Docket Nos. 50-361 50-362

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

Attention: Kenneth P. Baskin

Vice President, Nuclear

## Gentlemen:

Thank you for your letter dated August 1, 1984 from Mr. H. B. Ray, Vice President and Site Manager, San Onofice addressing our concern related to your assessment of the root cause of a violation as discussed in our letter of July 25, 1984.

Although our July 25, 1984 letter was not specifically referenced, Mr. Ray's letter adequately responds to our request.

Thank you for your cooperation in this matter. We will examine your corrective actions during a subsequent inspection.

Sincerely,

11 Signed 11

Ross A. Scarano, Director Division of Radiological Safety and Safeguards Programs

bcc: RSB/Document Control Desk (RIDS)

Distributed by RV: Mr. Martin, RV State of CA

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HAROLD B. RAY VICE PREBIDENT & BITE MANAGER SAN CHOPRE

August 1, 1984

TELEPHONE 714-361-8470

U.S. Nuclear Regulatory Commission Office of Inspection and Enforcement Region V 1450 Maria Lane, Suite 210 Walnut Creek, California 94596-5368

Attention: Mr. J. B. Martin, Regional Administrator.

Dear Sir:

Subject: Docket Nos. 50-361 and 50-362

IE Inspection Reports 50-361/84-14 and 50-362/84-14

Review of NRC Observations

San Onofre Nuclear Generating Station, Units 2 and 3

Reference: Letter, "Response to Notice of Violation," K. P. Baskin (SCE)

to J. B. Martin (NRC), dated June 25, 1984

Mr. R. A. Scarano's letter of May 25, 1984, issued the subject IE Inspection Reports and forwarded a Notice of Violation resulting from the May 6 and 7, 1984, special inspection conducted by Mr. G. P. Yuhas. The referenced letter provided our response to the Notice of Violation.

The purpose of this letter is to more fully respond to the inspector's observations concerning activities associated with the event. We have reviewed the observations in the context of Mr. Scarano's forwarding letter with respect to generic corrective actions.

The May 5, 1984 Unusual Event, and observations identified in the subject report, are of generic importance because they represent opportunities to\_ identify where management attention may result in significant improvements in plant performance and compliance. Following a careful evaluation, actions have been taken as described below. A number of these actions were already underway and are also noted in the subject inspection reports or the reference response.

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Unit 3 has experienced a higher level of Reactor Coolant System radioactivity than Unit 2. As a result, we had identified a number of circumstances (e.g., minor leakage from the Radioactive Waste Gas System during system manipulations) where airborne radioactivity levels could become significant, relative to various action requirements. We had monitored these developments carefully and had initiated action to revise designs and modify operating and maintenance approaches. In the case of the May 5, 1984 Unusual Event, however, we had not adequately forecasted the circumstances which then existed such that the Shift Superintendent, and other personnel on shift, were promptly led to make the Unusual Event declaration.

Actions which were already underway or that have now been taken are described below.

- Increasing alarm setpoints to more appropriate values allowed by the Technical Specifications, thereby eliminating unnecessary and distracting alarms was already being planned. We expedited our review of the effluent alarm setpoints and several monitor setpoints, including the wide range gas monitor 2 and 3 RE-7865, have now been raised to more appropriate values.
- 2. Training to ensure Operators are especially knowledgeable of effluent alarms to be expected during minor operating events and releases as a result of the increased level of Reactor Coolant System radioactivity is being provided. We have completed initial Operator training in this area and will include additional training on monitor alarm setpoints in the 1984-1985 Operator Requalification Program (ORP).
- 3. Significant resources were directed to maintaining the operability of effluent monitors and recorders to maximize the effluent assessment information available to the Operators. We increased our efforts to improve monitor availability and are also proceeding with the procurement of more reliable recorders.
- 4. Special Operator training classes devoted to full understanding of the release paths, effluent monitor performance, and special considerations such as the "streaming effect" in the common plenum are being provided. We have discussed the "streaming effect" in shift briefings and will include additional training on effluent pathways and monitor performance in 1984-1985 ORP.
- 5. Operator sensitivity and awareness of the effluent and radiation monitor readings during shift turnover and during unplanned releases is being enhanced. We have conducted shift briefings on the importance of these alarms. Operators are documenting any radiation monitors in alarm on shift turnover sheets and significant background radiation level changes will be noted on the common operator log, common operator turnover sheet, and brought to the Control Room Supervisor's attention.

- Station emergency and operating procedures are being validated to ensure 6. clarity in responding to abnormal conditions or monitor readings expected during these circumstances. We have revised several procedures to further clarify the conditions under which prompt declaration of an emergency is required.
- Equipment and instrumentation is being reviewed to ensure against 7. conflicting information, such as the plant computer and the corresponding radiation monitor having different alarm values. We are reviewing these problems and will complete an assessment by October 12, 1984.

Involvement of management is essential in controlling and anticipating plant performance, ensuring personnel sensitivity to system interactions, and in requiring alerthess and attention to detail. This involvement is being promoted at San Onofre in a number of specific ways, and we believe it is producing positive and effective results.

If you require any additional information, please so advise.

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Enclosure

Marold B. Ray cc: A. E. Chaffee (USNRC Resident Inspector, Units 1, 2, and 3) J. P. Stewart (USNRC Resident Inspector, Units 2 and 3)

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Docket Nos. 50-361 50-362

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

Attention: Kenneth P. Baskin Vice President, Nuclear

Gentlemen:

In view of the frequent reported releases of radioactive material from your facility, we conducted a special inspection of the airborne release that occurred on May 5, 1984. We transmitted a thorough report of our findings to you on May 25, 1984 and requested that in your response to the Notice of Violation you determine the root cause of the incident and your proposed corrective action.

In your response dated June 25, 1984, you stated that you believe the root cause was an isolated deficiency in the Radiation Monitor 2/3 RE 7808 alarm response procedure. We do not believe that this assessment is satisfactory. It fails to recognize several contributing factors as outlined in our inspector's exit interview and described in the inspection report; nor does it evidence any attempt on your part to look for other possible contributing problems. We feel strongly that introspective assessments of incidents are extremely important because identified causal weaknesses may be operative in other areas of plant operation.

This matter was discussed by our Regional Administrator, Mr. J. B. Martin with your Mr. Harold Ray on July 24, 1984. In that conversation, Mr. Lay agreed to reassess the May 5, 1984 incident and to submit the results of this reassessment to the Region V office of NRC. We request that you submit your reassessment within thirty days of the date of this letter.

Sincerely,

CC:

Mr. Martin; State of CA

bcc:

RSB/Document Control Desk (RIDS) pink/green/docket file copies

resident Inspector Joan Zollicoffer

RV Yuhas:rc 07/25/84 Wenslawski 07/24/84

Scarano 07/5/84 Ross A Scarano, Director
Division of Radiological Safety
and Safeguards Programs

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