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January 16, 1989

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

Gentlemen:

Subject: Docket Nos. 50-206, 50-361 and 50-362
Reply to a Notice of Violation
San Onofre Nuclear Generating Station
Units 1, 2 and 3

Reference: Letter, Mr. R. P. Zimmerman (NRC) to Mr. Kenneth P. Baskin (SCE),
dated December 16, 1988

The Reference forwarded NRC Inspection Report Nos. 50-206/88-24, 50-361/88-25
and 50-362/88-27 and a Notice of Violation resulting from the routine
inspection conducted by Messrs. F. R. Huey, J. E. Tatum, and A. L. Hon during
the period of September 25 through November 17, 1988. In accordance with
10 CFR 2.201, the enclosure to this letter provides the Southern California
Edison (SCE) reply to the subject Notice of Violation.

If you require any additional information, please so advise.

Very truly yours,

Kenneth P. Baskin

Enclosure

cc: J. B. Martin, Regional Administrator, NRC Region V
F. R. Huey, NRC Senior Resident Inspector, San Onofre Units 1, 2 and 3

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ENCLOSURE

REPLY TO A NOTICE OF VIOLATION

Appendix A to Mr. R. P. Zimmerman's letter, dated December 16, 1988, states in part:

"During an inspection conducted on September 25 through November 17, 1988, violations of NRC requirements was identified. In accordance with the 'General Statement of Policy and Procedure for NRC Enforcement Actions,' 10 CFR Part 2, Appendix C (1987), the violations are listed below:"

VIOLATION A

"A. 10 CFR Part 50, Appendix B, Criterion XVI requires that measures be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken shall be documented and reported to appropriate levels of management.

"Southern California Edison Topical Quality Assurance Manual, Chapter 1-F requires that systems be established, implemented and controlled by written procedures to assure that conditions adverse to quality are identified, documented, evaluated, and corrected and that action is taken to prevent recurrence of the condition.

"Station Procedure S0123-XV-5.0, Revision 2 paragraph 6.2.1, which defines nonconforming material, requires that a Nonconformance Report (NCR) be generated and properly evaluated by designated station technical personnel for deviations in the characteristic or material of safety related components. The procedure requires that this evaluation be performed prior to dispositioning repair of the component and requires that such repairs conform with component design requirements.

"Contrary to the above, on October 16, 1988, a safety related electrical conduit for safety injection valve HV852B was found to have been improperly repaired without the required NCR, engineering evaluation or authorized repair disposition having been generated. In particular, at some time prior to October 16, a tear in the plastic cover of the conduit was improperly repaired with electrical tape, which did not conform with the environmental qualification design requirements for the conduit. Furthermore, an NCR was not generated to document the conduit deficiency and an engineering evaluation of the nonconforming condition was not performed."

"This is a Severity Level IV violation (Supplement I) applicable to Unit 1."

RESPONSE

1. Reasons for the violation, if admitted.

SCE admits that the tear in the safety related and environmentally qualified (EQ) electrical conduit plastic film jacket for safety injection valve HV852B was repaired improperly, and the condition was not documented in a Nonconformance Report (NCR).

Based upon the conditions and the apparent aging of the attempted repair, it is estimated that the repair could have been performed anytime within the previous six to nine months. SCE has conducted personnel interviews and investigated maintenance activities which could have resulted in the attempted repair to the conduit. SCE has been unable to identify who made the attempted repair or when it was performed.

Because of the inability to identify who performed the attempted repair, SCE has concluded that the most likely scenario is that an individual performing unrelated work in a nearby area, observed a small tear in the conduit's protective plastic film jacket but did not realize that the conduit plastic film jacket was an EQ item (Note: EQ status is not apparent from a cursory examination). After wrapping the conduit with tape to prevent the small tear from widening (an acceptable work practice for non-safety related conduit tears), he (she) did not recognize the small tear as an EQ related deficiency requiring an NCR.

Because no other occurrences of this type have been recently identified, SCE believes that this is an isolated individual error in not recognizing the significance of the small tear in the protective plastic film jacket. SCE procedures and training clearly establish that no repair is to be made to a safety related item without a Maintenance Order and an NCR being issued with its attendant engineering evaluation.

2. Corrective steps that have been taken and the results achieved.

On October 24, 1988, an NCR was issued to document the condition. On November 2, 1988, the small tear in the protective film jacket was properly repaired.

3. Corrective steps that will be taken to avoid further violations.

A description of this event will be provided to maintenance personnel. In addition, this event will be discussed with maintenance workers during the upcoming quarterly crew meetings. The maintenance training program will be reviewed and enhanced, if necessary, to include this event in the discussions on when an NCR is appropriate.

4. Date when full compliance will be achieved.

Full compliance was achieved on November 2, 1988, when the small tear, which had been documented in an NCR on October 24, was repaired.

VIOLATION B

- "B. Technical Specification 6.8.1 requires that applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February, 1978 be established and implemented.

"Section 8.a of Appendix A of Regulatory Guide 1.33, Revision 2, states that procedures should be provided to ensure that instruments and controls, including alarm devices, are properly controlled and calibrated at specified periods to maintain accuracy.

"Contrary to the above requirement, as of November 1, 1988, procedures had not been established for the periodic calibration of time delay relays on 12 safety related feeder breakers, as set forth in paragraph 6.b of NRC Inspection Report No. 50-361/88-25. These time delay devices had not been calibrated since initial plant startup in 1982 and 1983.

"This is a Severity Level IV violation (Supplement I) applicable to Units 2 and 3."

RESPONSE

1. Reasons for the violation, if admitted.

SCE admits that although maintenance procedure S0123-II-11.152, "Circuit Device Tests and Overall Functional Tests", was established for the periodic calibration of time delay relays, the listed relays were not included in a calibration and preventive maintenance (PM) program which would have implemented the procedure. As a result, the listed relays have not been recalibrated since initial plant startup.

The subject time delay relays are 480 volt control relays (Agastat). These Agastat relays prevent nuisance alarms for short duration losses of power. The Agastat relays do actuate after approximately 13 seconds of continuous power loss to annunciate a loss of control power condition. 12 of the relays do not control or affect valve position. One relay controls valve 3HV6497, Salt Water from CCW Heat Exchanger.

At present, 696 safety related Agastat relays are in use in Units 2 and 3. 235 Agastat relays are tested due to regulatory requirements based on circuits they are in or are included in the PM program for 4kV and above breakers. 461 Agastat relays are not included in a PM program.

The requirement to periodically test the relays was not effectively transferred from the startup maintenance organization to the operating organization. Due to the length of time since the 1982 reorganization and subsequent personnel turnover, it has not been possible to establish who or how the subject relays were overlooked.

This deficiency was identified in August 1988 by an SCE special task force performing a 100% audit of the PM program. SCE identified that of the Agastat relays not included in a PM program, it appeared that some should be included. Actions were instituted in August to identify the scope of any control circuit (Agastat relay) issue(s) and to re-evaluate whether any additional relays should be included in a PM program.

The schedule for this re-evaluation and any subsequent corrective actions was commensurate with the safety significance of the issue and that, according to the manufacturer, these relays have a 10-year guarantee not to experience > 10% setpoint drift. In October, the review concluded that the subject relays should have been included in a PM program.

SCE notes that many of the corrective actions listed below were either underway or planned, prior to the NRC's subsequent involvement. SCE believes that this is a licensee identified and corrected item.

2. Corrective steps that have been taken and the results achieved.

The 12 time delay relays listed in Inspection Report No. 50-361/88-25 were scheduled for testing and recalibrated as necessary. One additional time delay relay was also identified and included in this program. Eleven relays were successfully tested. One relay, associated with the Refueling Water Tank outlet valve 3HV9301, failed to operate properly. An NCR was issued and the relay is being replaced. Another relay, associated with the Volume Control Tank discharge valve 3LV0227B, requires an outage to perform the test, and a Maintenance Order has been issued for implementation at the next available outage of sufficient duration.

3. Corrective steps that will be taken to avoid further violations.

The 100% audit of the PM program is continuing and is scheduled to be completed by September 1, 1989. This audit will identify any other potential instances where appropriate preventative maintenance has not been implemented. If additional deficiencies are identified, corrective actions will be implemented, as appropriate.

In addition, as part of this total audit, the detailed audit of Agastat relays, initiated in August 1988, is continuing to reconfirm that all appropriate Agastat relays are included in a calibration and PM program. Of the 461 Agastat relays which are not in a PM program, the review will reexamine whether the relay requires testing. The review will be

completed by April 1, 1989. If any additional relays are identified and reclassified, the reclassified relays will be subsequently included in a PM program and tested in accordance with S0123-II-11.152.

4. Date when full compliance will be achieved.

Full compliance will be achieved when plant conditions permit testing of the final relay which will be at the next available outage of sufficient duration.

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