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FACIL:50-362 San Onofre Nuclear Station, Unit 3, Southern Californ 05000362
AUTH.NAME AUTHOR AFFILIATION
MORGAN,H.E. Southern California Edison Co.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 88-006-00;on 880707,containment purge isolation sys
Train A actuation occurred.W/880808 ltr.

W/8 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 5
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

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	AEOD/DSP/ROAB	2	2	AEOD/DSP/TPAB	1	1
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	NRR/DEST/ADS 7E	1	0	NRR/DEST/CEB 8H	1	1
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	REG FILE 02	1	1	RES TELFORD,J	1	1
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EXTERNAL:	EG&G WILLIAMS,S	4	4	FORD BLDG HOY,A	1	1
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LICENSEE EVENT REPORT (LER)

Facility Name (1)	Docket Number (2)	Page (3)
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 3	0 5 0 0 0 3 6 2	1 of 0 4

Title (4)

CONTAINMENT PURGE ISOLATION SYSTEM (CPIS) ACTUATION WHILE TRANSPORTING RADIOACTIVE MATERIAL NEAR CPIS 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 7	0 7	8 8	8 8	--- 0 0 6	--- 0 0		0 8	0 8	8 8	NONE	0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9)	6
POWER LEVEL (10)	0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR (Check one or more of the following) (11)

___ 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	TELEPHONE NUMBER AREA CODE
H. E. Morgan, Station Manager	7 1 4 3 6 8 - 6 2 4 1

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)	XX NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On 7/7/88, at 2254, with Unit 3 in Mode 6 and containment purge in progress, a Containment Purge Isolation System (CPIS) Train "A" actuation occurred when bagged radioactive waste was transported past Containment Area Radiation Monitor 3RT-7856, resulting in the high alarm setpoint being reached. After verifying that all CPIS Train "A" components operated in accordance with design and that containment radiation levels were normal, CPIS was reset at 0020 on 7/8/88.

Prior to the movement of the trash (earlier in the shift), Operations was notified of the need to transport approximately 37 radioactive filters past the CPIS Train "B" Monitor 3RT-7857, and in order to preclude multiple actuations, 3RT-7857 was placed in bypass. Later in the shift, at 2235, in accordance with procedure, a Health Physics (HP) technician contacted the Control Operator (CO) to request permission to move radioactive trash past the CPIS monitor and described the route the trash would take. As a result of inadequate communication between the technician and the CO, the CO did not realize that this activity involved movement past 3RT-7856, which was not bypassed, rather than 3RT-7857. Because the operators believed that the actuation would be precluded with 3RT-7857 bypassed, the actuation was not expected, and therefore, not preplanned.

As corrective action, appropriate HP personnel were instructed to provide the instrument number of the monitor involved when requesting permission to transport radioactive material past CPIS monitors. Units 2 and 3 operators will also be instructed, via pre-shift briefings, to obtain the instrument number prior to granting permission for the transportation of radioactive material past the CPIS monitors.

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Plant: San Onofre Nuclear Generating Station
Unit: Three
Reactor Vendor: Combustion Engineering
Event Date: July 7, 1988
Time: 2254

A. CONDITIONS AT TIME OF THE EVENT:

Mode: 6 (Refueling) with containment purge in progress.
RCS Temperature: 85 F

B. BACKGROUND INFORMATION:

There are two independent Containment Purge Isolation System (CPIS) (EIIS System Code VA) trains which isolate containment ventilation system penetrations when an abnormal amount of radiation is detected in containment. Each train is comprised of a containment airborne radiation monitor (EIIS Component Code RIT), an area radiation monitor and a set of containment purge isolation valves (EIIS Component Code ISV).

The area radiation monitors (3RT-7856 for Train "A" and 3RT-7857 for Train "B") have setpoints that are less than or equal to 325 mR/hr in Modes 1 through 4, but are reduced to less than or equal to 2.4 mR/hr in Mode 6 in accordance with Technical Specifications. During refueling outages, with these monitors having a lower setpoint, the transportation of radioactive material near these monitors has the potential for causing a CPIS actuation. Health Physics (HP) procedures require a minimum distance from the monitors be maintained when transporting radioactive material, and if movement in the vicinity of the monitors cannot be avoided, then prior notification of Operations is required such that the CPIS actuation can be preplanned. If a preplanned CPIS actuation is not desirable, then the monitor is bypassed, effectively removing the actuation function of the monitor.

C. DESCRIPTION OF THE EVENT:

1. Event:

On July 7, 1988, with Unit 3 in Mode 6 and containment purge in progress, a CPIS Train "A" actuation occurred when radioactive trash was being transported in the vicinity of Area Radiation Monitor 3RT-7856. After verifying that all CPIS Train "A" components operated in accordance with design and that containment radiation levels were normal, the CPIS was reset and containment purge restored at 0020 on July 8, 1988.

In accordance with procedures, prior to the movement of the trash (earlier in the shift), Operations was notified of the need to transport approximately 37 radioactive filters past the CPIS Train "B" Monitor 3RT-7857. In order to preclude multiple actuations, 3RT-7857 was placed in bypass and transportation of filters past 3RT-7857 commenced.

Later in the shift, at 2235, in accordance with procedures, an HP technician contacted the Control Operator (CO) to request permission to move radioactive trash off the pressurizer platform, by the personnel elevator and out through the Personnel Hatch. The CO stated that the movement of trash could proceed. Shortly thereafter, the movement of the trash commenced and CPIS Train "A" actuated from a high alarm on 3RT-7856. The CO did not realize that this activity was different from the ongoing activity of moving filters and that it involved movement past 3RT-7856, which was not bypassed, rather than 3RT-7857.

2. Inoperable Structures, Systems or Components that Contributed to the Event:

None.

3. Sequence of Events on May 11, 1988:

DATE	TIME	ACTION
7/7	2254	CPIS Train "A" actuated.
7/8	0020	After verifying the cause to be the movement of radioactive material and that containment radiation levels were normal, Train "A" CPIS reset and containment purge restored.

4. Method of Discovery:

Control Room indications and alarms alerted the operators to the Train "A" CPIS actuation.

5. Personnel Actions and Analysis of Actions:

Operators responded properly to the CPIS actuation by verifying that system operation was proper and containment radiation levels were normal prior to returning the CPIS to the standby mode and restoring containment purge.

6. Safety System Responses:

All CPIS Train "A" components operated as designed and isolated the containment purge system.

D. CAUSE OF THE EVENT:

1. Immediate Cause:

CPIS Train "A" actuated from a high alarm on 3RT-7856 as a result of transporting radioactive trash past the monitor.

2. Root Cause:

The root cause of this event is inadequate communication. As a result of a lack of sufficient detail in the communication between the HP technician and the CO, the CO did not realize that the movement of radioactive trash was different from the ongoing activity of moving filters and that it involved movement past 3RT-7856, which was not bypassed, rather than 3RT-7857.

E. CORRECTIVE ACTIONS:

1. Corrective Actions Taken:

As corrective action, appropriate HP personnel were instructed to provide the instrument number of the monitor involved when requesting permission to transport radioactive material past the CPIS monitors. Units 2 and 3 operators will also be instructed, via pre-shift briefings, to obtain the instrument number prior to granting permission for the transportation of radioactive material past the CPIS monitors.

2. Planned Corrective Action:

This event did not involve an undesirable ESFAS actuation, but rather an actuation which was not fully preplanned. The corrective action stated above should be sufficient to preclude similar unplanned actuations, and therefore, further corrective action is not warranted.

F. SAFETY SIGNIFICANCE OF THE EVENT:

There is no safety significance to this event since all CPIS components operated as designed.

G. ADDITIONAL INFORMATION:

1. Component Failure Information:

Not applicable.

2. Previous LERs on Similar Events:

Similar CPIS actuations due to transporting radioactive material past the Containment Area Monitors were reported for Unit 2 in LER 84-069 (Docket No. 50-361). As corrective action, appropriate HP procedures were revised to require a minimum distance from the monitors be maintained when transporting radioactive material, and if movement in the vicinity of the monitors cannot be avoided, to require prior notification of Operations such that the CPIS actuation can be preplanned. As a result of inadequate communication, the prior notification made by the HP technician was ineffective, resulting in the unplanned CPIS actuation.

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

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H. E. MORGAN
STATION MANAGER

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(714) 368-6241

August 8, 1988

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

Subject: Docket No. 50-362
30-Day Report
Licensee Event Report No. 88-006
San Onofre Nuclear Generating Station, Unit 3

Pursuant to 10 CFR 50.73(a)(2)(iv), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving an actuation of the Containment Purge Isolation System. Neither the health and safety of plant personnel or the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely,

R W Krieger for H E Morgan

Enclosure: LER No. 88-006

cc: F. R. Huey (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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