

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 2																			
TITLE (4) IMPROPERLY INSTALLED SAMPLE PUMP																																	
EVENT DATE (5) MONTH DAY YEAR 0 3 3 0 8 5			LER NUMBER (6) YEAR MONTH DAY 8 5 0 2 1 5			REPORT DATE (7) YEAR MONTH DAY 0 0 0 5 1 5 8 5			OTHER FACILITIES INVOLVED (8) FACILITY NAMES DOCKET NUMBER(S) 0 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0																								
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) 0 0 0 0		20.402(b)		20.405(a)(1)(i)		20.405(a)(1)(ii)		20.405(a)(1)(iii)		20.405(a)(1)(iv)		20.405(a)(1)(v)		20.405(c)		50.73(a)(2)(iv)		50.73(a)(2)(v)		50.73(a)(2)(vii)		50.73(a)(2)(viii)(A)		50.73(a)(2)(viii)(B)		50.73(a)(2)(x)		73.71(b)		73.71(c)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
LICENSEE CONTACT FOR THIS LER (12) NAME J. G. HAYNES, STATION MANAGER																TELEPHONE NUMBER AREA CODE 7 1 1 4 4 9 2 1 - 7 7 0 0																	
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																	
CAUSE SYSTEM COMPONENT MANUFACTURER REPORTABLE TO NRCDS																																	
SUPPLEMENTAL REPORT EXPECTED (14)																																	
YES (If yes, complete EXPECTED SUBMISSION DATE) X NO																																	
EXPECTED SUBMISSION DATE (15)																																	
MONTH DAY YEAR																																	

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

On 3/30/85, at 0930, and again on 3/31/85 at 0930, with Unit 2 in Mode 4, an auxiliary sample pump, used to take noble gas, particulate and iodine samples from the Condenser Evacuation System when the normal monitoring equipment is out of service, was improperly installed, rendering both the monitor and the auxiliary sampling equipment inoperable. As a result, Technical Specification Limiting Condition for Operation 3.3.3.9, Action Statement 40, was not met. In each instance, the improper installation existed approximately 12 hours before it was discovered and corrected.

The cause of this event was personnel error. The responsible technician had performed the sample pump installation several times prior to this event, but this time he attempted to install the pump from memory, without taking the applicable procedure with him. He also failed to complete a procedurally required form that would have initiated the independent second verification. Corrective action taken was to discuss this event with appropriate personnel, emphasizing the importance of using procedures, and to take disciplinary action against the responsible technician.

There was no safety significance to this event because no detectable primary-to-secondary leaks existed. In the event of a steam generator tube leak, activity in the secondary side would have been detected by the Steam Generator Blowdown Monitor.

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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 1	8 5	- 0 2 1 5	- 0 1 0	0 2	OF	0 2

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

Technical Specification Limiting Condition for Operation (LCO) 3.3.3.9, Action Statement 40, states that when Condenser Evacuation System (EIS System Code SH) Radiation Monitor 2RI-7870 (EIS Component Code RIT) and redundant monitor 2RI-7818 are inoperable, effluent releases may continue through the Air Ejector Outlet provided a continuous sample is collected via an auxiliary sampling method.

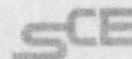
On March 30, 1985, at 0900, with Unit 2 in Mode 4, the Main Steam Isolation Valve (MSIV) (EIS Component Code ISV) bypasses were opened, which invoked the requirements of LCO 3.3.3.9. To comply with the LCO, a technician initiated installation of the auxiliary sampling method at 0930.

For two 12-hour periods, commencing at 0930 on March 30 and at 0930 on March 31, the auxiliary sample pump was improperly installed. Following routine review of completed work records, it was determined on April 16, that, for each of the two 12-hour periods, LCO 3.3.3.9, Action Statement 40, was not met.

The cause of the improper installation was personnel error. The responsible technician had performed the sample pump installation several times prior to this event, but this time he attempted to install the pump from memory, without taking the applicable procedure with him. He also failed to complete a procedurally required form that would have initiated the independent second verification. Corrective action taken was to discuss this event with appropriate personnel, emphasizing the importance of using procedures. In addition, the technician responsible for the improper installation received disciplinary action.

There was no safety significance to this event because no detectable primary-to-secondary leaks existed and no significant activity passed out of this effluent path. In the event of a primary-to-secondary leak due to a steam generator tube leak, activity in the secondary side would have been detected by the Steam Generator Blowdown Monitor 2RI-6759, which gives an alarm in the Control Room. Activity levels read by this monitor could then have been used to estimate the amount of any release through the Condenser Evacuation System.

Southern California Edison Company



SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

J. G. HAYNES
STATION MANAGER

May 15, 1985

TELEPHONE
(714) 492-7700

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

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 85-025
San Onofre Nuclear Generating Station, Unit 2

Pursuant to 10 CFR 50.36(c)(2) and 50.73(a)(2)(i)(B), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving Limiting Condition for Operation 3.3.3.9. 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,

Enclosure: LER No. 85-025

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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