

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2DOCKET NUMBER (2)
0 5 0 0 0 3 6 1PAGE (3)
1 OF 0 2TITLE (4)
SHUTDOWN COOLING VALVE 2HV9316 FOUND FULLY OPENEVENT DATE (5)
MONTH DAY YEAR
0 3 2 1 8 4LER NUMBER (6)
YEAR
8 4SEQ. NUMBER
0 1 7REV. NUMBER
0 0REPORT DATE (7)
MONTH DAY YEAR
0 4 1 2 8 4OTHER FACILITIES INVOLVED (8)
FACILITY NAMES
DOCKET NUMBER(S)
0 5 0 0 0 0 0 0 0 0OPERATING MODE (9)
1POWER LEVEL (10)
1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b)

20.405(c)

50.73(a)(2)(iv)

73.71(b)

20.405(a)(1)(i)

50.36(c)(1)

50.73(a)(2)(v)

73.71(c)

20.405(a)(1)(ii)

X

50.36(c)(2)

50.73(a)(2)(vii)

OTHER (Specify in Abstract below and in Text, NRC Form 366A)

20.405(a)(1)(iii)

X

50.73(a)(2)(i)

50.73(a)(2)(viii)(A)

20.405(a)(1)(iv)

50.73(a)(2)(ii)

50.73(a)(2)(viii)(B)

20.405(a)(1)(v)

50.73(a)(2)(iii)

50.73(a)(2)(x)

LICENSEE CONTACT FOR THIS LER (12)

NAME
J. G. HAYNES, STATION MANAGER

TELEPHONE NUMBER

AREA CODE

7 1 4 4 9 2 - 7 7 0 0

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) ☒ NO ☒

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

Abstract (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1830, on March 21, 1984, with Unit 2 in Mode 1 at 100 percent power, Shutdown Cooling Heat Exchanger Flow Control Valve 2HV9316 was discovered locked fully open, contrary to the requirements of Technical Specification Surveillance Requirement 4.5.2(a). An operator engaged the handwheel and positioned 2HV9316 to the required locked throttled position.

Local handwheel indication has been considered a reliable method of determining valve position. However, investigation revealed that the handwheel clutch was disengaged, enabling the handwheel to turn freely. Under these circumstances, handwheel position would indicate an erroneous valve position. The surveillance procedure did not require the operator to verify that the handwheel was engaged prior to checking valve position. The surveillance procedure was revised to verify that the handwheel is engaged when checking the position of 2HV9316. Additionally, all operating shifts received training on the circumstances of this event.

2HV9316 position is preset to limit shutdown cooling to prevent loss of suction to the Low Pressure Safety Injection (LPSI) Pump under certain post-accident conditions. However, operating procedures require that the operator verify adequate suction pressure to the LPSI Pump before placing the Shutdown Cooling System in service under these conditions. Therefore, this event did not significantly compromise plant safety.

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LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQ. NUMBER	REV. NUMBER			
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2	0 5 0 0 0 3 6 1	8 4	- 0 1 7	- 0 0	0 2	OF	0 2

TEXT (If more space is required, use additional NRC Form 366A's) (17)

At 1830, on March 21, 1984, with Unit 2 in Mode 1 at 100 percent power, an operator was performing procedure S023-3-3.25, "Once-A-Shift Surveillance." During a step in the procedure to verify that Shutdown Cooling Heat Exchanger Flow Control Valve 2HV9316 (EIIS Component Code FCV) was throttled open with air removed in accordance with Technical Specification Surveillance 4.5.2(a), the operator noted a discrepancy between the handwheel valve position indication and the limit switch position indication. The handwheel markings indicated that 2HV9316 was properly throttled, but the limit switch indication showed 2HV9316 at full open. The operator investigated this discrepancy and discovered that the handwheel clutch was disengaged. The operator engaged the handwheel clutch and found that 2HV9316 was full open, contrary to the requirement of Technical Specification Surveillance Requirement 4.5.2(a). 2HV9316 was repositioned and locked throttled to comply with Technical Specification Surveillance Requirement 4.5.2(a).

The cause of this event was procedural inadequacy. The surveillance procedure did not specify a preferred method of determining the position of 2HV9316 and did not require a cross check between indicators. Operators had considered the local handwheel indication to be a reliable indication of the position of 2HV9316. However, the handwheel can turn freely with the clutch disengaged and provide an erroneous indication. S023-3-3.25 has been revised to require verification that the handwheel is engaged and that a dual position indication for 2HV9316 is present in the Control Room. Additionally, all operating shifts received training on the circumstances of this event.

2HV9316 is locked throttled to provide a preset flow through the Shutdown Cooling Heat Exchanger (EIIS Component Code HX) when the Shutdown Cooling System (EIIS System Code BP) is used for long term cooling under post-accident conditions. 2HV9316 is a part of an interim design to meet the requirements of Branch Technical Position 5-1. Permanent design modifications, which are already completed on Unit 3, will be completed on Unit 2 during the first refueling outage scheduled for September, 1984. These design changes will remove 2HV9316 and will provide remotely operated throttle valves on the outlet of the Shutdown Cooling Heat Exchangers. The shutdown cooling flow is limited to 3500 gallons per minute under post-accident conditions to prevent flashing in the suction piping to the Low Pressure Safety Injection (LPSI) Pump (EIIS Component Code P) if the 16-inch suction line is not available and the Reactor Coolant System (EIIS System Code AB) is not adequately subcooled. Under these conditions, 2HV9316 being full open could result in a loss of suction to the LPSI Pump. However, operating procedures require that the operator verify sufficient pressurizer level and adequate subcooling before placing the Shutdown Cooling System in service if the 16-inch suction line is not available. Therefore, this event did not significantly compromise plant safety.

Southern California Edison Company

SCE

SAN ONOFRE NUCLEAR GENERATING STATION

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SAN CLEMENTE, CALIFORNIA 92672

J. G. HAYNES
STATION MANAGER

April 12, 1984

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U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 84-017
San Onofre Nuclear Generating Station, Unit 2

Pursuant to 10 CFR 50.36(c)(2) and 50.73(a)(2)(i)(B), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving Technical Specification Surveillance Requirement 4.5.2(a). The health and safety of plant personnel or the public were not affected by this event.

If you require any additional information, please so advise.

Sincerely,

JG Haynes

Enclosure: LER 84-017

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

J. B. Martin (Regional Administrator, NRC Region V)

Institute of Nuclear Power Operations (INPO)

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