

U.S. NUCLEAR REGULATORY COMMISSION  
OFFICE OF INSPECTION AND ENFORCEMENT

REGION V

Report No. 50-206/80-32  
Docket No. 50-206 License No. DPR-13 Safeguards Group \_\_\_\_\_

Licensee: Southern California Edison Company  
P. O. Box 800 - 2244 Walnut Grove Avenue  
Rosemead, California 91770

Facility Name: San Onofre Unit 1

Inspection at: San Onofre, California

Inspection conducted: November 3-26, 1980

Inspectors: B.H. Faulkenberry / FSC 12/30/80  
L. Miller, Resident Inspector Date Signed

Date Signed

Date Signed

Approved By: B.H. Faulkenberry 12/30/80  
B. H. Faulkenberry, Chief, Reactor Projects Section 2, Date Signed  
Reactor Operations and Nuclear Support Branch

Summary: Inspection on November 3-26, 1980 (Report No. 50-206/80-32)

Areas Inspected: Routine, resident inspection of plant operations during long term outage, monthly maintenance and surveillance observations, and follow-up on Immediate Action Letters. The inspection involved 56 inspector-hours by one NRC inspector.

Results: One item of noncompliance was identified (Failure to implement a physical security plan requirement - Severity Level IV).

8103050/35

## DETAILS

### 1. Persons Contacted

- \*J. G. Haynes, Manager of Nuclear Operations
- \*J. M. Curran, Plant Manager, San Onofre
- J. Willis, Training Manager, San Onofre
- G. Morgan, Superintendent Units 2 and 3
- \*J. R. Tate, Supervisor, Plant Operations
- J. D. Dunn, Project QA Supervisor
- \*G. McDonald, Supervisor, Quality Assurance/Quality Control
- \*M. Wharton, Supervising Engineer, Unit 1
- \*W. Frick, Nuclear Engineer

The inspector also interviewed other licensee employees on the maintenance, security and operations staffs during this inspection.

\*Denotes those attending the Exit Interview on November 26, 1980.

### 2. Monthly Maintenance Observations

#### a. Routine Activities

The inspector observed portions of the following maintenance:

- Steam driven auxiliary feedwater pump repair

The inspector determined that these activities did not violate limiting conditions for operation, that required administrative approvals and layouts were obtained prior to initiating the work, that approved procedures were being used by qualified personnel, and that radiological and fire prevention controls were appropriate for the activities.

#### b. Steam Generator Repair Program

In this inspection period, the licensee completed the water and magnetic decontamination of all three steam generators. The radiation levels inside the bowl of the channel head were reduced approximately threefold by this process. The surface honing of each tube planned to be sleeved continued in all three steam generators. Boroscopic inspections of some of the tubes were performed after they had been honed to determine whether or not the tube had been properly honed. At the conclusion of this inspection the licensee was evaluating boroscopic data which indicated that approximately 20% of the tubes honed in the "B" steam generator required rehoning. The inspector repeatedly observed honing and boroscopic inspections being performed, and reviewed the licensee's procedures for adequacy.

An Immediate Action Letter dated November 19, 1980, was issued to confirm that production insertion of sleeving would not commence prior to the review and approval of this phase of the repairs by the NRC's Office of Nuclear Reactor Regulation. (This review and approval was completed on November 28, 1980.)

The inspector discussed with a licensee representative the results of alpha radioactivity analyses on water decanted from the decontamination storage tank. The representative stated that the maximum alpha activity detected in this water, when analyzed by the General Atomic Company, had been about 1.5 nanocuries/gram. The inspector stated that this item was closed (OI 50-206/80-31-02).

No items of noncompliance or deviations were identified.

## 2. Monthly Surveillance Observations

The inspector observed licensee personnel perform radiation surveys, area radiation monitoring system daily checks, and the monthly load test of the #1 diesel generator. The activities observed were performed in accordance with the applicable procedures. Limiting conditions for operation were met where applicable. Logs and records of the activities were kept and were reviewed by licensee supervisory personnel, where required. The licensee's records indicate that all surveillances required to be completed during this period were completed.

The inspector observed that the daily test of the alarm setpoints of the area radiation monitoring system was being evaluated by licensed operators as acceptable based on eleven month old (outdated) alarm setpoint tolerances. (Unlicensed instrument technicians determine the setpoint tolerances for this system monthly, using S-II-1.5, "Area Radiation Monitoring System Calibration - Monthly Interval.") However, the inspector determined that setpoint tolerance data was not routinely communicated to the licensed operators. The inspector compared the November 25, 1980 setpoints with the correct setpoint tolerances and the actual alarm setpoints were not out of specification. A licensee representative stated that the procedure for the daily system checks was being revised to ensure that the correct setpoint tolerances were used by licensed operators and that pending the procedure revision, operators would be provided the correct setpoint tolerances by memorandum. The representative further stated that the procedural revision would be completed by January 31, 1981. (OI-80-32-01).

No items of noncompliance or deviations were identified.

3. Inspection of Plant Operations During Long-Term Outage

The inspector observed that the control room was properly manned, procedures and limiting conditions for operation were followed, and control room records and instruments reflected the plant status. The inspector reviewed logs and operating records regularly, and verified that radiation controlled area access points were safe and clean.

The inspector verified that the equipment clearance procedures were being used, that the fire protection plan was being implemented, and that the cleanliness of the facility was adequate. Frequent discussions with control room operators were held by the inspector to ascertain their understanding of the reasons for existing indications and plant conditions. The inspector witnessed the transfer of packaged low level radioactive waste from a temporary on site storage area to a shipping trailer, and observed that the transfer was performed in accordance with the licensee's procedures.

The inspector periodically observed physical security practices and determined that the plan was properly implemented, with one exception, which is described in Addendum 1 to this report. This exception is an apparent item of noncompliance at Severity Level IV. (80-32-03)

4. Followup on Immediate Action Letters

a. Immediate Action Letter of April 4, 1980 (Loss of Salt Water Cooling Event)

The inspector verified that the licensee had completed all items of this letter with the exception of Paragraphs 3.d (On-Site Review Committee review of surveillance and maintenance programs for safety-related equipment) and 4 (Determination of Changes to Auxiliary Salt Water Cooling Pump). A licensee representative stated that these commitments would be completed in accordance with the schedule provided in the April 4, 1980 letter. This item remains open. (OI 80-09-03)

b. Immediate Action Letter of October 15, 1980 (Foreign Material on the "A" Steam Generator)

The inspector verified that the procedural revisions required in Paragraph 1 had been completed. A licensee representative stated that the commitments of Paragraph 2 would be completed in accordance with the schedule provided in the October 15, 1980 letter. This item remains open. (OI 80-31-01)

5. Exit Interview

An exit interview (Paragraph 1) was held on November 26, 1980 to summarize the scope and findings of this inspection. At this meeting, the inspector reiterated the NRC's position that a hydraulic shock suppressor (snubber) was inoperable if it did not have sufficient fluid in its reservoir to cover the reservoir port, and confirmed that the licensee would submit a Licensee Event Report on the loss of station power event of November 22, 1980, and would revise the September 16, 1980 sequencer malfunction report to include a report of a sequencer design error discovered by the licensee in this inspection period. The inspector informed the licensee that an allegation had been received concerning electrical safety practices at San Onofre as a result of the electrocution of a station employee on November 22, 1980, and that the investigation of this event was being coordinated with CAL-OSHA, that agency being primarily responsible for personnel safety regulation. Finally, several personnel representing the licensee requested clarification of the policy of the NRC concerning "violation of licensee procedures" by NRC inspectors, specifically with respect to the item of noncompliance included in this report. The inspector stated his understanding that it was an NRC's inspectors responsibility to determine whether or not the licensee was observing all regulatory requirements, and that this determination might sometimes require the inspector to take actions which were not authorized for an employee of the licensee so long as these actions were not unsafe in his judgement. The inspector invited the licensee to seek further clarification from the Regional Office if this explanation was not sufficient.