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Pacific Gas and Electric Company

77 Beale Street San Francisco, CA 94106 415/972-7000 TWX 910-372-6587 James D. Shiffer Vice President Nuclear Power Generation

November 13, 1989

PG&E Letter No. DCL-89-281

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

Re: Docket No. 50-275, OL-DPR-80 Diablo Canyon Unit 1 Licensee Event Report 1-89-008-00 Control Room Ventilation System Shift to Pressurization Mode During Transfer of Shielded Cask Due to Inadequate Procedural Guidance

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(iv), PG&E is submitting the enclosed Licensee Event Report (LER) regarding the control room ventilation shift to pressurization mode during the transfer of a shielded cask. This event was caused by inadequate procedural guidance governing the transfer of radioactive material.

This event has in no way affected the public's health and safety.

Kindly acknowledge receipt of this material on the enclosed copy of this letter and return it in the enclosed addressed envelope.

Sincerely,

-/fr J. D. Shiffer

cc: J. B. Martin M. M. Mendonca P. P. Narbut H. Rood B. H. Vogler CPUC Diablo Distribution INPO

Enclosure

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On October 12, 1989 at 2140 PDT, with Unit 1 in Mode 6 and Unit 2 in Mode 1 (Power Operation), the control room ventilation system automatically shifted from its normal ventilation mode to the pressurization mode, an Engineered Safety Feature (ESF) actuation. This ESF was due to a high radiation signal from Unit 1 radiation detectors RE-25 and 26. The high radiation signal was generated when the detectors were exposed to radiation during the transfer of radioactive material from the reactor refueling cavity to a shielded cask outside the containment equipment hatch.

In accordance with 10CFR 50.72, a four hour, non-emergency report was made on October 13, 1989 at 0027 PDT.

Radiation Protection Management will issue memoranda that advises supervisors to consider the impact of the movement of radioactive material on installed plant radiation monitors. In addition, the Radiation Procedure RCP D-200, "Writing Radiation Work Permits," will be revised to include specific instructions to avoid ESF actuations that occur during movement of radioactive materials.

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I. <u>Plant Conditions</u>

Unit 1 was in a refueling outage (Mode 6). The Unit 1 reactor head was detensioned and the studs were removed. Unit 2 was in Mode 1 (Power Operation).

II. <u>Description of Event</u>

A. Event:

On October 12, 1989 at 2140 PDT, with Unit 1 in Mode 6 (outage condition with the reactor head detensioned and the studs removed), and Unit 2 in Mode 1 the control room ventilation (VI) system automatically shifted from its normal ventilation mode to the pressurization mode, an Engineered Safety Feature (ESF) actuation. This shift in mode was due to a high radiation signal from Unit 1 radiation detectors RE-25 and 26. The high radiation signal was generated when the detectors were exposed to radiation during the transfer of radioactive material from the reactor refueling cavity to a shielded cask outside the containment equipment hatch. The Control Room determined the cause of the alarm as being the transfer of radioactive material out of containment.

The radioactive material consisted of a drain strainer from the lower reactor cavity transfer canal drain. Previous activities included the cleaning and flushing of the canal. The strainer was removed, placed inside a plastic bag, which was subsequently transferred to a plastic bucket for retrieval from the reactor cavity. After retrieval from the reactor cavity, the bucket was transported to the equipment hatch and placed inside a shielded cask.

During the transfer of the radioactive material to the shielded cask, nominal detectors, RE-25 and 26 were exposed to a dose rate in excess of the detectors, nominal set point of 1.6 mr/hr.

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

None.

C. Dates and Approximate Times for Major Occurrences:

 October 12, 1989, 2140 PDT: Event/Discovery date - Control room ventilation shifted from its normal ventilation mode to the pressurization mode.

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IV.	<u>Ana</u>	lysis of Event		s									
	Α.	Safety Analysis:	• •										
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t		The Radiation Prot radiation protecti radioactive materi determined that ra evolution, then th control room is fo notification are c radiation work per "Writing Radiation instruction on the may cause the actu	ection Department Manag on supervisors to consi- al on installed radiati diation monitors are af he Radiation Protection ormally notified and tha controlled by a work ord mit (SWP). 2. Radiation Work Permits," will be control of radiation p mation of ESF radiation	er w der on m fect supe t th er, on C rev rote dete	ill the onit ed du rvis e the proce ontro ised ction ctor	issu impa ors. urin or m e wo edur ol P to to n wo fun	e a ct g a ust rk, roc inc rk cti	men of n f il ens evol or s edun lude acti ons	no 1 nove sure sure luti spec re F spec re F	to al ement ed wo tha on a cial CCP D ecif ties	1 of t th nd -200 ic that	ne),	
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guidance, in that the procedures did not consider the presence of radiation detectors in the proximity of the steam dump valves being examined. Also, the procedures did not adequately define departmental responsibilities for the performance of radiographic examinations. The corrective actions for this event could not have prevented the October 12, 1989 ESF actuation due to the specificity of addressing radiography controls and corresponding impacts on plant radiation detectors.

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