

LICENSEE EVENT REPORT

CONTROL BLOCK: 1 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 C A S O S 2 200-000000-000 3411111 4 5
7 8 9 14 15 25 26 38 57 CAT 58

CON'T
01 REPORT SOURCE L 605000361 7042283 8052083 9
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

02 With both Units 2 and 3 in Mode 5 at 0600, Emergency Chiller E-335 (Train B) was
03 declared inoperable when it stalled during operability testing of Train B Control Room
04 Emergency Air Cleanup System (CREACUS) prior to returning the train to service after
05 design modifications. Inoperability of E-335 renders inoperable, equipment in
06 rooms in both units where chilled water is provided to cool ambient air in the event
07 of TGIS, SIAS or loss of offsite power (see attachment).

08 _____ 80

09 SYSTEM CODE A A 11 CAUSE CODE A 12 CAUSE SUBCODE C 13 COMPONENT CODE Z Z Z Z Z Z 14 COMP SUBCODE Z 15 VALVE SUBCODE Z 16
7 8 9 9 10 11 12 13 18 19 20
17 LER NO. 83 21 22 SEQUENTIAL REPORT NO. 042 24 26 OCCURRENCE CODE 03 28 29 REPORT TYPE L 30 REVISION NO. 0 32
ACTION TAKEN X 18 FUTURE ACTION X 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0000 22 ATTACHMENT SUBMITTED Y 23 NRPD-4 FORM SUB N 24 PRIME COMP SUPPLIER Z 25 COMPONENT MANUFACTURER Z999 26
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

10 Subsequent investigation revealed that the chiller failure was due to a valve being
11 closed on the surge line from Compression Tank T-122. This caused the chiller to
12 stall because of low compressor suction pressure. The valve was opened and the chiller
13 was declared operable in accordance with Procedure S023-3-3.20 at 0140 on April 23,
14 1983 (see attachment).

15 FACILITY STATUS B 28 % POWER 000 29 OTHER STATUS NA 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION Testing 32
7 8 9 10 12 13 44 45 46 80

16 ACTIVITY CONTENT RELEASED OF RELEASE Z 33 Z 34 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36
7 8 9 10 11 44 45 80

17 PERSONNEL EXPOSURES NUMBER 000 37 TYPE Z 38 DESCRIPTION NA 39
7 8 9 11 12 13 80

18 PERSONNEL INJURIES NUMBER 000 40 DESCRIPTION NA 41
7 8 9 11 12 80

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43
7 8 9 10 80

20 PUBLICITY ISSUED N 44 DESCRIPTION NA 45
7 8 9 10 80

8305270131 830520
PDR ADOCK 05000361
S PDR

NRC USE ONLY

NAME OF PREPARER

H.B. Ray
H.B. RAY

PHONE

714/492-7700

5010-108-01

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

H. B. RAY
STATION MANAGER

RECEIVED
NRC
SCE
1983 MAY 23 PM 12:41
REGION VISE
TELEPHONE
(714) 492-7700

May 20, 1983

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

Attention: Mr. J. B. Martin, Regional Administrator

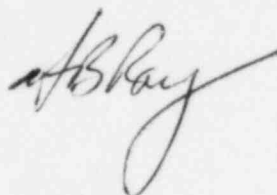
Dear Sir:

Subject: Docket Nos. 50-361 and 50-362
30-Day Report
Licensee Event Report No. 83-042
(Docket No. 50-361)
San Onofre Nuclear Generating Station, Units 2 & 3

Pursuant to Section 6.9.1.13.b of Appendix A, Technical Specifications to Facility Operating Licenses NPF-10 and NPF-15 for San Onofre Units 2 and 3, respectively, this submittal provides the required 30-day written report and a copy of Licensee Event Report (LER) 83-042 addressing an occurrence involving the Emergency Chilled Water System. Since this occurrence involves a shared system between Units 2 and 3, in accordance with NUREG-0161, a single LER for Unit 2 (Docket 50-361) is enclosed.

If there are any questions regarding this event, please contact me.

Sincerely,



Attachment

IE-22

ATTACHMENT TO LER 83-042
SOUTHERN CALIFORNIA EDISON COMPANY
SAN ONOFRE NUCLEAR GENERATING STATION
UNIT NO. 2, DOCKET NO. 50-361

SUPPLEMENTAL INFORMATION FOR EVENT DESCRIPTION
AND PROBABLE CONSEQUENCES

Since both units were in Mode 5, LCO 3.7.5 (CREACUS) was invoked. As required by Action Statement 'a' of LCO 3.7.5, actions were immediately initiated to return the chiller to operable status. There was no impact on plant operation or the health and safety of plant personnel or the public as a result of this occurrence, since normal HVAC was operating throughout the event.

SUPPLEMENTAL INFORMATION FOR CAUSE DESCRIPTION
AND CORRECTIVE ACTION

The time and cause of the valve closing has not been determined. A CREACUS surveillance performed on April 1, 1983 was successful. Procedure SO23-3-3.20 requires the system to run for 10 hours. This would have resulted in a compression trip, had the valve been closed at this time. Additionally, a valve lineup per Procedure SO23-1-3.1 was performed satisfactorily on April 18, 1983. This lineup requires valves in the surge line to Compression Tank T-122 to be open. Therefore, the closing of the valve was possibly due to unauthorized operation between April 18, 1983 and the surveillance test performed on April 22, 1983.

Due to an earlier problem of this nature (see LER 83-024, Docket 50-361), all Station personnel have been informed of the consequences of unauthorized valve manipulation. Additionally, all Station departments have been requested to review procedures concerning valve positioning to insure restoration of valves to their normal position following valve manipulations and to assure that only authorized persons perform these operations.

May 20, 1983

cc: A.E. Chaffee (USNRC Resident Inspector, Units 2 and 3)
R.J. Pate (USNRC Resident Inspector, Units 2 and 3)
P. J. Stewart (USNRC Resident Inspector, Units 2 and 3)

U.S. Nuclear Regulatory Commission
Office of Inspection and Enforcement

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

Institute of Nuclear Power Operations (INPO)