

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

H. B. RAY
STATION MANAGER

September 30, 1983

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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
Prompt Report
Licensee Event Report No. 83-073
San Onofre Nuclear Generating Station, Unit 3

Pursuant to Section 6.9.1.12.f of Appendix A, Technical Specifications to Facility Operating License NPF-15 for San Onofre Unit 3, this letter provides prompt notification of a reportable occurrence involving the operability of the charging pumps.

As a result of excessive unidentified leakage from the Reactor Coolant System (RCS), the reactor was placed in Mode 3 at 1205 on September 29, 1983, and action was initiated to localize the source of the leakage. In preparation for cooldown, the RCS was bled to the shutdown margin required for cold shutdown conditions.

Cooldown was then commenced in parallel with continuing efforts to locate the leakage source. During the swingshift, at about 2100, manual isolation valves S31208MU084 and S31208MU091 were closed in accordance with an abnormal valve lineup provided to the operating foreman by the Plant Superintendent. This abnormal lineup had been developed by the superintendent in consultation with station engineers as a progressive effort to locate the leakage source. At that time, RCS temperature was being held constant at about 480°F in order to measure leak rate accurately.

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These two manual valves isolate flow from the charging pumps to the RCS. At 0145 on September 30, as the leak rate check with these valves secured was being completed, the graveyard Shift Supervisor recognized that isolating charging flow by closure of the valves in Mode 3 violates Technical Specification requirements, even though it may be done in an attempt to isolate a leak from the RCS. The valves were opened within 12 minutes of this determination.

An investigation is being conducted to establish all the circumstances under which closure of the valves was approved. At least in part, it resulted from direction from the Plant Superintendent (an SRO) to shift supervision under abnormal circumstances relating to ongoing efforts to localize excessive RCS leakage. Because of the abnormal circumstances, this direction did not receive independent review ordinarily performed.

We recognize it is a serious error to isolate charging flow for any period, contrary to the Technical Specifications. Corrective action to prevent recurrence will be implemented immediately. The results of our investigation, and corrective action to prevent recurrence, will be described in our 14-day followup report and Licensee Event Report No. 83-073 to be submitted prior to October 14, 1983.

If there are any questions regarding the above, please contact me.

Sincerely,



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,
Division of Technical Information and Document Control
Institute of Nuclear Power Operations