REGULAT[redacted] INFORMATION DISTRIBUTION[redacted]YSTEM (RIDS)

ACCESSION NBR: 8709300164 DOC. DATE: 87/09/23 NOTARIZED: NO DOCKET #
FACIL: 50-275 Diablo Canyon Nuclear Power Plant, Unit 1, Pacific Ga 05000275
AUTH. NAME AUTHOR AFFILIATION
WILSON, S. D. Pacific Gas & Electric Co.
SHIFFER, J. D. Pacific Gas & Electric Co.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-013-00: on 870824, containment ventilation isolation sys occurred. Caused by licensed operation inadvertently initiating source check on wrong radiation monitor. Operator counseled. W/870923 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 6
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR	COPIES ENCL
	PD5 LA	1	1	PD5 PD	1	1
	TRAMMELL, C	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/DRIS/SIB	1	1
	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	2	2	NRC PDR	1	1
	NSIC HARRIS, J	1	1	NSIC MAYS, G	1	1

TOTAL NUMBER OF COPIES REQUIRED: LTTR 45 ENCL 44

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
DIABLO CANYON UNIT 1	0 5 0 0 0 2 7 5	1 OF 0 5

TITLE (4)

CONTAINMENT VENTILATION ISOLATION INITIATION DUE TO PERSONNEL ERROR

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)
0 8	2 4	8 7	8 7	0 1 1 3	0 0	0 9	2 3	8 7		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (11)
1	[X] 10 CFR 50.73(a)(2)(iv)
POWER LEVEL (10) 1 0 0	[ ] OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER AREA CODE	
STEPHEN D. WILSON, REGULATORY COMPLIANCE ENGINEER	8 0 5	5 9 5 - 7 3 5 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)

[X] NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

ABSTRACT (16)

On August 24, 1987, at 1347 PDT, with the unit in Mode 1 (Power Operation), an automatic initiation of the containment ventilation isolation system (CVIS) occurred. The sample line isolation valves for gaseous radiation monitors (RM) RM11 and RM12 closed as designed. All other CVIS valves that receive isolation signals were already closed when the event occurred. As required by 10 CFR 50.72 (b)(2)(ii), a 4-hour non-emergency event report was made at 1425 PDT, August 24, 1987.

This event was caused by a licensed senior operator performing a source check on the incorrect radiation monitor prior to a liquid radwaste discharge. The CVIS was reset at 1347 PDT, August 24, 1987.

The operator was counseled concerning his improper action. An incident report was issued on this event and will be reviewed with operators to emphasize the importance of verifying equipment prior to actuating any functions associated with testing.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

I. Initial Conditions

Unit 1 was in Mode 1 (Power Operation).

II. Description of Event

A. Event:

On August 24, 1987, at 1347 PDT, with the unit in Mode 1 (Power Operation), an automatic initiation of the containment ventilation isolation system (CVIS) (TM) occurred. The sample line isolation valves for gaseous radiation monitors (IL)(MON) RM11 and RM12 closed as designed. All other CVIS valves that receive isolation signals were already closed when the event occurred. As required by 10 CFR 50.72(b)(2)(ii), a 4-hour non-emergency event report was made at 1425 PDT, August 24, 1987.

Operators were performing the predischarge checks on RM-18, the liquid radwaste effluent monitor, as required by Operating Procedure G-1:II, "Liquid Radwaste System - Processing and Discharge of Liquid Radwaste," prior to the planned discharge of Floor Drain Receiver (FDR) O-2. When the operator in the control room attempted to perform the source check on RM-18, he inadvertently initiated a source check on RM-14B, the plant vent radiogas monitor, whose control panel is directly below the control panel for RM-18. RM-14B exceeded its high trip setpoint while being source-checked, initiating the CVIS. The CVIS was reset at 1347 PDT, August 24, 1987, after which RM11 and RM12 sample line isolation valves were reopened.

B. Inoperable structures, components or systems that contributed to the event:

None

C. Dates and approximate times for major occurrences:

1. August 24, 1987, at 1347 PDT: Event, discovery date, and CVIS reset.

2. August 24, 1987, at 1425 PDT: 4-hour non-emergency event report completed.

D. Other systems or secondary functions affected:

None

E. Method of discovery:

The event was immediately apparent due to alarms and indications in the control room.

F. Operator actions:

Operators reset the CVIS, reset the alarm, and placed RM-11 and RM-12 back in service.

G. Safety system responses:

None required

III. Cause of Event

A. Immediate cause:

A licensed operator inadvertently initiated a source check on the wrong radiation monitor.

B. Root cause:

Lack of attention to detail (cognitive error) by the operator performing the source check on RM-18. The close proximity of the two radiation monitors in the control room rack contributed to the error.

IV. Analysis of Event

This CVIS initiation, from an inadvertent source check on the incorrect radiation monitor, represents a conservative event. Therefore, no adverse safety consequences or implications resulted.

V. Corrective Actions

A. The operator was counseled concerning his improper action.

B. An incident report was issued on this event and associated corrective actions will be reviewed with all operators. This review will emphasize the importance of verification of equipment prior to actuating any functions associated with testing.

C. Lessons learned from this event will be incorporated into the initial non-licensed operator training program.

VI. Additional Information

A. Failed components:

None

B. Previous LERs on similar events:

1-87-008-00: Containment Ventilation Isolation Due to Personnel Error

LER 1-87-008 reported an error by a non-licensed operator who performed a source check on the incorrect radiation monitor causing a containment ventilation isolation. The corrective actions included improving the labeling on the radiation monitors.

2-86-002-00: Inoperability of Both RHR Trains Due to Operator Error

LER 2-86-002-00 reported an error made by a non-licensed operator who transferred the incorrect instrument panel to an alternate power supply. The corrective actions of LER 2-86-002-00 emphasized the importance of verifying the location of the proper equipment prior to initiating action.

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TEXT *(If more space is required, use additional NRC Form 366A's)* (17)

1-86-009-00: Inadvertent Actuation of Auxiliary Feedwater Pump 1-3 Due to Personnel Error During Surveillance Testing

LER 1-86-009-00 reported an error made by a licensed operator who actuated the incorrect slave relay because it was similarly numbered. The corrective actions for this LER emphasized the importance of good operating practices and a revision to the applicable surveillance test procedure.

The lack of attention to detail and error on the part of the operator would not have been prevented by the specific corrective actions of improved labeling or revised procedures noted in the above LERs.

PACIFIC GAS AND ELECTRIC COMPANY

PG&E

77 BEALE STREET • SAN FRANCISCO, CALIFORNIA 94106 • (415) 781-4211 • TWX 910-372-6587

JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

September 23, 1987

PGandE Letter No.: DCL-87-235

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 1-87-013-00
Containment Ventilation Isolation Initiation Due to
Personnel Error

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(iv), PGandE is submitting the enclosed Licensee Event Report concerning a containment ventilation isolation initiation event.

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,

J C Carroll for
J D Shiffer

Enclosure

cc: L. J. Chandler
J. B. Martin
P. P. Narbut
B. Norton
CPUC
Diablo Distribution
INPO

1687S/0051K/DJH/669

DC1-87-OP-N100

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