

Southern California Edison Company

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H. B. RAY
STATION MANAGER

November 17, 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. 50-361
14-Day Follow-Up Report
Licensee Event Report No. 82-127
San Onofre Nuclear Generating Station, Unit 2

Reference: Letter, H. B. Ray (SCE) to R. H. Engelken (NRC),
dated November 5, 1982

The referenced letter confirmed our prompt notification to the NRC on November 3, 1982 of a reportable occurrence involving the Iodine Removal System (IRS). Pursuant to Appendix A Technical Specification 6.9.1.12b to Operating License NPF-10 for San Onofre Unit 2, this submittal provides the required follow-up report with a completed Licensee Event Report (LER) for this occurrence.

Limiting Condition for Operation (LCO) 3.6.2.2 requires the IRS to be operable in Modes 1, 2 and 3, with a minimum spray additive solution volume of 1456 gallons and two spray chemical addition pumps capable of adding the solution to the Containment Spray System (CSS). The associated Action Statement permits the IRS to be inoperable for up to 72 hours before cooldown is initiated.

On October 19, 1982 while in Mode 3, to prevent leakage from a defective manway gasket the IRS tank fluid level was lowered and jumpers were installed across level alarm output relays to bypass the low level cutout so that the full required NaOH volume would still be available. Normally, when the low level cutout point is reached the pump is stopped and its associated discharge valve is shut. The temporary change which was used to install the jumpers contained an error. This was discovered on November 2, 1982. The jumpers did not prevent the chemical pump discharge valves from closing upon tank low level signal, hence, between October 19 and October 26 both trains were inoperable to the extent that they would not have delivered the full volume of sodium hydroxide solution required by the safety analysis.

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R. H. Engelken

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November 17, 1982

The jumpers remained installed but the tank level was restored to normal after the gasket was replaced on October 26, 1982, hence Train A was operable after that date in spite of the jumpers. Train B remained inoperable through November 3, 1982, because of a malfunctioning level instrument which failed on October 26, 1982.

On November 3, 1982, after the jumper installation was corrected, Train B was restored to operable status since the erroneous "valve shut" signal was bypassed. The low level instrument problem was corrected, the jumpers were removed and the instrument was returned to service on November 5, 1982.

The cause of this event was an oversight in the design of the temporary modification. Engineering Management has investigated the details of this occurrence and its cause. As a result of Management's investigation and discussion with those involved, it has been concluded that this was an isolated error and no additional corrective measures are judged to be appropriate.

The cause of the level instrument malfunction was determined to be improperly installed heat tracing which resulted in excessive temperatures in the instrument tubing (reference leg) causing boiling of the NaOH solution in the tubing and, therefore, erroneous instrument output.

The public health and safety were not affected by this occurrence since the CSS was operable at all times and the IRS would have functioned at a reduced efficiency, assuming a design basis event.

If there are any other questions, please contact me.

Sincerely,

HBRay / T. W. ...

Enclosure: LER 82-127

cc: A. E. Chaffee (USNRC Resident Inspector, San Onofre Unit 2)

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Office of Inspection and Enforcement

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

Institute of Nuclear Power Operations