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September 8, 1983

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. 50-361
Prompt Report
Licensee Event Report No. 83-117
San Onofre Nuclear Generating Station, Unit 2

Pursuant to Section 6.9.1.12.f of Appendix A, Technical Specifications to Facility Operating License NPF-10 for San Onofre Unit 2, this letter provides written confirmation of the prompt notification on September 7, 1983, of a reportable occurrence involving the Post Accident Monitoring Instrumentation.

Technical Specification 3.3.3.5, Table 3.3-9, requires a monthly channel check of post accident monitoring instrumentation. A channel check is defined to be a qualitative assessment by observation of channel behavior during operation, including a comparison with other independent indications. On September 5, 1983, during the performance of Surveillance Procedure SO23-3-3.28, "Remote Shutdown Panel Instrumentation Monthly Channel Checks," it was discovered that pressurizer level instrument LI-0103A, which is located on panel L411, varied from its correct reading as determined from two other level indicators by approximately 15%, which exceeds the ±10% acceptance criteria established in the procedure for the channel check.

A Limiting Condition for Operations Action Requirement (LCOAR) report was promptly initiated indicating that the level indication needed to be corrected within seven days in accordance with the applicable action statement. The level instrument was then determined to be properly responding to changes in pressurizer level with a constant offset. A level correction was therefore identified at the instrument location and the LCOAR was closed. Also, action was initiated to issue a work order to recalibrate the level instrument.

IE-22

Further investigation indicated that a variation in indicated level in excess of the surveillance procedure acceptance criteria had also been identified during the preceding monthly surveillance completed on August 7, 1983. However, due to a misinterpretation of Table 3.3-9, which includes the requirement for single pressurizer level indicators in two locations, it was not recognized at that time that one of these indicators is required to be on panel L411. Instead, it was concluded incorrectly that the two indicators on panel L042 exceeded the minimum requirement of Table 3.3-9. A LCOAR was not written at that time and the action statement was not invoked. Also, this investigation indicated that a work order to investigate calibration of LI-0103, which is the comparable indicator in the control room to LI-0103A on panel L411, had been written on July 28, 1983. This investigation had been initiated but was not completed pending containment entry during a future outage.

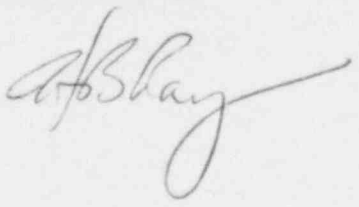
Pressurizer level instrument LI-0103A is a non-safety grade indicator on panel L411, the Essential Plant Parameters Monitoring Panel. The indicator performs no automatic protective functions. This panel is a backup to panel L042, the Control Room Evacuation Shutdown Panel which contains pressurizer level instruments LI-0110B1 and LI-0110B2.

A review was conducted to identify the effect on use of pressurizer level instrument LI-0103A of the 15% level variation described above without applying the level correction. This review indicated that Operating Instruction SO23-3-5.18, "Shutdown from Outside Control Room," leads to maintaining pressurizer level in a range where either the 15% level variation of LI-0103A, or the 10% variation permitted by the surveillance procedure acceptance criteria, could result in uncovery of the pressurizer heaters due to incorrect indication of pressurizer level. Action will be taken to revise procedures as necessary such that use of level instrument readings at the limit of the surveillance procedure acceptance criteria will not result in uncovering of the heaters.

This occurrence, including corrective action to prevent recurrence, will be described in our 14-day follow-up report and Licensee Event Report (LER) No. 83-117 to be submitted prior to September 22, 1983.

If there are any questions, please contact me.

Sincerely,



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