



SOUTHERN CALIFORNIA
EDISON

An EDISON INTERNATIONAL Company

R. W. Krieger
Vice President
Nuclear Generation

March 4, 1996

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

Subject: Docket Nos. 50-361 and 50-362
30-Day Report
Licensee Event Report No. 96-001
San Onofre Nuclear Generating Station, Units 2 and 3

Pursuant to 10 CFR 50.73(d), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving an inoperable hydrogen monitor in the common waste gas system for Units 2 and 3. 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,

R. Walden for R.W. Krieger

Enclosure: LER No. 96-001

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

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9604010292 960304
PDR ADOCK 05000361
S PDR

P. O. Box 128
San Clemente, CA 92674
714-368-6255
Fax 714-368-6183

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LICENSEE EVENT REPORT (LER)															
Facility Name (1) SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2										Docket Number (2) 0 5 0 0 0 3 6 1			Page (3) 1 of 0 3		
Title (4) Inoperable Waste Gas System Hydrogen Monitor															
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 2	0 5	9 6	9 6	---	0 0 1	---	0 0	0 3	0 4	9 6	SONGS Unit 3		0 5 0 0 0 3 6 2		
OPERATING MODE (9) 1			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)												
POWER LEVEL (10) 1 0 0		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)		Other (Specify in Abstract below and in text)					
		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)									
		20.405(a)(1)(iii)		X 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, Vice President, Nuclear Generation										TELEPHONE NUMBER AREA CODE 7 1 4 3 6 8 - 6 2 5 5					
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)															
CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	////////	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	////////				
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SUPPLEMENTAL REPORT EXPECTED (14)												Expected Submission Date (15)	Month	Day	Year
<input type="checkbox"/> Yes (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO															
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)															

At approximately 0130 on 02/05/96, the night shift Radioactive Waste Assistant Control Operator (Radwaste Operator) (utility, non-licensed) communicated the results of the daily channel check of the Explosive Gas Monitoring Instrumentation to the Control Room. The reading reported for waste gas surge tank hydrogen (H2) monitor AE-0574 was 0% H2. The Assistant Control Operator (ACO) (utility, licensed) and the Radwaste Operator recognized and discussed that the 0% reading was abnormally low, but did not recognize that the monitor might have been inoperable. Contrary to management expectations, the ACO did not inform Control Room supervision, and no action was taken to declare AE-0574 inoperable. Therefore, the action required by the Technical Specifications to align the remaining operable instrumentation channel to the waste gas surge tank or obtain 4 hour grab samples was not taken. Edison is reporting this event in accordance with 10CFR50.73(a)(2)(i).

The last non-zero reading on AE-0574 occurred around 0900 on 02/04/96. During normal rounds at about 1630 on 02/05/96, the day shift Radwaste Operator notified Control Room personnel of the 0% reading on AE-0574. The day shift personnel promptly declared AE-0574 inoperable and directed that the operable instrumentation channel be aligned to the waste gas surge tank. This alignment was completed at 1715. The operable channel confirmed that AE-0574 had failed.

AE-0574 failed due to a blown fuse. Edison replaced the blown fuse and performed a channel calibration and a channel functional test on H2 monitor AE-0574. Management conducted pre-shift briefings for all operating crews stressing the normal values of the waste gas surge tank H2 monitor and that a 0% reading should be considered a monitor failure until proven otherwise. Management coached the personnel involved on performance expectations.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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DESCRIPTION OF THE EVENT:

Plant: San Onofre Nuclear Generating Station, Units 2 & 3
 Reactor Vendor: Combustion Engineering
 Discovery Date: February 5, 1996
 Mode: Both Units were in Mode 1
 Power: Both Units were at 100% power

Technical Specification (TS) Surveillance Requirement 4.3.3.9 requires a daily channel check of the Explosive Gas Monitoring Instrumentation of the waste gas holdup system [WE]. At approximately 0130 on 02/05/96, the night shift Radioactive Waste Assistant Control Operator (Radwaste Operator) (utility, non-licensed) communicated the results of the daily channel check to the Control Room Assistant Control Operator (ACO) (utility, licensed). The reading reported for the waste gas surge tank hydrogen (H2) monitor AE-0574 was 0% H2. The ACO and the Radwaste Operator recognized and discussed that the 0% H2 reading was abnormally low (normal readings are between 20% and 40%) but did not recognize that the H2 monitor might have been inoperable. Contrary to management expectations, the ACO did not inform the Control Operator and the Control Room Supervisor, and no action was taken to declare the H2 monitor inoperable. Therefore, the action required by TS 3.3.3.9.b to align the remaining operable instrumentation channel to the waste gas surge tank or obtain 4 hour grab samples was not taken. Edison is reporting this event in accordance with 10CFR50.73(a)(2)(i).

In the subsequent investigation, the Radwaste Operator recalled that during normal rounds at 2000 on 02/04/96 (prior to the TS surveillance), he observed the waste gas surge tank H2 monitor reading 0% H2. At the time, he did not recognize the significance of the reading. The last non-zero reading on AE-0574 occurred around 0900 on 02/04/96.

During normal rounds at about 1630 on 02/05/96, the day shift Radwaste Operator notified Control Room personnel of the 0% reading on H2 monitor AE-0574. The day shift personnel promptly declared AE-0574 inoperable and directed that the operable instrumentation channel be aligned to the waste gas surge tank. This alignment was completed at 1715. The operable channel confirmed that H2 monitor AE-0574 had failed.

CAUSE OF THE EVENT:

H2 monitor AE-0574 failed due to a blown fuse in the instrument power supply. Edison considers this to be a random fuse failure.

The night shift Radwaste Operator and ACO did not recognize the need to take the action required by TS and did not inform the Control Operator and Control Room Supervisor due to cognitive personnel error.

CORRECTIVE ACTIONS:

Edison replaced the blown fuse and performed a channel calibration and a channel functional test on H2 monitor AE-0574. Management conducted pre-shift briefings for all operating crews stressing the normal values of the waste gas surge tank H2 monitor and that a 0% reading should be considered a monitor failure until proven otherwise. Management coached the personnel involved on performance expectations.

SAFETY SIGNIFICANCE OF THE EVENT:

The Explosive Gas Monitoring Instrumentation consists of monitors for oxygen as well as hydrogen in the waste gas stream, including alarms for high oxygen concentrations. Because there were no high oxygen concentration alarms during the period that H2 monitor AE-0574 was inoperable, there was no potential for a flammable gas mixture to exist in the waste gas surge tank. Therefore, there was no safety significance to this event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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ADDITIONAL INFORMATION:

Edison has reviewed LERs for the past three years and has concluded there were no previous similar events.