NRC FORM 366 (12-81) 10 CFR 50

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

APPROVED BY OMB 3150-0011

CONTROL BLOCK: [| | | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | LICENSEE CODE: C A S O S 2 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT (5)

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 3 6 1 (7) | EVENT DATE: 0 9 1 1 8 3 (8) | REPORT DATE: 0 9 2 3 8 3 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 With the plant in Mode 1 at 1810, containment isolation valve 2HCV-9945 was
03 found locked open. Technical Specification 3.6.3 requires 2HCV-9945 to be
04 closed or as one of several alternatives, a manual valve in the line closed
05 (Action Statement c). The manual valve 2HV-9946 in the line was verified closed
06 and the requirements of the Action Statement considered satisfied. There was no
07 impact on plant operation or the health and safety of plant personnel or the
08 public.

09 | SYSTEM CODE: S D (11) | CAUSE CODE: A (12) | CAUSE SUBCODE: A (13) | COMPONENT CODE: Z Z Z Z Z Z (14) | COMP. SUBCODE: Z (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR: 8 3 | — | SEQUENTIAL REPORT NO.: 1 1 8 | / | OCCURRENCE CODE: 0 3 | REPORT TYPE: L | — | REVISION NO.: 0

ACTION TAKEN: X (18) | FUTURE ACTION: X (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0 0 0 0 0 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: N (24) | PRIME COMP. SUPPLIER: Z (25) | COMPONENT MANUFACTURER (26): Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 2HCV-9945 was incorrectly positioned on 9/6/83 when system alignment was being
11 established following work on the hydrogen purge supply unit. The error was
12 not identified until 9/11/83. 2HCV-9945 was immediately returned to its proper
13 position and other valves in the room were checked. In addition, appropriate
14 disciplinary action has been taken.

15 | FACILITY STATUS: B (28) | % POWER: 1 0 0 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: B (31) | DISCOVERY DESCRIPTION (32): Visual Inspection

16 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

PERSONNEL EXPOSURES

17 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES

18 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)

19 | TYPE: Z (42) | DESCRIPTION: NA

PUBLICITY

20 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

NAME OF PREPARER: H. B. RAY   PHONE: 714/492-7700

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September 23, 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
30-Day Report
Licensee Event Report No. 83-118
San Onofre Nuclear Generating Station, Unit 2

Pursuant to Section 6.9.1.13.c of Appendix A, Technical Specifications to Facility Operating License NPF-10 for San Onofre Unit 2, this submittal provides the required 30-day written report and copy of Licensee Event Report (LER) form for an occurrence involving Limiting Condition for Operation (LCO) 3.6.3 associated with containment isolation valves.

On September 11, 1983, at 1810 with the plant in Mode 1, containment isolation valve 2HCV-9945 (hydrogen purge supply) was found locked open. Technical Specification 3.6.3 requires 2HCV-9945 to be closed or as one of several alternatives, a manual valve in the line closed (Action Statement 'c'). The manual valve in the line (2HV-9946) was verified closed and the requirements of the Action Statement considered satisfied. Although this occurrence caused an entry into the Action Statement, CONTAINMENT INTEGRITY, as defined in Section 1.0 of the Technical Specifications, was maintained throughout this occurrence, by virtue of 2HV-9946 being operable and closed.

2HCV-9945 was incorrectly positioned on September 6, 1983, when system alignment following work on the hydrogen purge supply unit was erroneously specified on the Work Authorization form. System alignment was established in accordance with this form which prescribed that 2HCV-9945 be placed and verified in a locked open position. Subsequent operating shifts identified that Control Room indication did not indicate that 2HCV-9945 was closed, however no investigation was undertaken as the indication was properly tagged with a deficiency tag indicating that a limit switch for 2HCV-9945 was failed.

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On September 11, 1983, the improper position of 2HCV-9945 was identified and the valve was returned to its proper position. After returning 2HCV-9945 to its proper position, all other containment isolation valves located in the same room were verified to be in their proper positions.

As corrective action to prevent recurrence, the recently adopted policy that a Shift Supervisor's Emergency shall be declared for any containment isolation valve position indication failure will be emphasized to all operations personnel in shift briefings. In addition, appropriate disciplinary action has been taken.

There was no impact on plant operations or the health and safety of plant personnel or the public.

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

Sincerely,

H B Ray

Enclosure: LER No. 83-118

cc: A. E. Chaffee (USNRC Resident Inspector, Units 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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