

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2										DOCKET NUMBER (2) 05000361				PAGE (3) 1 OF 02	
TITLE (4) INADVERTENT ACTUATION OF SAFETY INJECTION SYSTEM															

EVENT DATE (5) 03/08/85			LER NUMBER (6) 0212			REPORT DATE (7) 00042585			OTHER FACILITIES INVOLVED (8) FACILITY NAMES DOCKET NUMBER (5) 05000361						
OPERATING MODE (9) 4			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)												
POWER LEVEL (10) 000			20.402(b)			20.405(c)			<input checked="" type="checkbox"/> 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, NRC Form 366A)			
			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 J. G. HAYNES, STATION MANAGER										TELEPHONE NUMBER AREA CODE 714 492-7700					
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)															
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS					

SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
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)

On 3/30/85, with Unit 2 in Mode 4, an Instrumentation and Controls (I&C) technician team was performing a monthly surveillance on the Pressurizer Pressure Low (PPL), Channel B of the Plant Protection System (PPS). PPL Channels A, C and D of the PPS were in trip bypass because the Reactor Coolant System pressure was below 400 psia, in accordance with the appropriate operating procedures. In order to satisfy a procedural step of the surveillance, a technician elected to remove the bypass from Channels A, C and D, contrary to the procedure. Upon removal of the bypass from Channel C and D, the two out of four trip logic was satisfied on low pressurizer pressure and the Safety Injection System was actuated. The technician returned the PPS channels to bypass, safety injection was secured and all appropriate Operations actions were performed.

The cause of the event was technician error, with a contributing cause of procedure inadequacy. As corrective actions: the technician was disciplined; a review of the event with all I&C technicians was conducted; and I&C procedures are being enhanced.

There are no reasonable or credible circumstances under which this event would have been more severe.

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LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQ. NUMBER	REV. NUMBER		
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2	0 5 0 0 0 3 6 1	8 5	- 0 2 2	- 0 0	0 2	OF 0 2

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

On March 30, 1985, with Unit 2 in Mode 4, an Instrumentation and Controls (I&C) technician team was performing a monthly surveillance on the Pressurizer Pressure Low (PPL), Channel B (EIIS Component Code CHA) of the Plant Protection System (PPS) (EIIS System Code JC). PPL Channels A, C and D of the PPS were in trip bypass because the Reactor Coolant System (RCS) (EIIS System Code AB) pressure was below 400 psia, in accordance with the appropriate operating procedures. In order to satisfy a procedural step of the surveillance, a technician elected to remove the bypass from Channels A, C and D, contrary to the procedure.

The specific procedural step calls for the annunciator UA-0056A/window 57 (EIIS Component Code ANN) to automatically reset as a simulated pressure is increased through 400 psia on the PPL channel being tested. This annunciator is a common alarm for all four PPL channels and is in alarm whenever any PPL Channel bistable is in bypass. During the test, the annunciator did not reset as expected and the technician elected to remove the bypass from the other channels in an attempt to clear the annunciator. He failed to verify whether any of the other channels were in a trip condition and upon removal of the bypass on Channels C and D, the minimum two of four trip logic was satisfied on low pressurizer pressure and the Safety Injection System (SIS) (EIIS System Code BQ) was actuated. The technician returned the PPS channels to bypass, safety injection was secured and all appropriate Operations actions were performed.

The cause of this event was personnel error for failure to conduct the procedure as written and for not stopping and informing his supervisor or a Control Operator when an expected condition did not occur. Also, a contributing cause was that the procedure addresses only normal operating conditions when RCS pressure is above 400 psia and assumes that only the PPS channel being tested is in bypass. As corrective actions: the responsible technician was disciplined; a review of this event with all I&C technicians was conducted; the I&C procedure concerning this surveillance is being revised to cover all modes; and a review of all I&C procedures is being performed to determine if revisions are required to ensure that the procedures address all modes.

During the event all required systems operated as designed and upon securing the Safety Injection System, the plant was returned to normal Mode 4 operation. Because this event is considered an isolated personnel error, and all Safety Systems performed their function, there are no reasonable or credible circumstances under which this event would have been more severe.

*Southern California Edison Company*

SAN ONOFRE NUCLEAR GENERATING STATION

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SAN CLEMENTE, CALIFORNIA 92672

J. G. HAYNES  
STATION MANAGER

April 25, 1985

SCE

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

Subject: Docket No. 50-361  
Licensee Event Report No. 85-022  
San Onofre Nuclear Generating Station, Unit 2

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 inadvertent actuation of the Safety Injection System. Neither the health and safety of plant personnel nor the health and safety of the public was affected by this event.

If you require any additional information, please so advise.

Sincerely,

*J. G. Haynes*

Enclosure: LER No. 85-022

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, NRC Region V)

Institute of Nuclear Power Operations (INPO)

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