Southern California Edison Company

P. O. BOX 800

2244 WALNUT GROVE AVENUE ROSEMEAD, CALIFORNIA 91770 June 24, 1981

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L.T. PAPAY VICE PRESIDENT

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

Attention: Mr. R. H. Engelken, Director

DOCKET No. 50-206 SAN ONOFRE - UNIT 1

Dear Sir:

Your letter of June 1, 1981 forwarded a Notice of Violation resulting from IE Inspection Report No. 50-206/81-15 which took place March 29 through May 1, 1981.

Enclosure (I) of this letter provides our response to Appendix A to your Notice of Violation.

I trust the enclosure responds adequately to all aspects of the Violation. If you have any questions or if we can provide additional information, please let me know.

Subscribed on the 24th day of

> Papay Vice President

Southern California Edison Company

Subscribed and sworn to before me this 24th day of

AGNES CRABTREE NOTARY PUBLIC - CALIFORNIA PRINCIPAL OFFICE IN My Commission Exp. Aug. 27, 1982

trabbee Notary Public in and for the County Los Angeles, State of California

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Enclosure I

cc: L. F. Miller (NRC Site Inspector - San Onofre Unit 1)

ENCLOSURE I

Response to Items of Non-Compliance identified in Appendix A to IE Inspection Report No. 50-206/81-15.

ITEM 1

Paragraph 9e of Appendix A to Regulatory Guide 1.33, Revision 1 states that general procedures for the control of maintenance, repair, replacement and modification work should be prepared. These procedures should include information such as the following: (1) Method for obtaining permission and clearance for operation personnel to work and for logging such work.

Station Order S01-A-17, "Work Authorizations" requires that no person shall work on station equipment without first obtaining proper authorization from the operator in charge or the Watch Engineer.

On April 1, 1981, a wireman removed the wire supplying power to fuse #2 (Temporary Feed to FI 2004), not knowing that the wire had not been deenergized. As the wire was pulled out of the panel, it grounded the safety-related Vital Bus #2, blew a fuse in the normal power supply to that bus, causing the bus to be transferred to its alternate supply, and created a transient which tripped open the firewater deluge valve to the #2 Diesel Generator.

Contrary to the above requirements, proper authorization to perform the wire removal had not been obtained prior to performing this work.

This is a Severity Level V Violation (Supplement I).

RESPONSE

1. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The individual responsible for the incident referenced in the Item of Non-compliance was a construction contractor employee working under the general direction of SCE Construction.

An investigation into the incident was concluded by SCE Construction on April 8, 1981. The cause of the incident was attributed to the fact that the individual involved did not fully understand the boundaries of the clearance for the work in progress. During the investigation, the following corrective steps were taken:

- a. The boundaries of each Station clearance in place on April 8, 1981 and held by individuals under the supervision of the SCE Generation Related Improvements Project were reviewed with a Unit 1 Watch Engineer, the contractor Chief Field Engineer and the Craft General Foreman. The results of each review were documented.
- b. The bound ries for the corresponding craft clearance held by a contractor employee was reviewed with the General Foreman and the Craft Foreman. The results of each review were documented.

The above steps a. and b., provided an increase in awareness of existing clearance boundaries among first and second level supervisors associated with the contract work.

- c. An SCE Testman was assigned to review and accept clearances for the remainder of the Project Three Mile Island - related work in the Control Room.
- d. A revision was issued to the Project Clearance Procedure to define the Testman's role in the request, review and acceptance of clearances. Definitions of Control Room Approvals and Permissions were added, and the revised procedure reviewed with all Project clearance requesters. The review of the procedure change was documented.
- e. An SCE Construction supervisor was assigned to coordinate the Project construction, testing and startup activities in the Control Room area.

Steps c., d., and e. above were implemented to include the involvement of personnel more skilled and knowledgeable in Edison clearance procedures. This would provide a greater degree of coordination between Edison and contract personnel.

f. A review of the contractor, SCE Construction and Station requirements for obtaining and observing equipment clearances has been a part of the SCE Project Construction program. SCE Construction/Startup personnel, including those agency personnel under the direct supervision of the Project, receive procedural instruction and a check-off sheet is used to document understanding of the requirements. Subsequent to the April 1, 1981 incident, the check-off sheet was updated to be more specific. Upon completion of the procedural review, the Unit 1 Superintendent signs the checkoff form to authorize the indicated individual to hold a clearance. The forms are kept on file in the Control Room and only authorized individuals may request and receive clearances for the Project.

A formal Electrical Clearance/Checker Training Program was instituted at San Unofre Unit 1 in November, 1980. On April 3, 1981, a Station memorandum was issued to specify that Station personnel would not be permitted to function as checkers or be allowed to hold clearances without completing the training course.

On May 8 and May 28, 1981, Vital Busses No. 4 and No. 1, respectively, automatically transferred to backup power when workers inadvertently grounded or shorted equipment on those busses. During the May, 1981 routine monthly exit interview, the San Onofre Unit 1 Resident NRC Inspector requested that a discussion of these items be included in the response to the April 1, 1981 Non-Compliance.

These two instances do not directly parallel the item cited in this Non-Compliance, since the work was knowingly being performed on energized equipment which could not be removed from service. In both these subsequent instances, proper authorization in the form of a Control Room Approval had been received and the incidents resulted from the necessity of working on energized equipment in confined spaces. Backup power was immediately transferred to the busses and appropriate corrective action taken within a short period of time.

Although the incidents were discussed with the individuals involved, there was no indication that carelessness was a factor in either case. Supervision is aware of the seriousness of the matter and the potential consequences of these inadvertent vital bus transfers.

There have been no further instances of failure to observe clearance requirements at San Onofre Unit I since the April 1, 1981 occurence.

2. CORRECTIVE STEPS WHICH !!! L BE TAKEN TO AVOID FURTHER ITEMS OF NON-COMPLIANCE

Procedures currently in effect concerning the request, review, approval and observation of equipment clearances will be adhered to without exception. Continual reinforcement and emphasis on this necessity will be directed to all personnel involved by the responsible supervision.

SCE Construction will continue to provide instruction to clearance requesters prior to the Station management granting approval for those individuals to hold clearances. The Electrical Clearance/Checker Training Program conducted by the Nuclear Training Division will be made available to SCE Construction personnel.

Bechtel Power Corporation will issue a new procedure (GP19.32, REV. 0) entitled "Clearance Tagging Procedure" by July 24, 1981. This procedure will specify a documented training session on BPC and SCE clearance requirements for all new contractor employees at San Onofre Unit I whose duties will require such knowledge.

Station Order SOI-A-17, "Work Authorizations," will be revised by July 31, 1981 to specify the necessity of the appropriate training and require clearances to be issued to trained personnel only.

By August 1, 1981, SCE will implement the use of a revised Maintenance Order Form. A part of this program is to simplify the current system and upgrade equipment control.

3. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

With the exception of the referenced April 1, 1981 incident, San Onofre Unit I was, and remains in, full compliance with the procedural requirements for equipment clearance control.

ITEM 2

Paragraph 9a of Appendix A to Regulatory Guide 1.33, Rev. 1 states that maintenance that can affect the performance of safety-related equipment should be properly pre-planned and performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances.

Nonconformance Report SOI-P-485 Revision O, detailed the licensee's procedure for the repair of a leaking epoxy patch in the discharge line of the South Saltwater Pump. Paragraph 20.8.2 of this procedure required that an initial service leak test per ANSI B31.1 be performed prior to the return to service of the line.

The applicable edition of ANSI B31.1, Paragraph 137.6.2 states that "when performing an initial service leak test the piping system shall be gradually brought up to normal operation pressure and continuously held for a minimum time of 10 minutes. Examination for leakage shall be made of all joints and connections. The piping system...shall show no visual evidence of weeping or leaking."

On April 13, 1981, licensee personnel performed this initial service leak test. At 8:40 a.m. the inspector was informed by the witnessing test engineer that the test had been satisfactorily completed. At 8:45 a.m. the Control Operator's log stated that the "South Saltwater Pump Leak Test completed satisfactory. South Saltwater Pump O.K. for service."

ITEM 2 (Continued)

Contrary to the above requirements, the inspector observed that the acceptance criteria of the procedure had not been met. At 8:45 a.m. the South Saltwater Pump flange downstream of POV-6 had not yet been observed for 10 minutes with no leakage, and was, in fact, still leaking from several points.

This is a Severity Level VI violation (Supplement I).

RESPONSE

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

On April 13, 1981, repairs to the South Salt Water Pump discharge piping had been completed in accordance with SCE Non-Conformance Report SOI-P-485, Rev. O. An initial service leak test per ANSI B31.1 was required by the disposition of the NCR. The contractor field engineer responsible for the final testing was unaware of the exact test duration and leakage criteria of Paragraph 137.6.2 of ANSI B31.1 and thus failed to meet the requirements while conducting the test.

When this matter was brought to the attention of the licensee, the adequacy of the necessary repairs was verified and the initial service leak test satisfactorily performed lace in the day on April 13, 1981.

SCE Corrective Action Request No. S01-F-285 was issued by the Quality Assurance Organization on April 14, 1981 to address the problem. Training was administered to contractor personnel concerning the correct requirements for such pressure testing.

San Onofre Unit I Special Engineering Procedure SPE-186 was reviewed and found to correctly delineate Station inservice leak test requirements. However, to avoid future confusion, all pressure testing requirements have been incorporated into one procedure. SOI-V-2.18, System Pressure Testing, was revised and re-issued on May 29, 1981.

There has been no recurrence of this problem at San Onofre Unit I.

2. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER ITEMS OF NON-COMPLIANCE

Training of contractor personnel to assure future adherance to procedural and code pressure testing requirements was verified by SCE Quality Assurance on April 17, 1981.

DATE WHEN FULL COMPLIANCE WAS ACHIEVED

San Onofre init I was in full compliance with the requirements of Paragraph 137.6.2 of ANSI B31.1 and applicable Station procedures on April 13, 1981.

ITEM 3

Paragraph 7b Appendix A to Regulatory Guide 1.33, Revir on 1 recommends that procedures for control of radioactivity include spent resin handling.

S01-1.56, "Transfer of Spent Resins," Step 6.11 requires an operator to "Close primary flush water to spent resin tank," following spent resin transfer.

Contrary to this requirement, on April 23, 1981 at about 6:30 p.m. the operator did not close this valve following spent resin transfer. This error caused the Auxiliary Building Sump and the Decontamination Drain Tank to overflow the next morning. Approximately 150 gallons of contaminated water spilled over the upper and lower level floor drains of the Auxiliary Building Sump and the decontamination shower in the Control Building.

This is a Severity Level V Violation (Supplement !).

RESPONSE

1. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

During the event in question, the operator performing the activity was in possession of a copy of the approved procedure. The operator failed to perform the step that called for closing the water supply to the spent resin storage tank.

The employee's past performance and the adequacy of the procedure were reviewed by supervision. It has been concluded that the incident was an unfortunate oversight on the part of the employee and that the procedure is adequate. The employee has been counseled regarding his performance. There has not been a recurrence of the problem.

ENCLOSURE 1 Page 7

RESPONSE (Continued)

2. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER ITEMS OF NON-COMPLIANCE

The Nuclear Training Division has increased the emphasis on the need for careful attention to the details of procedures and the necessity for adherence to them. Procedural compliance is a separate lesson plan taught during the current QA/QC and the General Employee (new hire) Training Programs. At a minimum, all operations employees receive emphasis on the subject during the annual Radiation Badge Qualification Training.

3. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on April 27, 1981, upon counseling the operator involved in this incident.

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