Southern California Edison Company

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December 10, 1982

U. S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region V
1450 Maria Lane, Suite 210
Walnut Creek, California 94596-5368

Attention: Mr. R. H. Engelken, Regional Administrator

Dear Sir:

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 82-144
San Onofre Nuclear Generating Station, Unit 2

This submittal is in accordance with the reporting requirements of Section 6.9.1.13b of Appendix A to Facility Operating License NPF-10. It describes a reportable occurrence involving Limiting Condition for Operation (LCO) 3.1.3.1 associated with the Control Element Assemblies (CEA's). A completed copy of LER 82-144 is enclosed.

LCO 3.1.3.1 requires that while in Modes 1 and 2 all CEA's which are inserted in the core, shall be operable with each CEA of a given group positioned within 7 inches (indicated position) of all other CEA's in its group.

On November 11, 1982, at 1828 with the plant in Mode 1, regulating CEA 68 (Group 2) slipped from the fully withdrawn to fully inserted position resulting in entry into Action Statement 3.1.3.1.c.1.

Action Statement 3.1.3.1.c.1 allows operation to continue in Modes 1 and 2 provided that within one hour the misaligned CEA is restored to operable status within its specified alignment requirements. At 1834, CEA 87 (Shutdown Group B) slipped into the fully inserted position resulting in a reactor trip due to high Local Power Density (LPD)/low Departure from Nucleate Boiling Ratio (DNBR).

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Subsequent investigation revealed that the slippages were attributable to overheating in the Control Element Drive Mechanism Control System (CEDMCS) cabinet associated with the two CEA's. The overheating was a result of removal of the temporary CEDMCS cabinet HVAC system and the placing of protective plastic over the cabinet during on-going construction modification work in the CEDMCS Room. The cabinet overheating caused failure of the CEDMCS power supply to the affected CEA's and resulted in the slippages. The protective plastic was removed from all CEDMCS cabinets and the temporary HVAC was put back into operation. After exercising all 40 CEA's in the affected cabinet reactor startup commenced at 0132 on November 12, 1982.

As further corrective action to prevent recurrence, the following has been implemented:

1. The CEDMCS Room has been locked and access is controlled.

2. All work orders concerning CEDMCS are being routed to Equipment Control for screening. They will assure that HVAC is not impaired when work is undertaken in the area of the CEDMCS.

This event had no effect on public health and safety since it did not affect the ability of the CEA's to be inserted into the core, when required.

If there are any problems, please contact me.

Sincerely,

Enclosure: LER 82-144

cc: A. E. Chaffee (USNRC Resident Inspector, San Onofre Unit 2)

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Office of Inspection and Enforcement

U. S. Nuclear Regulatory Commission
Office of Management Information and Program Control

Institute of Nuclear Power Operations