U. S. NUCLEAR REGULATORY COMMISSION

REGION V

Report No. 50-206/82-35

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 Site, San Clemente, California

Inspection conducted: November 1 - 30, 1982

Inspectors: R. S. Kirsch 12-20-82
for L. Miller, Senior Resident Inspector, Unit 1 Date Signed

Approved by: R. S. Kirsch 12-20-82
D. F. Kirsch, Chief, Reactor Projects Section No. 3 Date Signed
Reactor Projects Branch No. 2

Summary:

Inspection on November 1 - 30, 1982 (Report No. 50-206/82-35)

Areas Inspected: Routine, resident inspection of plant operations during long-term shutdown; monthly maintenance and surveillance activities; followup of Licensee Event Report, inspector identified items and 10 CFR 21 reports; and independent inspection. This inspection involved 80 inspection hours by one NRC inspector.

Results: In the seven areas inspected, no items of noncompliance were identified.

DETAILS

1. Persons Contacted

*H. Ray, Station Manager
*G. McDonald, Quality Assurance/Control Supervisor
*B. Katz, Station Technical Manager
*G. Patrissi, Fire Protection Supervisor
*M. Speer, Compliance Engineer
*W. Moody, Deputy Station Manager
*R. Schweinberg, Project Construction Manager

The inspector also interviewed other licensee and contractor personnel during this inspection.

*Denotes those attending the Exit Interview on November 30, 1982.

2. Inspection of Plant Operations During Long-Term Outage

The inspector frequently observed Control Room operations for proper shift manning, adherence to procedures and limiting conditions for operation, and appropriate recorder and instrument indications. To determine operator awareness of plant status, the inspector discussed the status of annunciators with Control Room operators and observed shift turnovers. Selected morning meetings were attended to assess the licensee's outage coordination.

The Control Operator's log was reviewed to obtain information on plant conditions and to determine whether regulatory requirements had been met. Other logs, including the Watch Engineer's Log, were also reviewed several times. Selected maintenance orders for the current month were reviewed. The licensee's system for identifying equipment deficiencies appeared to be functioning adequately. The equipment control, abnormal equipment, and clearance records were audited, and tags for the reactor coolant pumps and No. 1 Diesel Generator were verified to have been hung properly.

The inspector frequently toured the accessible areas of the facility to assess equipment conditions, radiological controls, security, housekeeping, and fire protection.

The inspector's tours indicated that controlled area access points were generally safe and clean. Several Radiation Exposure Permits were reviewed for completeness. Surveys of low specific activity material were observed, including a truck shipment of this material on November 17, 1982. The inspector surveyed a portion of this shipment and confirmed that the licensee had performed an adequate survey. On November 4, 1982 the inspector observed that a health physics technician failed to frisk out of a controlled area at a monitoring station which had been established by the licensee. The technician exited the area to enter another controlled area. The inspector discussed this observation with licensee supervisory personnel. They stated it was not an acceptable practice to ignore a frisking station and reinstructed the technician. The inspector stated that this was adequate corrective action for an apparently isolated occurrence. No potentially contaminated material was observed in spotchecks of trash containers. Selected radiation measuring instruments in use appeared operable and were in calibration.

Manning of security posts, integrity of protected area barriers and isolation zones, conduct of search procedures, and personnel identification measures were all periodically observed by the inspector.

Plant housekeeping had improved during this period. No hazardous open flame practices were observed. Construction activities were greatly reduced while the scope of work for this outage was being reassessed. The effectiveness of the licensee's program to reduce these hazards during periods of active construction will be examined when this work resumes (currently planned for February, 1983).

The inspector discussed Technical Specification 3.14B(2) with licensee representatives on November 2 and 18, 1982. During this period, the containment fire spray/sprinkler system was out of service, and, therefore, a continous firewatch with backup fire suppression equipment was required. The inspector observed that health physics personnel, who were performing the fire watch role for the residual heat removal pump area, were not aware that they had been assigned some fire watch responsibilities. Also, some fire watches had not been aware that they were expected to continously patrol the containment, rather than tour it once each hour. It appeared that additional training of personnel in this area was advisable to avoid a violation of this requirement. A licensee representative stated that licensee personnel would be more thoroughly instructed in their responsibilities. The inspector accepted this commitment. This item is closed.

On November 2, 1982, at 11:04 a.m., the unit experienced a surveillance test failure of the No. 2 Diesel Generator while the No. 1 Diesel Generator and the main transformer were removed from service for maintenance. The Unit was in Mode 5. This reduced the power available to the unit to one offsite power source, the auxiliary transformer. The licensee immediately began work to restore one of the two diesel generators and the main transformer. This was accomplished at about 7 p.m. The licensee concluded that this event was not an "unusual event" as defined by the emergency plan implementing procedures. The inspector questioned this decision since the licensee's emergency plan stated that loss of onsite power should be categorized as an unusual event. The inspector determined that the licensee had recently modified the implementing procedures to require reporting of this, and many other events, while in Modes 1-4 and not in Modes 5 and 6.

A licensee representative stated that these procedure revisions amplified but did not change the intent of the plan. Further, the representative stated that it was the licensee's intent to modify the plan to include these same mode restrictions on reporting. The licensee believes that such changes would be authorized by 10 CFR 50.54q because, in their view, they do not decrease the effectiveness of the plan. The inspector stated his concern that these changes may diminish the effectiveness of the plan, since the mode of a plant was not a reliable indication of the plant's susceptability to threaten the public health and safety following an event This item is unresolved. (OI 50-206/82-35-01).

No items of noncompliance or deviations were identified.

3. Monthly Surveillance and Maintenance Activities

The inspector witnessed portions of the following activities:

a. Concrete Placement in the Auxiliary Feedwater Tank Pipe Trench

b. HV-851 A,B (Safety Injection Discharge Valve) Recoupling

c. No. 1 Diesel Generator Annual Preventive Maintenance (SOI-I-6.48)

d. Source Range Nuclear Instrument Channel 1202 Troubleshooting

e. No. 1 Diesel Generator Troubleshooting

The inspector determined that the procedures used for these activities were consistent with applicable limiting conditions for operation, clearances were obtained where necessary for protection of equipment and personnel, necessary tools were properly calibrated and used, and the activities were properly authorized.

No items of noncompliance or deviations were identified.

4. Independent Inspection

a. The inspector observed that a leak on the discharge side of the north circulating water pump had been temporarily repaired with a wooden plug, pending a planned weld repair. The inspector discussed the repair with licensee personnel and reviewed the record of nondestructive testing of the affected area dated August 19, 1982. The inspector noted that the leak occurred in an isolated area of corrosion on the pump casing and that there was no indication of general deterioration of the pump casing. The inspector concluded that the licensee's corrective action for this deficiency was adequate.

b. An anonymous telephone allegation was received that three unqualified electrical welders were working at Unit 1 for the Bechtel Corporation, a licensee contractor. The inspector reviewed the qualification of each of these welders on November 16 and 17, 1982. All of the welders had been laid off in November as a result of the construction slowdown at Unit 1. The inspector reviewed their qualification test records, Bechtel Forms WR-1. These records indicated that each welder had been examined by a certified level II welding inspector. The welding inspector had qualified each welder by radiography of a test weld made by the welder. The inspector determined that this qualification method was in accordance with the Bechtel Welder Qualification procedure, WQ-2, and AWS D1.1, 1980 edition. The inspector concluded that the allegation was not substantiated.

No items of noncompliance or deviations were identified.

5. Followup on Inspector Identified Items

a. (Closed) (82-24-02) Dispositon of Noncomformance Reports

The inspector reviewed a revised nonconformance reporting form (SCE Form 37-22, Rev. 10/82) developed by the licensee to more carefully identify the apparent nonconformance cause and necessary corrective action. The revised form provides several categories into which the reports may be sorted. The inspector concluded that this revision appeared acceptable.

b. (Open) (82-24-01) Saltwater Cooling Pump Valve Failures

The inspector noted that POV-6, the south saltwater cooling pump discharge valve, failed to open when tested on October 29, 1982. The pump was declared inoperable until the following afternoon, when the cause for the failure was determined to be an open air receiver drain valve. The inspector concluded that this failure was unrelated to previous valve malfunctions in this system, but it did indicate an area where operator training on the system may be improved. Licensee personnel stated that training on the lessons learned from this event would be incorporated into the training program. This item is open pending that training implementation and the completion of the system reliability study.

c. (Open) (82-02-03) Control of Surveillance Activities

The inspector confirmed that a summary of all Technical Specification surveillance requirements had been issued as Station Order SOI-XV-3.0 (Technical Specification Surveillance Program Implementation). This item remains open pending review of a Quality Assurance audit of the licensee's corrective action, and a detailed review of all license amendments to ensure that commitments are specifically assigned.

d. (Closed) (82-32-04) Pipe Wall Thickness Measurements

The inspector reviewed the nonconformance reports initiated as a result of the wall thickness measurements made during a previous inspection (F-2665, F-2666, and P-1260). The inspector observed that the licensee had initiated corrective action for the deficiencies identified, and concluded that there was reasonable assurance that all of the pipes measured had adequate wall thickness.

e. (Closed) (80-31-04) Stainless Steel Corrosion Control Program

The inspector reviewed the licensee's lengthy study of the cause and prevention of corrosion of stainless steel piping exposed to the near ocean atmosphere. This report, dated January 28, 1982 (Surface Stress Corrosion Cracking of Stainless Steel Piping Exposed to a Chloride Environment), thoroughly investigated the history of this phenomena and explored alternative corrective measures. The inspector reviewed procedure SOI-V-5.2 written by the licensee to implement the recommendations of the report. At the Exit Interview, the inspector stated that the licensee's followup on this item appeared exceptional.

No items of noncompliance or deviations were identified.

6. Followup on Part 21 Reports

a. Pacific Scientific Mechanical Snubbers

The inspector reviewed this report, which concerned improper testing of this vendor's mechanical snubbers. Licensee personnel stated that no improper testing of the mechanical snubbers at Unit 1 had been performed (because no testing at all had been performed). The personnel stated that a snubber testing machine was being procured to test these snubbers in the future. This item is closed.

b. Power Conversion Products Battery Chargers

The inspector reviewed this report, which concerned slightly undersized fuses in Model 35-130-200 battery chargers. Licensee personnel stated that a proposed facility change had been prepared to replace these fuses with the size currently recommended by the manufacturer.

No items of noncompliance or deviations were identified.

7. Followup on Licensee Event Reports (LERs)

a. (Closed) LER 82-025: Lapsed Fire Watch Coverage

The inspector reviewed this report, which discussed three instances of lapsed fire watch coverage. Amendment 44 to the operating license requires that the automatic lube oil foam system and the automatic cable tray directed water systems be installed. The inspector observed that these systems had been installed, and were required to be controlled by Station Procedure SOI-23-XIII-26 (Fire Protection Impairment) whenever they were unavoidably out of service. The inspector observed during a review of the Abnormal Equipment Log that the automatic lube oil area foam and seal oil spray system had been out of service since April 7, 1982 and the automatic cable tray sprinkler system was out of service since August 22, 1982. At the Exit Interview, the inspector stated that the review of this report was closed, but followup of the related violation citied in Inspection Report 82-32 remains open pending review of the licensee's response.

No items of noncompliance or deviations were identified.

8. Exit Interview

The inspector met with licensee representatives (denoted in paragraph 1) On November 30, 1982 to summarize the scope and findings of this inspection.