

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

EVENT DESCRIPTION AND PROBABLE CONSEQUENCESCAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

PHONE 714-492-7700

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SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

REGION V I&E

J. G. HAYNES
STATION MANAGER

November 23, 1983

TELEPHONE
(714) 492-7700

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
30-Day Report
Licensee Event Report No. 83-126
San Onofre Nuclear Generating Station, Unit 2

Pursuant to Section 6.9.1.13.c of Appendix A, Technical Specifications to Facility Operating License NPF-10 for San Onofre Unit 2, this submittal provides the required 30-day written report and a copy of the Licensee Event Report (LER) form for an occurrence involving Limiting Condition for Operation (LCO) 3.3.1 associated with the Reactor Protective Instrumentation. This report was delayed in order to provide a complete response.

On October 18, 1983, with Unit 2 in Mode 1 at 100% power, a review of the Nuclear Instrumentation System (NIS) Safety Channel Drawer surveillance records indicated that the surveillances for Channels A, B, and D required by Surveillance Requirement 4.3.1.1 and Table 4.3-1, Item 2, may not have been completed within the required surveillance interval. The Channel A, B, and D surveillances were immediately performed to verify that LCO 3.3.1 and its associated Action Statements were not exceeded. The surveillances were completed at 1530 on October 18, 1983, at approximately the same time a review of the previous month's surveillance records established that the allowable surveillance interval had ended at 2400 on October 17, 1983. The results of the surveillances confirmed that the LCO was satisfied without reliance on any Action Statement.

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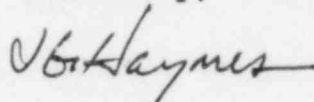
November 23, 1983

The cause of exceeding the surveillance interval was personnel error in not either completing the surveillance as originally scheduled or taking adequate action to complete the surveillance expeditiously when it was not completed as originally scheduled. In addition, this event was complicated by the recent reassignment from the Station Technical Division to the Station Maintenance Division of the responsibility for performance of the surveillance. The NIS surveillance was not yet incorporated into the tracking system of the Station Maintenance Division, thereby resulting in the failure to properly identify the approach of the end of the surveillance interval.

Although this is an isolated occurrence because of transferring the responsibility for performing the surveillance from one Station Division to another, appropriate personnel have been reinstructed as to the importance of completing the surveillance as scheduled or taking adequate action to assure completion of surveillance expeditiously when they are not completed as scheduled. There was no impact on the health and safety of plant personnel or the public associated with this event.

If you have any additional questions, please so advise.

Sincerely,



Enclosure: LER 83-126

cc: A.E. Chaffee (USNRC Resident Inspector, Units 1, 2 and 3)
J.P. Stewart (USNRC Resident Inspector, Units 2 and 3)

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

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