Southern California Edison Company

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SAN ONOFRE NUCLEAR GENERATING STATION P.O. BOX 128 SAN CLEMENTE, CALIFORNIA 92672

H. B. RAY STATION MANAGER

December 30, 1982

U.S. Nuclear Regulatory Commission Office of Inspection and Enforcement Region V 1450 Maria Lane, Suite 210 Walnut Creek, California 94596-5368

Attention: Mr. R. H. Engelken, Regional Administrator

Dear Sir:

- Subject: Docket No. 50-362 14-Day Follow-Up Report Interim Licensee Event Report No. 82-006 San Onofre Nuclear Generating Station, Unit 3
- Reference: a) Letters, H.B. Ray (SCE) to R.H. Engelken (NRC) dated December 20, 1982, and December 27, 1982, "Prompt Report - Licensee Event Report No. 82-006"
 - b) Letter R. Dietch (SCE) to D.G. Eisenhut (NRR) dated December 28, 1982
 - c) Letter R. Dietch (SCE) to D.G. Eisenhut (NRR) dated December 29, 1982

The reference (a) letters provided you with confirmation of our prompt notifications pursuant to Technical Specifications Sections 6.9.1.12e and 6.9.1.12i of Appendix A to Operating License NPF-15 for San Onofre Unit 3 of a reportable occurrence on December 17, 1982, involving the Engineered Safety Features Actuation System (ESFAS).

Pursuant to Section 6.9.1.12, this submittal provides a written followup report together with an interim Licensee Event Report (LER) No. 82-006.

On December 17, 1982, at 1410 while in Mode 5, the ESFAS was inadvertently activated. This event resulted in the simultaneous actuation of several signals including Safety Injection Actuation Signal (SIAS) and the Recirculation Actuation Signal (RAS). Details concerning this event were discussed with NRR in meetings in Washington D.C. on December 27 and 28, 1982, and our corrective action was included in references (b) and (c) as indicated below.

8301170471 821230 PDR ADOCK 05000362 S PDR The cause of this failure and future corrective actions are under investigation and will be reported at a later date with a revised LER. Immediate corrective actions include administrative controls placed on personnel access to the Plant Protection System cabinets.

Reference (c) identifies three actions we are implementing:

- a. Modifying RAS actuation to prevent high pressure safety injection pump miniflow valves from closing. This will also require an operating instruction change to close these valves prior to initiating recirculation when actually required.
- b. Conducting a review of the PPS design to confirm that there are no other problems with inadvertent ESFAS combination.
- c. Proposing changes to the plant to confirm that the plant conforms to 10CFR50 Appendix A General Design Criteria 35 by January 14, 1983.

There were no consequences to the public health and safety as a result of this event.

Please note that reference (a) letters contained two typographical errors in that the words "Emergency" and "Signal" should have read "Engineered" and "Safety" respectively in the description of ESFAS.

If there are any questions regarding the above, please contact me.

Sincerely,

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Enclosure: LER 82-006

cc: A.E. Chaffee (USNRC Resident Inspector, San Onofre, Units 2 and 3)

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

U.S. Nuclear Regulatory Commission Office of Management Information and Program Control (MIPC)

Institute of Nuclear Power Operations