

CONTROL BLOCK

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 CAS0S3 200-00000-00 341111 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

CONT

01 REPORT SOURCE L 605000362 7120283 8010384 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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

02 On 12/2/83, at 0343, with Unit 3 in Mode 2, CEA 64 slipped 10 inches.

03 In accordance with LCO 3.1.3.1, Action Statement 'd', the rod was re-

04 aligned to within 7 inches of its group within one hour. Public health

05 and safety were not affected.

06

07

08

09 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE  
R B 11 E 12 G 13 C R D R V E 14 Z 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

LER/RO  
REPORT  
NUMBEREVENT YEAR  
8 3SEQUENTIAL  
REPORT NO.  
117OCCURRENCE  
CODE  
03REPORT  
TYPE  
LREVISION  
NO.  
0ACTION  
TAKENFUTURE  
ACTIONEFFECT  
ON PLANTSHUTDOWN  
METHOD

HOURS

ATTACHMENT  
SUBMITTEDNPRD-4  
FORM SUB.PRIME COMP.  
SUPPLIERCOMPONENT  
MANUFACTURER

A 18 Z 19

Z 20

Z 21

0000

N 23

N 24

N 25

C 4 9 0

26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

10 The cause of the slipping was a faulty IC chip on the rod's timer card.

11 As corrective action the timer card was replaced. This is considered

12 an isolated occurrence and no further corrective action is planned.

13

14

15 FACILITY STATUS % POWER OTHER STATUS 30 METHOD OF DISCOVERY DISCOVERY DESCRIPTION 32  
C 28 000 29 NA 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

16 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35 LOCATION OF RELEASE 36  
Z 33 Z 34 NA NA  
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

17 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 39  
000 37 Z 38 NA  
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

18 PERSONNEL INJURIES NUMBER DESCRIPTION 41  
000 40 NA  
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

19 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION 43  
Z 42 NA  
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

20 PUBLICITY ISSUED DESCRIPTION 45  
N 44 NA  
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

NAME OF PREPARER

J. G. HAYNES

PHONE

714/492-7700

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RECEIVED  
NRC

*Southern California Edison Company*

1984 JAN -6 AM 10:28

SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

REGION VISE

SCE

J. G. HAYNES  
STATION MANAGER

January 3, 1984

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. 83-117  
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) 3.1.3.1 associated with the Control Element Assemblies (CEA's).

On December 2, 1983, at 0343, with Unit 3 in Mode 2 and reactor startup in progress, CEA 64 slipped resulting in it being misaligned from the other CEA's in its group by ten inches. Pursuant to Action Statement 'd' of LCO 3.1.3.1 the rod was realigned to within seven inches of all other CEA's in it's group within one hour.

The cause of the slipping was a faulty IC chip on the rod's timer card. The card was replaced and CEA 64 was realigned to within seven inches of it's group at 0344, December 2, 1983. This is considered an isolated occurrence and will require no further corrective action.

There was no impact on the health and safety of the plant personnel associated with this occurrence.

IE 22

January 3, 1984

The cause of the misalignments of CEA's 57, 61 and 65 on November 1, and December 2, was due to sluggish operation of the CEA's drive mechanism which causes the upper and lower grippers to sequence improperly. As corrective action, the voltage and timing sequences of the gripper assemblies were adjusted to compensate for the sluggish operation.

These occurrences are similar to those reported in LER's 83-014, 83-090, 83-102 (Docket No. 50-361) and LER's 83-062, 83-097 (Docket No. 50-362). Since misaligned CEA's have become a recurring problem, we are continuing an investigation to provide resolution.

There was no impact on the health and safety of plant personnel or the public associated with these occurrences.

If you require any additional information, please so advise.

Sincerely,

*J. Haynes / HBR*

Enclosure: LER No. 83-110

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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Division of Technical Information and Document Control

Institute of Nuclear Power Operations (INPO)