No. 50-361</u>	<u>Docket No. 50-362</u>
LER 85-036 LER 84-011 LER 84-062	LER 87-006 LER 86-008 LER 85-005 LER 85-011 LER 85-014

The Country of

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

H. E. MORGAN STATION MANAGER

September 29, 1987

TELEPHONE (714) 368-6241

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

Subject: Docket No. 50-362

30-Day Report

Licensee Event Report No. 87-015

San Onofre Nuclear Generating Station, Unit 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 the actuation of the Containment Purge Isolation System. 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, UEMng

Enclosure: LER No. 87-015

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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