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

On 8/16/84 at 0100, during an unrelated surveillance, an Assistant Control Operator (ACO) noted that Steam Generator Wide Range Level Indicator 3LI-1125-2 (EIIS Component Identifier LI) had failed low. However, because the instrument was not uniquely identified as part of Accident Monitoring Instrumentation (AMI), the ACO did not recognize that it had to be restored within seven days. The ACO prepared a routine maintenance request instead of an accelerated maintenance request. This condition was observed at 1920 on 8/23/84 with the unit in Mode 3 and cooldown to Mode 4 was initiated in accordance with Limiting Condition for Operation 3.3.3.6. At 2000, on 8/23/84, 3LI-1125-2 was returned to service following replacement of a faulty lumnigraph assembly and cooldown to Mode 4 was terminated.

As corrective action, all AMI has been labeled. Additionally, the significance of this event, the labeling of AMI, and the use of accelerated maintenance requests were discussed at shift briefings.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPLORE: 8/31/85

CONTINUATION								
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On 8/23/84, with Unit 3 in Mode 3, a routine equipment control review of maintenance orders was in progress. At 1920, during this review, Steam Generator Wide Range Level Indicator 3LI-1125-2 (EIIS Component Identifier LI) was discovered to have been inoperable since 0100 on 8/16/84, contrary to Limiting Condition for Operation

(LCO) 3.3.3.6, Action Statement 20. This Action Statement requires restoration of the inoperable indicator within 7 days or be in Mode 4 within the next 12 hours. Cooldown to Mode 4 was initiated and corrective maintenance 3LI-1125-2 was commenced. At 2000, on 8/23/84, 3LI-1125-2 was returned to service following replacement of a faulty

lumnigraph assembly and cooldown to Mode 4 was terminated.

On 8/16/84 during an unrelated surveillance, an Assistant Control Operator (ACO) noted that 3LI-1125-2 had failed low. However, because the instrument was not uniquely identified as part of Accident Monitoring Instrumentation (AMI), the ACO did not recognize that it had to be restored within seven days. The ACO prepared a routine maintenance request instead of an accelerated maintenance request. As corrective action, all AMI has been labeled. Additionally, the significance of this event, the labeling of AMI, and the use of accelerated maintenance requests were discussed at shift briefings.

Redundant monitor 3LI-1125-1 remained operable throughout this event. There are no reasonable or credible alternative circumstances under which this event would have been more severe.

Southern California Edison Company



TELEPHONE

SAN ONOFRE NUCLEAR GENERATING STATION

P.O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

J. G. HAYNES

September 24, 1984

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

Subject:

Docket No. 50-362

30-Day Report

Licensee Event Report No. 84-036

San Onofre Nuclear Generating Station, Unit 3

Pursuant to 10 CFR 50.73(a)(2)(i)(B), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving Accident Monitoring Instrumentation. Neither the health and safety of the public nor plant personnel were affected by this event.

If you require any additional information, please so advise.

Vos Haynes

Enclosure: LER No. 84-036

cc: A. E. Chaffee (USNRC Senior 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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