LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
HUMBOLDT BAY POWER PLANT UNIT 3	0 5 0 0 0 1 3 3	1 OF 0 3

TITLE (4) ACTUATION OF THE GAS TREATMENT SYSTEM DUE TO INADVERTENT DE-ENERGIZING OF AN ISOLATION 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 1	3 0	8 8	8 8	0 0 1	0 0	0 2	2 4	8 8		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): N

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (11)

- [X] 10 CFR 50.73(a)(2)(i.)
- [ ] OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
PETER E. RIGNEY, POWER PLANT ENGINEER	7 0 7	4 4 3 - 2 7 8 7

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)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
[ ] YES (If yes, complete EXPECTED SUBMISSION DATE)	[X] NO				

ABSTRACT (16)

On January 30, 1988, at 2010 PST, while the unit was in Mode N (Shutdown) in the process of being decommissioned, the gas treatment system was actuated when an operator, cleaning the control board, inadvertently de-energized one of the refueling building isolation monitors. No abnormal plant radiation levels existed at the time of the actuation. Operating personnel verified that the plant conditions were normal and restored the gas treatment system to the standby mode.

The root cause of this event was personnel error in that the operator did not exercise proper care while cleaning the control board.

Corrective action to prevent recurrence included counseling the operator. Also, a protective guard will be placed around the toggle switch.

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

I. Initial Conditions

Unit 3 was in Mode N (Shutdown) in the process of being decommissioned.

II. Description of Event

A. Event:

On January 30, 1988, at 2010 PST, while the unit was in Mode N (shutdown) in the process of being decommissioned, the gas treatment system (VL) was inadvertently actuated.

While cleaning the control board, an operator inadvertently de-energized the +27 ft. elevation refueling building isolation monitor. This caused the gas treatment system to actuate. The operator verified that no abnormal radiation levels existed and reset the gas treatment system to the standby mode.

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

None.

C. Dates and approximate times for major occurrences:

1. January 30, 1988, at 2010 PST: Event and discovery

2. January 30, 1988, at 2012 PST: Isolation monitor reset

D. Other systems on secondary functions affected:

None.

E. Method of discovery:

The event was immediately apparent due to the sounding of the Unit 3 trouble alarm (ALM).

F. Operator actions:

The operator verified that no abnormal radiation levels existed and reset the system.

G. Safety system responses:

The gas treatment system scrubber recirculation pump (P) and gas treatment fan (FAN) started.

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

III. Cause of Event

A. Immediate cause:

The gas treatment system was actuated when the +27 ft. elevation refueling building isolation monitor was de-energized and the refueling building ventilation system shifted from the normal mode to the "Building Isolation" mode of operation.

B. Root cause:

The root cause of the gas treatment system actuation was personnel error in that the operator did not exercise proper care while cleaning the control board.

IV. Analysis of Event

During the event all equipment operated as designed. The isolation monitor and the gas treatment system were reset. The event was caused by personnel error and there was no actual release, therefore, no adverse safety consequences or implications resulted.

V. Corrective Actions

A. The operator was counseled, and the event was reviewed with all operating crews.

B. A protective guard will be placed around the control board power switches for the isolation and area monitors.

VI. Additional Information

A. Failed components:

None.

B. Previous LERs on similar events:

1. 87-003 - A technician, while repairing a broken input lead from the isolation monitor to the area monitor recorder, grounded the isolation monitor which caused the actuation of the gas treatment system.

The corrective actions of the previous LER would not have prevented this occurrence since the causes were unrelated.

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PACIFIC GAS AND ELECTRIC COMPANY

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JAMES D. SHIFFER
VICE PRESIDENT
NUCLEAR POWER GENERATION

February 24, 1988

PG&E Letter No.: HBL-88-017

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

Re: Docket No. 50-133, OL-DPR-7
Humboldt Bay Power Plant, Unit 3
Licensee Event Report 88-001-00
Actuation of the Gas Treatment System due to
Inadvertent De-energizing of an Isolation Monitor

Gentlemen:

Pursuant to 10 CFR 50.73(a)(2)(iv), PG&E is submitting the enclosed Licensee Event Report concerning the actuation of the gas treatment system when an isolation monitor was inadvertently de-energized due to personnel error.

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,

W. B. Kaefer for

J. D. Shiffer

Enclosure

cc: P. B. Erickson
J. B. Martin
Humboldt Distribution
Humboldt Service List
INPO

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