

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 14 15 25 26 30 37 CAT 38																			
CONT																			
01 REPORT SOURCE L 6 0 5 0 0 0 3 6 2 7 1 1 0 8 8 3 8 1 2 0 8 8 3 9																			
7 8 9 60 61 68 69 74 75 80																			
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10																			
02 On 11/8/83, at 0630, with Unit 3 in Mode 1, QSPDS Channel A began con-																			
03 tinuously cycling through its pages. The channel was declared inoper-																			
04 able, and LCO 3.3.3.6, Table 3.3-10, Action Statement 20 was invoked.																			
05 During troubleshooting of the problem, the display began functioning																			
06 properly, and after observation, the channel was declared operable on																			
07 11/10/83, at 1500. There was no impact on the health and safety of																			
08 plant personnel or the public associated with this event.																			
7 8 9										80									
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE																			
09 I D 11 X 12 Z 13 I N S T R U 14 I 15 Z 16																			
7 8 9 10 11 12 13 18 19 20																			
17 LER/PO REPORT NUMBER 8 3 21 22										SEQUENTIA REPORT NO. 0 9 8 24 26									
18 ACTION TAKEN E 18 Z 19										OCCURRENCE CODE 0 3 27 29									
19 FUTURE ACTION Z 20										REPORT TYPE L 30 31									
20 EFFECT ON PLANT Z 20										REVISION NO. 0 32									
21 SHUTDOWN METHOD Z 21										COMPONENT MANUFACTURER 0 4 9 0 33 34 35 36 47									
22 HOURS 0 0 0 0 37 40										ATTACHMENT SUBMITTED N 23 41									
23 N 23										NPRD-4 FORM SUB N 24 42									
24 N 24										PRIME COMP SUPPLIER N 25 43									
25 N 25										26									
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27																			
10 The specific cause of this incident is suspected to be a loose circuit																			
11 board and, as corrective action, the loose board was reseated. Since																			
12 this is considered an isolated occurrence, no further corrective actions																			
13 are planned.																			
14																			
7 8 9										80									
FACILITY STATUS 1 5 B 28 0 8 0 29 NA										METHOD OF DISCOVERY 30 A 31 Operator Observation 32									
7 8 9 10 12 13 44 45 46										80									
ACTIVITY CONTENT RELEASED OF RELEASE 1 6 Z 33 Z 34 NA										LOCATION OF RELEASE 35 NA 36									
7 8 9 10 11 44 45 46										80									
PERSONNEL EXPOSURES NUMBER 1 7 0 0 0 37 Z 38 NA										39									
7 8 9 11 12 13										80									
PERSONNEL INJURIES NUMBER 1 8 0 0 0 40 NA										41									
7 8 9 11 12										80									
LOSS OF OR DAMAGE TO FACILITY TYPE 1 9 Z 42 NA										43									
7 8 9 10										80									
PUBLCITY ISSUED DESCRIPTION 2 0 N 44 NA										45									
7 8 9 10										80									
NAME OF PREPARER J. G. HAYNES										PHONE 714/492-7700									
7 8 9 10										80									

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*Southern California Edison Company*

SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

J. G. HAYNES  
STATION MANAGER

December 8, 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. 50-362  
30-Day Report  
Licensee Event Report No. 83-098  
San Onofre Nuclear Generating Station, Unit 3

Pursuant to Section 6.9.1.13.b of Appendix A, Technical Specifications to Facility Operating License NPF-15 for San Onofre Unit 3, 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) 3.3.3.6 associated with Accident Monitoring Instrumentation.

On November 8, 1983, at 0630 with Unit 3 in Mode 1 at 80% power the Qualified Safety Parameter Display System (QSPDS) Channel A was observed to be continuously cycling through the pages of its display, and the channel was declared inoperable. In accordance with LCO 3.3.3.6, Table 3.3-10, Action Statement 20, actions were initiated to restore the channel to operable status within seven days.

While the inoperability of QSPDS Channel A was under investigation, but before the exact cause could be isolated, the unit began functioning properly. The specific cause of this incident is suspected to be a loose circuit board, and as corrective action the loose board was reseated. On November 10, 1983, at 1500, after observation, QSPDS Channel A was declared operable. This is considered an isolated occurrence and no further corrective actions are planned. There was no impact on the health and safety of plant personnel or the public associated with this event.

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DEC 12 PM 2:23

22  
IE-27/11

December 8, 1983

If you require any additional information, please so advise.

Sincerely,

*W. H. Haynes*

Enclosure: LER No. 83-098

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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