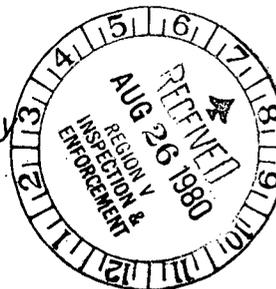


Southern California Edison Company

P.O. BOX 800  
2244 WALNUT GROVE AVENUE  
ROSEMEAD, CALIFORNIA 91770



SCE

August 21, 1980

U. S. Nuclear Regulatory Commission  
Office of Inspection and Enforcement  
Region V  
Suite 202, Walnut Creek Plaza  
1990 North California Boulevard  
Walnut Creek, California 94596

Attention: Mr. R. H. Engelken, Director

Docket No. 50-206  
San Onofre Unit 1

Dear Sir:

This report describes a 30 day reportable occurrence involving the Salt Water Cooling System. Submittal is in accordance with the reporting requirements stipulated in Section 6.9.2.b(3) of Appendix A to Provisional Operating License DPR-13.

On Monday, July 28, 1980, the North Salt Water Cooling Pump was in operation providing cooling water to the residual heat removal system. Actions were initiated at that time to perform the routine rotation of salt water cooling pumps by placing the south pump in service. The South Salt Water Cooling Pump (SSWCP) was placed in service, but its air operated discharge valve (POV-6) failed to open automatically. The operator in attendance immediately opened the valve manually and flow was obtained. As a check, the pump was shut off and POV-6 automatically closed. The pump was then restarted and again the valve failed to open automatically. The valve was reopened manually and the south pump placed in service. During this period, the North Salt Water Cooling Pump (NSWCP) continued in operation. Since the plant was shut down for refueling, the Technical Specification requirements of Section 3.8.A.3 were satisfied with only the North Salt Water Cooling Pump operational. It should be noted that adequate redundancy existed during this mode of operation as described in our response to IE Bulletin 80-12, with the SSWCP requiring manual action to initiate operation of this redundant train. Had the NSWCP failed prior

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to this pump rotation, significant time would have existed to manually start the SSWCP due to the small residual heat load present at this point in the refueling outage.

Operability problems with POV-6 were initially identified soon after the preventive maintenance overhaul of SV-25, performed on June 29, 1980. On July 7, 1980, POV-6 failed to operate due to a burned out solenoid valve. Investigation revealed that the failure was due to installation of the wrong solenoid within the valve operator, SV-25 (ASCO 4-way solenoid valve #8344 B66MO). The solenoid installed into SV-25 was originally in service in the screen wash system. At the time of this conversion, the solenoid valve was considered to be identical (i.e., same manufacturer, model number, and procured by the same specification). Thus, its use in this safety related application was considered acceptable. However, due to an oversight, it was not recognized that the solenoid was an AC solenoid and the solenoid for POV-6 required a DC solenoid. To correct this deficiency the regional distributor of these valves was contacted as to the conversion requirements. The distributor replied that replacing the AC coil with a DC coil was the only requirement for changing the service of this solenoid operator. After replacement of the solenoid the system was restored to service.

Failure of POV-6 on July 28, 1980 initiated further discussions regarding this most recent failure. These discussions revealed that failure of the solenoid valve was due to the fact that the spring force for the original AC service was too strong for the replaced DC coil to overcome. It was concluded that the spring subassembly as well as the coil must be replaced when converting from AC to DC. The valve remained manually operable until August 9, 1980 when, at that time, a new DC solenoid valve was installed.

This incident is reportable since there was a breakdown in the procedural controls that are invoked to confirm the adequacy of such plant modifications. Station procedures do exist which require a design change review for performing equipment modifications. However, the overhaul of solenoid valve SV-25 was considered to be an equipment repair versus a modification. Our review of this matter had determined that the work performed on SV-25 should have been handled as a modification. Station personnel have been counseled regarding the procedural actions (i.e., design review requirements) that must be taken when performing modifications of this nature to safety related equipment.

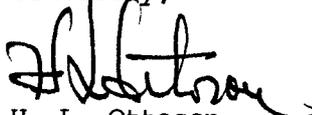
By letter dated June 29, 1980, the Office of Nuclear Reactor Regulation (NRR), Division of Licensing, requested certain information concerning the failure of the Salt Water Cooling System at San Onofre Unit 1 in March, 1980. Our response to this request, as submitted by letters dated July 24, 1980 and August 8, 1980, are currently being reviewed by NRR. In order to provide NRR with all pertinent information concerning recent incidents involving the Salt Water Cooling System, a copy of this letter

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is being forwarded directly to the Office of Nuclear Reactor Regulation,  
Division of Licensing, to assist in their ongoing evaluation.

Should you require additional information on this matter, please let  
me know.

Sincerely,



H. L. Ottoson  
Manager of Nuclear Operations

Enclosure: Licensee Event Report 80-031 Rev. 0

cc: Director, Nuclear Reactor Regulation (30)  
Director, Office of Management Information & Program Control (3)  
Director, Nuclear Safety Analysis Center