

NRC FORM 365  
(12-81)  
10 CFR 50U.S. NUCLEAR REGULATORY COMMISSION  
LICENSEE EVENT REPORTAPPROVED BY OMB  
3150-0011

CONTROL BLOCK

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 C A S 0 S 3 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CONT

01 REPORT SOURCE L 6 0 5 0 0 0 3 6 2 7 1 2 1 7 8 2 8 0 7 1 5 8 3 9  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While in Mode 5, the Engineered Safety Features Actuation System (ESFAS) was  
03 inadvertently activated. The event resulted in the simultaneous actuation of  
04 several signals including Safety Injection Actuation Signal (SIAS) and  
05 Recirculation Actuation Signal (RAS). There were no consequences to the public  
06 health and safety as a result of this event.

07

08

09 I B 11 B 12 A 13 I N S T R U 14 X 15 Z 16  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

17 LER NO REPORT NUMBER 8 2 21 22 23 SHUTDOWN METHOD Z 21 24 25 26 HOURS 0 0 0 0 0 27 28 29 ATTACHMENT SUBMITTED Y 23 30 31 N 24 32 33 N 25 34 35 Z 9 9 9 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The probable cause of the failure was a brief, simultaneous failure of two  
11 independent power supplies associated with the Plant Protection System (PPS).  
12 In particular, the switch from Vital Bus "A" to the PPS was found to be making  
13 poor contact and overheating, and slightly loose screws were found on the output  
14 terminals of DC Power Supply PS 32, located in PPS Bay D. (See Attachment.)

15 FACILITY STATUS 6 28 0 0 0 0 29 NA 30 METHOD OF DISCOVERY A 31 Operator Observation 32  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 10016 Z 33 Z 34 NA 35 NA 36 LOCATION OF RELEASE 36  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 10017 PERSONNEL EXPOSURES NUMBER 0 0 0 37 Z 38 NA 39  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 10018 PERSONNEL INJURIES NUMBER 0 0 0 40 NA 41  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 10019 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 NA 43 8307250459 830715 PDR ADOCK 05000362 PDR  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 10020 PUBLICITY ISSUED DESCRIPTION N 44 NA 45  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NAME OF PREPARER

H. R. RAY

PHONE

714/492-7700

ATTACHMENT TO LER 82-006  
SOUTHERN CALIFORNIA EDISON COMPANY  
SAN ONOFRE NUCLEAR GENERATING STATION  
UNIT NO. 3, DOCKET NO. 50-362

SUPPLEMENTAL INFORMATION FOR CAUSE DESCRIPTION AND CORRECTIVE  
ACTIONS

Technicians were taking voltage readings in Bay D at the time of the event. The combination of the two defects (poor contact and loose screws) resulted in a momentary de-energization of the AD Bistable Relay Matrix.

Immediate corrective actions included placing administrative controls on personnel access to the PPS cabinets and revising procedures to increase operator awareness of the potential for complete ESFAS operation during the period that the cabinet is open.

As further corrective action, the defective switch was replaced with a spare and the loose screws on PS 32 were tightened. These actions provide reasonable assurance that this event will not recur.

In the course of the investigation of this event, Combustion Engineering identified a single 40-pin amphenol connector (J-3109) in Bay "D" of the Plant Protection System which, if disconnected, could initiate a similar actuation of all the ESFAS. Although the connector was inspected, found securely fastened, and determined not to have caused the event; steps were taken to eliminate the single failure vulnerability of J-3109. The connector was modified by reassignment of some of the wires so that no single failure at the connector was capable of simultaneously initiating the SIAS and RAS.

*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 JUL 19 PM 12:19

REGION VICE

TELEPHONE  
(714) 492-7700

July 15, 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. 50-362  
Revised Licensee Event Report No. 82-006  
San Onofre Nuclear Generating Station, Unit 3

Reference: (a) Letter, H. B. Ray (SCE) to R. H. Engelken (NRC),  
dated December 27, 1982  
"Prompt Report - Licensee Event Report No. 82-006"  
(b) Letter, R. Dietch (SCE) to D. G. Eisenhut (NRC),  
dated December 28, 1982  
(c) Letter, R. Dietch (SCE) to D. G. Eisenhut (NRC),  
dated December 29, 1982  
(d) Letter, H. B. Ray (SCE) to R. H. Engelken (NRC),  
dated December 30, 1982  
"Interim Licensee Event Report No. 82-006"

This letter provides a follow-up to Reference d, Licensee Event Report (LER) which was submitted pursuant to Sections 6.9.1.12.e and 6.9.1.12.1 of Appendix A, Technical Specifications to Facility Operating License NPP-13 for San Onofre Unit 3, for an occurrence involving inadvertent initiation of the Engineered Safety Features Actuation System (ESFAS) resulting in a simultaneous Safety Injection Actuation Signal (SIAS) and Recirculation Actuation Signal (RAS).

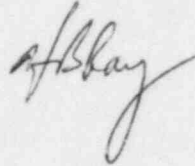
Enclosed is the revision to LER 82-006 which includes the cause of the event and corrective actions to prevent recurrence as stated previously in References a, b, and c.

1/1 IL-22

July 15, 1983

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

Sincerely,



Enclosure

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