NRC Form 366
(9/83)

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

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 3	0 5 0 0 0 3 6 2	1 OF 0 3

TITLE (4)
HIGH PRESSURE SAFETY INJECTION PUMPS INOPERABILITY

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQ. NUMBER	REV. NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 8	2 1	8 4	8 4	0 3 5	0 0	0 9	1 7	8 4		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

	20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)
	20.405(a)(1)(i)		50.36(c)(1)	X	50.73(a)(2)(v)		73.71(c)
	20.405(a)(1)(ii)	X	50.36(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
	20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
J. G. HAYNES, STATION MANAGER	7 1 4 — 4 9 2 - 7 7 0 0

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On 8/21/84 at 1815, with Unit 3 in Mode 1 at 100 percent power, a review of operator logs by the Control Room Supervisor identified that Train A HPSI subgroup relay testing had been conducted concurrent with the draining of the saltwater side of the Train B Component Cooling Water (CCW) Heat Exchanger.

Investigation determined that at 0416 on 8/21/84, the saltwater side of Train B CCW Heat Exchanger was removed from service for cleaning. Train B components cooled by CCW, including the Train B HPSI pump, were therefore inoperable. At 0518 on 8/21/84, the Train A HPSI bypass valves MU184 and MU186 were opened in accordance with the approved surveillance procedure for conduct of subgroup relay testing. Opening the Train A bypass valves rendered the Train A HPSI pumps inoperable. The bypass valves were shut at 0536 on 8/21/84 restoring the Train A HPSI pumps to an operable status.

The cause of this event was failure of the Control Operator (CO) and Control Room Supervisor (CRS) to follow procedure precautions in the subgroup relay testing procedure. The CO and CRS received disciplinary action and counseling on the importance of attention to detail and strict compliance with procedural requirements.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

On August 21, 1984 at 1815, with Unit 3 in Mode 1 at 100 percent power, a review of operator logs by the Control Room Supervisor identified that Train A High Pressure Safety Injection System (HPSI) (EIIS System Identifier BQ) subgroup relay testing had been conducted while the saltwater side of the Component Cooling Water (CCW) Heat Exchanger (EIIS Component Identifier HX) was drained for cleaning.

Investigation determined that at 0416 on August 21, 1984, the Train B CCW Heat Exchanger was removed from service for cleaning. Train B Engineered Safety Features components cooled by CCW (EIIS System Identifier CC), including the Train B HPSI pump, were therefore inoperable. At 0518 on August 21, 1984, the Train A HPSI bypass valves were opened in accordance with the approved surveillance procedure for conducting Train A subgroup relay testing. Opening the Train A HPSI bypass valves rendered Train A HPSI inoperable. The loss of both trains of HPSI while operating at 100 percent power constitutes operation outside Limiting Condition for Operation (LCO) 3.5.2 and its associated Action Statements. However, the miniflow bypass valves were shut within 18 minutes at 0536 on August 21, 1984, restoring the Train A HPSI pumps to an operable status, and placing the unit in compliance with Action Statement (a) of LCO 3.5.2.

It was initially reported to the resident NRC inspector that both trains of HPSI were inoperable for 15 minutes, but further investigation established that both trains of HPSI may have been inoperable for up to 18 minutes.

Further investigation into the reasons for this event revealed that established administrative controls intended to make all control room operators aware of inoperable safety systems were not followed by control operators. Initiation of ESF subgroup relay testing on train A should have resulted in the recording of entry into a Limiting Condition for Operation Action Requirement (LCOAR) and the manual entry of Train A HPSI pump inoperability on the Bypassed and Inoperable Status Monitor (BISM). Had this action been properly taken by the previous shift when ESF subgroup relay testing was commenced, control operators would have been made aware of train A status and removal of the Train B CCW Heat Exchanger from service would have been delayed until completion of Train A testing and restoration to operable status.

In addition to disciplinary action taken against operators involved, corrective action has included an in-depth review of this event by station management. In conjunction with an overall review of action being taken to implement guidance provided in I&E Information Notice 84-51 and Item I.C.6 of NUREG-0737, operator training is being enhanced to emphasize the importance of the SRO function of authorizing removal of equipment from service, the importance of the manipulation of locked valves and the importance of re-reviewing procedure precautions and prerequisites prior to recommencing activity begun on a previous shift. Action has also been initiated to evaluate what improvements could be made to the Bypassed and Inoperable Status Monitor such that automatic control room indication of system inoperability would be provided as a result of any safety system valve being mispositioned.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Since both trains of HPSI were inoperable for only 18 minutes and the operators who opened the Train A HPSI bypass valves remained in the valve room with communications capability and could have closed the valves restoring Train A HPSI operability in the event of ESFAS actuation, this event did not represent a significant degradation in safety margin.

Since Unit 3 was at 100 percent power throughout this event, there are no reasonable alternative conditions under which this event would have been more severe.

Southern California Edison Company

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J. G. HAYNES
STATION MANAGER

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September 17, 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. 84-035
San Onofre Nuclear Generating Station, Unit 3

Pursuant to 10 CFR 50.36(c)(2), 50.73(a)(2)(i)(B), and 50.73(a)(2)(v), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving the High Pressure Safety Injection System. Neither the health and safety of plant personnel nor the public were affected by this event.

If you require any additional information, please so advise.

Sincerely,

JG Haynes

Enclosure: LER 84-035

cc: A. E. Chaffee (USNRC 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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