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YES (If yes, complete EXPECTED SUBMISSION DATE (15)	
Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)	

On 5/04/85 at 1550, with Unit 2 in Mode 1 at 80% power and Unit 3 in Mode 1 at 100% power, a spurious Toxic Gas Isolation System (TGIS) Train 'A' actuation occurred. Subsequent to this date, an additional spurious actuation occurred on 5/11. The Control Room Emergency Air Cleanup System (CREACUS) actuated as required. Each actuation was verified to be spurious by confirming that the meter indications on the TGIS panel were less than their respective setpoints, and TGIS was reset. Previous occurrences of this event were most recently discussed in LER 85-010 (Docket No. 50-361).

Spurious TGIS actuations have been a recurring event, and have been the result of one or more of the following conditions: overly conservative alarm setpoints; electrical noise; rapid temperature and pressure changes; radio transmissions; vibration; and dust and dirt accumulation. Corrective actions have significantly reduced the number of spurious actuations. A Technical Specification amendment has implemented more appropriate setpoints which should further reduce the number of spurious actuations. A TGIS Task Force has recommended additional corrective actions, which are discussed in detail in LER 85-010. Implementation of these corrective actions is currently in progress.

There are no reasonable or credible circumstances which could have increased the severity of this event. The health and safety of plant personnel or the public was not affected.

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Southern California Edison Company



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

Subject: Docket No. 50-361

30-Day Report

Licensee Event Report No. 85-029

San Onofre Nuclear Generating Station, Units 2 and 3

Pursuant to 10 CFR 50.73(a)(2)(iv), this submittal provides the required 30-day written Licensee Event Report (LER) for spurious actuations of the Toxic Gas Isolation System (TGIS). Since these events involved shared systems between Units 2 and 3, these events have been combined into a single report in accordance with NUREG-1022. Neither the health and safety of plant personnel nor the health and safety of the public was affected by these events.

If you require any additional information, please so advise.

Sincerely, Ib Laynes

Enclosure: LER No. 85-029

cc: F. R. Huey (USNRC Senior Resident Inspector, Units 1, 2 and 3)

J. P. Stewart (USNRC Resident Inspector, Units 2 and 3)

J. B. Martin (Regional Administrator, USNRC Region V)

Institute of Nuclear Power Operations (INPO)

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