

*Southern California Edison Company*

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128

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R. W. KRIEGER  
STATION MANAGER

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October 2, 1991

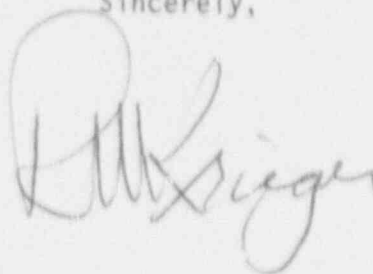
U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D.C. 20555

Subject: Docket No. 50-361  
30-Day Report  
Licensee Event Report No. 91-013  
San Onofre Nuclear Generating Station, Unit 2

Pursuant to 10 CFR 20.20(d), this submission provides the required 30-day written Licensee Event Report (LER) for an occurrence involving the Units 2 and 3 Toxic Gas Isolation System. Since this occurrence involves similar systems, cause, and corrective actions applicable to Units 2 and 3, a single report for Unit 2 is being submitted in accordance with NUREG-1022. Neither the health nor the safety of plant personnel or the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely,



Enclosure: LER No. 91-013

cc: C. W. Caldwell (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) AN OHIO RE NUCLEAR GENERATING STATION, UNIT 2										Docket Number (2) 0150101013611			Page (3) 1 of 01	
Title (4) Spurious Train "A" Toxic Gas Isolation System (TGIS) Actuation due to Cognitive 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 Name		Docket Number(s)			
019	015	911	911	0113	010	110	012	911	SONGS, UNIT 3		0150101013612			
OPERATING MODE (9) 6				THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)										
POWER LEVEL (10) 0100				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)				
				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 R. W. Krieger, Station Manager										TELEPHONE NUMBER 7114 3161 161215				
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)														
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC					
SUPPLEMENTAL REPORT EXPECTED (14)										Expected Submission Date (15)		Month	Day	Year
Yes (If yes, complete EXPECTED SUBMISSION DATE) <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)														

At 0718 on 9/5/91, with Unit 2 in Mode 6 and Unit 3 at 100% power, the Train "A" Toxic Gas Isolation System (TGIS) [VI] actuated. Control room alarms and indications alerted control room operators (utility, licensed) of the actuation. Operators responded properly to the Train "A" TGIS actuation by promptly: 1) verifying proper system operation, and 2) determining that the actuation was spurious due to a momentary loss of power. At 0815 the NRC was notified via red phone of both a TGIS and a Control Room Isolation System (CRIS) actuation. Subsequent investigation has determined that only a TGIS actuation occurred. Train "A" TGIS was reset and normal control room ventilation restored at 0822.

Preparations were being made for a Unit 2 Train "A" electrical Bus outage at the time of the actuation, with Unit 3 supplying power to the Train "A" TGIS. An operator was reading Circuit Breaker (CB) [52] numbers and required CB positions from a checklist while another operator (both utility, non-licensed) was tagging and positioning the CBs. While positioning the CBs, the second operator inadvertently opened the CB which supplies power from Unit 3 to the Train "A" TGIS sample pump and analyzers. The operator immediately re-closed the CB.

This event was caused by inattention to detail (cognitive error) by the operator positioning the CBs. The operator involved in this event has received appropriate disciplinary action. In addition, the circumstances of this event have been reviewed with appropriate Operations personnel. There was no safety significance to this event since all Train "A" TGIS components functioned as designed.