

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

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May 9, 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 No. 50-361
Prompt Report
Licensee Event Report No. 83-040
San Onofre Nuclear Generating Station, Unit 2

Pursuant to Section 6.9.1.12.b of Appendix A, Technical Specifications to Operating License NPF-10 for San Onofre Unit 2, this submittal provides the written confirmation of our prompt notification to the NRC on May 7, 1982, of a reportable occurrence involving a containment isolation valve.

On April 26, 1983, Safety Injection Tank (SIT) T-007 was filled in the course of preparations for unit startup. In order to fill the tank, procedures require that the fill line be recirculated to the Refueling Water Storage Tank via a two-inch recirculation return line which penetrates containment. Containment isolation valves in this line are motor-operated valve 2HV9334 (inside containment isolation valve operated from the Control Room) and MU099 (outside containment manual isolation valve with remote position indication in the Control Room). Procedure SO23-3-2.7, checklist no. 6 controls this evolution, and it includes a procedure termination valve line-up checklist to ensure normal valve alignment following completion of SIT filling.

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Valves 2HV9334 and MU-099 are listed in Table 3.6-1 of the Technical Specifications which indicates that 2HV9334 closes automatically on a Containment Isolation Actuation Signal and MU-099, a manual valve, may be opened under administrative control. On April 16, 1983, when the valves were opened in accordance with Procedure SO23-3-2.7 checklist no. 6 to fill SIT T-007. Pursuant to that procedure, 2HV9334 was then closed on April 26, 1983, from the Control Room following filling of the tank. At the time of the transition from graveyard to day shift on April 26, 1983, valve 2HV9334 was closed and checklist no. 6 was complete except for the termination valve line-up checklist and the chemistry sampling of SIT T-007. All valves in this termination checklist are correctly positioned by earlier procedural steps except for manual valves MU-099 and MU-060 (an additional manual block valve in the recirculation path to the RWST, not a containment isolation valve).

The graveyard shift foreman in the Control Room has stated that he turned over orally to the day shift foreman the information that the termination valve line-up checklist needed to be completed. However, he made the error of initialing the Master Startup Procedure SO23-5-1.3 indicating that checklist no. 6 had been completed. For this error, and as a result of the oral turnover of important plant status information, disciplinary action has been taken (two weeks suspension pending further evaluation) against the graveyard foreman effective May 7, 1983. (This foreman is the same individual who was responsible for the error described in our response to the Notice of Violation associated with Inspection Report No. 50-361/83-06.) In addition, these errors have been reviewed with each oncoming shift.

Oncoming Control room personnel routinely review containment isolation valve position status as indicated in the Control Room. However, a work order was opened for the position indication for MU-099 on April 12, 1983, and it was tagged as not operable in the Control Room. Accordingly, although the valve apparently remained open, and the termination valve line-up checklist remained open in the set of active procedures, it was not identified as being open until May 7, 1983.

On May 7, 1983, the graveyard shift foreman decided to physically check the position of MU-099, as it indicated open in the Control Room, even though the indication was tagged as inoperable. It was physically checked, found open, closed, and locked. At this time, the position indication appeared to work properly even though the work order was still open.

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As the work order states that there was no indication, it is believed at this time that an intermittent fault exists in the position indication and that it cleared and the valve indicated open shortly before it was noted on May 7, 1983. Control Room personnel questioned thus far state that the valve did not indicate open when checked prior to May 7. Instead, it evidently had no position indication.

Throughout the period from April 26 to May 7, 1983, when MU-099 was open, 2HV9334 was closed and the termination checklist remained incompleated. Corrective action to prevent recurrence of this event includes the disciplinary action, further evaluation of individual performance and shift notification described above. In addition, Procedure S023-3-2.7 will be revised to include positive steps to close MU-099 and MU-060 (rather than to rely on the termination valve line-up checklist to close these valves) and shift relief Procedure S023-0-10 will be revised to require documented verification of containment isolation valve position status indicated in the Control Room and declaration of emergency maintenance to immediately repair any inoperable position indication for these valves.

A 14-day followup report with a copy of Licensee Event Report (LER) No. 83-040 will be submitted by May 23, 1983, to address this event.

If you require any additional information please so advise.

Sincerely,

HBRing / NLM

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

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