

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													
LICENSEE CODE										LICENSE NUMBER										LICENSE TYPE										CAT 58									
REPORT SOURCE										DOCKET NUMBER										EVENT DATE										REPORT DATE									
01	L	0	5	0	0	0	3	6	2	7	1	2	0	2	8	3	8	0	1	0	3	8	4	9															
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)																																							
02	On 12/2/83 and 12/22/83, with Unit 3 in Mode 2 during startup,																																						
03	CEA's 61, and 65 slipped and were misaligned from other CEA's in their																																						
04	group between 7 and 19 inches. In addition, CEA's 57, 61 and 65 slipped																																						
05	and were misaligned from their group greater than 19 inches. In each																																						
06	case, pursuant to LCO 3.1.3.1, Action Statements 'c' and 'd', CEA's																																						
07	were realigned to within 7 inches of their group within one hour. Public																																						
08	health and safety were not affected. See also LER's 83-014, 83-090,																																						
83-102 (Docket 50-361), 83-062, 83-097 (Docket No. 50-362).																																							
09	R	B	E	B	C	R	D	R	V	E	Z	Z																											
CAUSE CODE CAUSE SUBCODE COMPONENT CODE SUBCODE VALVE SUECODE																																							
17	8	3			1	1	0		0	3	L			0																									
EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.																																							
18	E	X	Z	Z																																			
ACTION FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER																																							
10	The cause of the slippage was sluggish operation of CEA's 57, 61 and 65																																						
11	which causes the CEA upper and lower grippers to sequence improperly.																																						
12	CEA 57, 61 and 65 voltage and timing sequences were adjusted. An invest-																																						
13	igation to establish appropriate corrective actions is being conducted.																																						
14																																							
FACILITY STATUS % POWER OTHER STATUS (30) METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)																																							
15	B	0	0	0	NA	A																																	
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)																																							
16	Z	Z			NA																																		
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)																																							
17	0	0	0	Z	NA																																		
PERSONNEL INJURIES NUMBER DESCRIPTION (41)																																							
18	0	0	0		NA																																		
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION (43)																																							
19	Z				NA																																		
PUBLICITY ISSUED DESCRIPTION (45)																																							
20	N				NA																																		
NAME OF PREPARER J. G. HAYNES 462 PHONE 714/492-7700																																							

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Southern California Edison Company

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SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

REGION V

J. G. HAYNES
STATION MANAGER

TELEPHONE
(714) 492-7700

January 3, 1984

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. 83-110
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 eighteen occurrences involving Limiting Condition for Operation (LCO) 3.1.3.1 associated with the Control Element Assemblies (CEA's). Since the eighteen occurrences involved the same components, system, cause and method of discovery, these events have been combined into a single report in accordance with NUREG-0161.

On December 2, 1983, with Unit 3 in Mode 2 and a reactor startup in progress, CEA's 61 and 65 slipped twelve times resulting in the rods being misaligned from other CEA's in their group by more than seven inches but less than nineteen inches. In addition, CEA's 57, 61, and 65 slipped five times resulting in the rods being misaligned from other CEA's in their group by more than nineteen inches.

In addition, on December 22, 1983, at 1809, with Unit 3 in Mode 2 and a reactor startup in progress, CEA 65 slipped ten inches and then dropped 115 inches, to the fully inserted position, while realignment was being attempted. In each of these cases, in accordance with LCO 3.1.3.1, Action Statements 'c' and 'd', the CEA's were realigned to within seven inches of all other CEA's in their group within one hour. At no time during these occurrences was more than one CEA misaligned at one time and, therefore, LCO 3.1.3.1, Action Statement 'b,' was not entered.

IE 22

January 3, 1984

The cause of the misalignments of CEA's 57, 61 and 65 on December 2, and December 22, 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). As a result of the slippages reported in this LER and those previously reported, an investigation to establish appropriate corrective actions is being conducted.

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/HAR

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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