



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION V

1450 MARIA LANE
WALNUT CREEK, CALIFORNIA 94596-5368

MAR 17 1994

Docket Nos. 50-361
50-362

Southern California Edison Company
Irvine Operations Center
23 Parker Street
Irvine, California 97204

Attention: Mr. Harold B. Ray
Senior Vice President

Gentlemen:

Thank you for your letter of February 28, 1994, in response to our Notice of Violation and Inspection Report No. 50-361/93-38 and 50-362/93-38, dated January 28, 1994, informing us of the steps you have taken to correct the items which we brought to your attention. Your corrective actions will be verified during a future inspection.

Your cooperation with us is appreciated.

Sincerely,

C. A. VanDenburgh
Acting Deputy Director
Division of Reactor Safety and Projects

CC:
Mr. Edwin A. Guiles, Vice President Engineering & Operations, San Diego Gas and Electric Co.
T. E. Oubre, Esq., Southern California Edison Company
Chairman, Board of Supervisors, County of San Diego
Mr. Sherwin Harris, Resource Project Manager, Public Utilities Department
Mr. Charles B. Brinkman, Manager, ABB Combustion Engineering Nuclear Power
Mr. R. W. Krieger, Vice President, Southern California Edison Company
Mr. Don J. Womeldorf, Chief, Environmental Management Branch
Mr. Thomas E. Bostrom, Project Manager, Bechtel Power Corporation
Mr. Robert G. Lacy, Manager Nuclear Department
Mr. Steve Hsu, Radiologic Health Branch
Mayor, City of San Clemente

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bcc w/copy of letter dated February 28, 1994:
Docket File
Resident Inspector
Project Inspector
G. Cook
K. Perkins
D. Clevenger

bcc w/o copy of letter dated February 28, 1994:
M. Smith

Region V/ann

HWong
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CVanDenburgh
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REQUEST COPY	REQUEST COPY	REQUEST COPY	REQUEST COPY	SEND TO PDR
YES / NO	YES / NO	YES / NO	YES / NO	YES / NO

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Southern California Edison Company

P. O. BOX 128

SAN CLEMENTE, CALIFORNIA 92674-0128

R. W. KRIEGER
VICE PRESIDENT
NUCLEAR GENERATION

February 28, 1994

TELEPHONE
714-388-6255

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

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

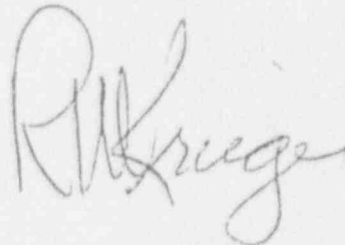
Reference: Letter, C. A. VanDunburgh (USNRC) to
Mr. Harold B. Ray (SCE), dated January 28, 1994

The referenced letter provided the results of the routine inspection conducted by Messrs. J. A. Sloan et al, at San Onofre Nuclear Generating Station, Units 2 and 3, from November 16 to December 31, 1993. This inspection was documented in NRC Inspection Report Nos. 50-361, 362/93-38, dated January 28, 1994. The Inspection Report also included a proposed Notice of Violation resulting from that inspection.

In accordance with 10CFR2.201, the enclosure to this letter provides the Southern California Edison (SCE) reply to the Notice of Violation.

If you have any questions, please call me.

Sincerely,



Enclosure

cc: Mr. K. E. Perkins, Jr., Acting Regional Administrator, NRC
Region V
J. A. Sloan, NRC Senior Resident Inspector, San Onofre
Units 1, 2 & 3
M. B. Fields, NRC Project Manager, San Onofre Units 2 and 3

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ENCLOSURE

REPLY TO A NOTICE OF VIOLATION

The enclosure to Mr. C. A. VanDenburgh's letter, dated January 28, 1994, states in part: "During an NRC inspection conducted on November 18 through December 31, 1993, a violation 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, the violation is listed below:

"Criterion V of 10 CFR Part 50, Appendix B, 'Instructions, Procedures, and Drawings,' states in part that 'Activities affecting quality shall be prescribed by documented instructions, procedures or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures ...'

- "1. Procedure SO23-3-1.8, TCN 7-16, 'Draining the Reactor Coolant System,' Step 1.33.3 of Attachment 2, requires personnel to 'Adjust the ... CET/HJTC Temperature high - 5 degrees above the present RCS temperature...' and Procedure SO123-0-20, TCN 0-10, 'Use of Procedures,' Step 6.2.6, requires that personnel adhere to 'the sequence of performing procedure steps ...'

"Contrary to the above, on December 9, 1993, during a draindown of the Unit 3 reactor coolant system (RCS), two out of four inputs to the CET/HJTC temperature high alarm were not set 5 degrees above the indicated RCS temperature before performing the other steps of the procedure and commencing the draindown.

- "2. Procedure SO123-0-20, TCN 0-10, 'Use of Procedures,' Step 6.8.1, states that 'Alternately Controlled should be used when a procedure step or section cannot be performed because the associated equipment is being controlled by another plant document.'

"Contrary to the above, on November 2, 1993, the Unit 3 common emergency core cooling system miniflow isolation valve, 3HV9347, was alternately controlled when releasing Work Authorization Record 3R7PP111, 'Safety Injection Pumps Miniflow Overhaul,' even though the associated equipment (valve 3HV9347) was not being controlled by another plant document (sic).

- "3. Procedure SO123-XV-5.1, Revision 1, 'Temporary Modification Control,' Step 6.3.1, states that, 'If leak repair will be in this manner (Furmanite or equivalent) on safety related, QCI and QCII, important to safety ...components the approval/documentation shall be by the NCR process.'

"Contrary to the above, on November 4, 1993, Unit 2 valve S21301MU1000, a safety-related quality class II steam trap isolation valve, was repaired for a body-to-bonnet steam leak using Furmanite without approval by the NCR process.

"This is a severity level IV violation (Supplement I)."

ITEM (1): FAILURE TO RESET CORE EXIT THERMOCOUPLE/HEATED JUNCTION THERMOCOUPLE (CET/HJTC) ALARM SETPOINTS

1. REASON FOR THE VIOLATION

The violation was the result of individual personal error due to lack of attention to detail. The Control Room Supervisor (CRS) did adjust two of the four inputs, but failed to exert due diligence and inadvertently omitted adjusting the remaining two inputs.

The Units 2/3 Assistant Plant Superintendent identified and corrected the omission during his routine review of Procedure SO23-3-1.8 approximately one hour after commencing Reactor Coolant System drain down.

The CET/HJTC alarm is a secondary indication for a loss of shutdown cooling. Several other indications were in place, such as pump running amps and flow rates, that would have alerted the operators in the event of loss of shutdown cooling in addition to the two channels of the CET/HJTC alarm which had been appropriately set. Therefore, this event had minimal safety significance.

2. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The CRS was counseled shortly after the condition was identified.

3. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

No further corrective actions are required

4. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on December 9, 1993, when the remaining two alarm setpoints were adjusted.

ITEM (2): FAILURE TO ENSURE ALTERNATE CONTROL FOR VALVE 3HV9347

1. REASON FOR THE VIOLATION

The CRC inappropriately used the "Alternate Control" process, in that he shifted the administrative control of the position of 3HV9347 from one document which was being closed out, to another document which had been initiated, but had not yet established administrative control of the position of 3HV9347 (i.e., plant operators had not yet acted on the second document and the valve had not been opened).

One way in which Edison controls plant equipment is through the Work Authorization Request (WAR) process. 3HV9347 had been controlled by WAR 3-R7PP111 which was being closed out (Operators removing control tags and restoring systems in accordance with the control tag instructions). When the tags are removed, the restoration of each system component controlled by the WAR is annotated on the WAR tag sheet. If a valve requires repositioning for a different purpose, following implementation of a new WAR, the old WAR tags and tag sheet can be annotated "Alternately Controlled" to indicate that the component is still under the control of a WAR.

In this case, when WAR 3-R7PP111 was being closed out, control tags removed, and the tags and tag sheet annotated, a new WAR, 3-R7HYD14, was in the process of being implemented. The CRC believed it was acceptable to annotate WAR 3-R7PP111 to indicate that 3HV9347 was "Alternately Controlled" because he believed WAR 3-R7HYD14 would be issued within a short period. WAR 3-R7HYD14 would have caused a caution tag to be hung on 3HV9347 and have the operator open the valve.

Because the CRC allowed WAR 3-R7PP111 to be closed out before WAR 3-R7HYD14 had administrative control of valve position, control room caution tags were removed. Had the tags remained in place, the control room caution tags would have noted 3HV9347 was closed and kept Operators from starting High Pressure Safety Injection (HPSI) Pump P-018 (with 3HV9347 closed the flow path was deadheaded).

Prior to the full issuance of WAR 3-R7HYD14, while there was still no control room indication that 3HV9347 was closed, Operators actuated HPSI P-018. The pump was damaged during operation and required repair.

2. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The CRC involved has been counseled. Procedure SO123-XX-5, "Work Authorization," has been modified to enhance guidance on the proper use of "Alternately Controlling" equipment with another WAR.

3. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

Edison will enhance procedure SO123-0-20, "Use of Procedures," to expand the general guidance provided for the use of Alternate Control. Additionally, On-The-Job training will be provided for those individuals responsible for approving the use of Alternate Control. These actions will be completed by May 31, 1994.

4. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved when valve 3HV9347 position was properly controlled on November 3, 1993.

ITEM (3): FAILURE TO HAVE AN APPROVED NCR PRIOR TO FURMANITE REPAIR

1. REASON FOR THE VIOLATION

The individual involved did not verify the quality class of the valve prior to initiating the Furmanite Repair. The individual made a misjudgment that the valve was non-safety related because it was downstream of an isolation valve, and accordingly did not initiate an NCR for a Furmanite repair of it. Supervision discovered and corrected the oversight as a result of a special review of Fermanite usage at San Onofre following an industry event concerning inappropriate fermanite repair of a safety-related valve.

2. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

The individual involved has been counseled on management's expectations regarding job performance and ensuring proper information has been reviewed.

Edison ensured that the valve repair was properly documented through the NCR process. In addition, Edison reviewed all Furmanite repairs made to safety related valves and found this to be an isolated incident.

3. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

This occurrence will be included in the required reading program for appropriate Station Technical Personnel by April 1, 1994.

4. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved December 13, 1993, when the valve repair was documented through the NCR process.