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September 20, 1995

R. W KRIEGER VICE PREBIDENT NUCLEAR GENERATION

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

Subject: Docket No. 50-361 30 Day Report Licensee Event Report No. 95-015 San Onofre Nuclear Generating Station, Unit 2

This submittal provides a written Licensee Event Report (LER) for the discovery of one of three reactor coolant system leak detection systems that was inoperable longer than allowed by the technical specifications without the required compensatory action being implemented. Neither the health nor the safety of plant personnel or the public was affected by this occurrence.

Sincerely,

Enclosure: LER No. 95-015

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cc: L. J. Callan, Regional Administrator, NRC Region IV
J. E. Dyer, Director, Division of Reactor Projects, NRC Region IV
K. E. Perkins, Jr., Director, Walnut Creek Field Office, NRC Region IV
J. A. Sloan, NRC Senior Resident Inspector, San Onofre Units 2 & 3
M. B. Fields, NRC Project Manager, San Onofre Units 2 and 3
Institute of Nuclear Power Operations (INPO)

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Tech. Spec. (TS) 3.4.5 requires the containment atmosphere particulate rad monitor [IJ,RI] 2RT-7804B or 2RT-7807B to be operable in Modes 1-4. When both monitors are out of service, operation may continue for 30 days if containment atmosphere is sampled and analyzed every 24 hours. These monitors move filter paper tape slowly across a sample line suction port with a detector mounted directly above the paper.

On 8/22/95, the system engineer discovered the filter paper tape roll installation for 2RT-7807B was reversed from that specified. The reversed orientation of the paper roll had allowed a gap to form between the filter paper and the sample port, allowing sample flow to bypass the paper. Based on readings from 2RT-7804B, Edison believes its paper was also installed incorrectly. A review of plant records indicates the system was inoperable for about 31 hours between 8/21/95 and 8/22/95. Because it was not known both monitors were inoperable (both did have residual readings), the required air samples were not collected and analyzed.

This event was caused when Chemistry Technicians (utility, non-licensed) inadvertently installed the filter paper supply roll upside down (cognizant personnel error). In this configuration, sufficient tension on the filter paper is not always maintained allowing the paper to gap. Chemistry technician knowledge and training focused on ensuring the paper path was over the sample port and not on the orientation of the supply roll. Notwithstanding that a local diagram showed the correct supply roll orientation, personnel did not appreciate that supply roll orientation could result in intermittent failure.

The paper for both monitors was corrected on 8/22/95. Edison confirmed that all other similar monitors have their paper installed correctly. Chemistry technicians were retrained on the installation of the filter paper and the importance of the supply roll orientation. During the period that the particulate monitors were inoperable, the two other TS required leak detection systems remained operable and indicated normal readings. Therefore, there was no safety significance to this event. There have been no LERs in the past three years involving inoperable radiation monitors.