UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION V
1990 N. CALIFORNIA BOULEVARD
SUITE 202, WALNUT CREEK PLAZA
WALNUT CREEK, CALIFORNIA 94596

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June 7, 1979

Docket Nos. 50-206
50-361
50-362

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

Attention: Mr. Jack B. Moore
Vice President

Gentlemen:

This Information Notice is provided as an early notification of a possibly significant matter. It is expected that recipients will review the information for possible applicability to their facilities. No specific action or response is requested at this time. If further NRC evaluations so indicate, an IE Circular, Bulletin, or NRR Generic Letter will be issued to recommend or request specific licensee actions. If you have questions regarding the matter, please contact the Director of the appropriate NRC Regional Office.

Sincerely,

J. K. Crews for
R. H. Engelken
Director

Enclosures:
1. IE Information Notice No. 79-15
2. List of IE Information Notices
Issued in 1979

cc w/encl:
J. M. Curran, SCE
J. T. Head, SCE
J. H. Drake, SCE

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UNITED STATES
NUCLEAR REGULATORY COMMISSION
OFFICE OF INSPECTION AND ENFORCEMENT
WASHINGTON, D.C. 20555

June 7, 1979

IE Information Notice No. 79-15

DEFICIENT PROCEDURES

Summary

On June 2, 1979, at Arkansas Nuclear One - Unit 1, while observing conditions in the control room, an NRC inspector discovered an operational deficiency that could have resulted in the emergency feedwater system remaining isolated during subsequent power operation.

Description of Circumstances

On June 2 while Arkansas Nuclear One - Unit 1 was preparing for startup, an NRC inspector in the control room found that during a surveillance test of the main feedwater check valves, the controls of the emergency feedwater system were positioned so that the system could not automatically respond if needed. The NRC inspector found that the test procedure being used by the licensed operators did not include, as it should have, instructions either to bypass the emergency feedwater system or to return it to normal. The plant operators, without approved procedures covering this aspect of the test, bypassed the controls that would have started the feedwater system automatically. Lacking a procedural requirement to return the system to normal, there was no assurance that emergency feedwater would be provided automatically if needed.

Following the Three Mile Island accident, the NRC required that operators be trained to initiate promptly the emergency feedwater system manually if it does not come on automatically. Thus, while no immediate safety hazard existed at the Arkansas Unit 1 plant because of the improper action, the NRC staff is concerned about the potential safety hazard of leaving the emergency feedwater system in the bypassed condition, about the possibility that other procedures at the Arkansas plant may be deficient and about the fact that the operators deviated from procedures in performing the surveillance test.

Arkansas Power and Light Company has returned the plant to cold shutdown. The June 2, 1979, NRC Order confirmed the requirement for a cold shutdown until the Commission staff is satisfied with the utility's method of controlling the development of operating procedures, the adequacy of existing procedures, and until there is assurance that operators will not deviate from those procedures.

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