UNITED STATES
NUCLEAR REGULATORY COMMISSION

In the Matter of	)	
	)	
Southern California Edison Company	)	Docket No. 50-362
San Onofre Nuclear Generating Station	)	License No. NPF-15
Unit 3	)	EA 84-34

ORDER IMPOSING CIVIL MONETARY PENALTY

I

Southern California Edison Company (the "licensee") is the holder of Facility Operating License No. NPF-15 (the "license") issued by the Nuclear Regulatory Commission (the "Commission") which authorizes the licensee to operate the San Onofre Nuclear Generating Station, Unit 3, in accordance with the conditions specified therein. The license was issued on November 15, 1982. The facility consists of a pressurized water reactor (PWR) located at the licensee's site at San Clemente, California.

II

A special inspection of the licensee's activities under the license was conducted during the period March 17 through March 29, 1984. As a result of this inspection, it appears that the licensee has not conducted its activities in full compliance with the conditions of its license. A written Notice of Violation and Proposed Imposition of Civil Penalty was served upon the licensee by letter dated May 16, 1984. The Notice states the nature of the violations, the requirements of the Commission that the licensee had violated, and the amount of civil penalty proposed for the violations. An answer dated June 15, 1984, and supplemented by letter dated August 13, 1984, to the Notice of Violation and Proposed Imposition of Civil Penalty was received from the licensee.

III

Upon consideration of Southern California Edison Company's response and the statements of fact, explanation, and argument contained therein, as set forth in the Appendix to this Order, the Director, Office of Inspection and Enforcement, has determined that the penalty proposed for the violations designated in the Notice of Violation and Proposed Imposition of Civil Penalty should be mitigated by 50% based upon the licensee's prompt and extensive corrective action, including initiatives to improve management and supervisory effectiveness.

IV

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (42 U.S.C. 2282, PL 96-295), and 10 CFR 2.205, IT IS HEREBY ORDERED THAT:

The licensee pay a civil penalty in the amount of One Hundred Twenty-five Thousand Dollars ($125,000) within thirty days of the date of this Order, by check, draft, or money order, payable to the Treasurer of the United States and mailed to the Director of the Office of Inspection and Enforcement, USNRC, Washington, D.C. 20555.

V

The licensee may, within thirty days of the date of this Order, request a hearing. A request for a hearing shall be addressed to the Director, Office

of Inspection and Enforcement. A copy of the hearing request shall also be sent to the Executive Legal Director, USNRC, Washington, D.C. 20555. If a hearing is requested, the Commission will issue an Order designating the time and place of hearing. Upon failure of the licensee to request a hearing within thirty days of the date of this Order, the provisions of this Order shall be effective without further proceedings and, if payment has not been made by that time, the matter may be referred to the Attorney General for collection.

In the event the licensee requests a hearing as provided above, the issues to be considered at such hearing shall be:

(a) whether the licensee was in violation of the Commission's requirements as set forth in the Notice of Violation and Proposed Imposition of Civil Penalty referenced in Section II above; and

(b) whether on the basis of such violation, this Order should be sustained.

FOR THE NUCLEAR REGULATORY COMMISSION

RC DeYoung

Richard C. DeYoung, Director
Office of Inspection and Enforcement

Dated at Bethesda, Maryland
this 14th day of September 1984

APPENDIX

EVALUATION AND CONCLUSIONS

On May 16, 1984 the NRC issued a Notice of Violation and Proposed Imposition of Civil Penalty (NOV) to Southern California Edison Company (SCE) for violations identified at the San Onofre Nuclear Generating Station Unit 3. Southern California Edison Company's responses to the Notice, dated June 15, 1984 and August 13, 1984, have been reviewed by the staff.

SCE admits the violations cited in the Notice of Violation. However, the licensee contends that the violation not assessed a civil penalty should not be considered an independent violation from the violations assessed a civil penalty and, therefore, should be withdrawn. In addition, the licensee objects to the proposed civil penalty and requests that it be remitted. The licensee's assertions and the NRC's evaluations and conclusions follow.

LICENSEE'S OBJECTION AND REQUEST FOR REMISSION OF CIVIL PENALTY

The licensee sets forth several assertions as the basis for the request for remission of the civil penalty proposed in the NOV. Notwithstanding that during the Enforcement Conference on May 7, 1984 and in the letter transmitting the NOV the NRC Regional Administrator's primary focus was on the need for improvement in management, the licensee's response dated June 15, 1984 seemed to be directed toward the adequacy of administrative controls in the nature of the existing written procedures for controlling activities at the licensee's San Onofre facilities, with only a reference to a document given to the Senior Resident Inspector concerning steps to improve individual management and supervisory effectiveness. Although inadequacies in the licensee's procedures involving administrative controls were identified during our evaluation of the violations, the NRC is primarily concerned with the overall management controls at San Onofre. No matter how excellent written procedures may be, management must be involved in the day-to-day work activities to assure that personnel using the procedures are properly trained and supervised so that everyone in the organization understands management's attitude and commitment to safe operations and compliance with regulatory requirements.

To ensure that the licensee fully understood the NRC's main concerns related to the effectiveness of management personnel responsible for the operation of the nuclear facility, the Director, Office of Inspection and Enforcement, the Regional Administrator, and other members of the NRC staff met with the Chairman of the Board and Chief Executive Officer, the President, and other responsible managers of the licensee on August 8, 1984. The licensee explained that the Regional Administrator's primary focus at the meeting on May 7, 1984 had not gone unheeded and set forth actions that had been taken to improve management. These actions were further described in its supplemental response dated August 13, 1984.

The licensee's assertions in its June 15 response appear to result from a misunderstanding of the terms "management controls." This was resolved by the August 8, 1984 meeting. However, these assertions are discussed below for the record.

Licensee Assertion 1

The NRC letter from J. B. Martin to D. J. Fogarty dated May 16, 1984 does not accurately or fairly characterize the adequacy of the licensee's management and administrative controls. It concludes that inadequate controls contributed substantially as an underlying cause of the inoperability of the San Onofre Unit 3 Containment Spray System (CSS) when Unit 3 entered Mode 3 on March 4, 1984. Inoperability of the Unit 3 CSS was not caused by inadequate administrative controls. Inoperability of the Unit 3 CSS was caused by an individual personnel error in the development of the checklist to be utilized to verify proper system alignment of the CSS prior to entering Mode 3 on March 4, 1984. No administrative control program can completely eliminate individual personnel errors; it can only serve to:

1. minimize the possibility of an error by providing for activities to be performed in documented, reviewed methods by properly trained and qualified individuals, and

2. promptly detect any error by independent verification, check or review of activities.

NRC Evaluation

Inoperability of the Unit 3 CSS was caused by inadequate administrative controls. The NRC staff agrees that personnel error was a strong contributor. As pointed out in licensee assertion 5, the licensee's administrative controls allowed a trained and qualified individual to develop a checklist (differing from that in the standard operating procedure) without requiring an independent review or check to minimize the possibility of error in the checklist. This violates the two fundamental objectives upon which the licensee's administrative control program is based, as stated above. Had an independent check of the qualified individual's work in developing the checklist been required and performed, the individual's error would likely have been identified and the violation of NRC requirements because of personnel error could have been avoided.

Conclusion

The licensee's administrative controls were not adequate in that procedures allowed one individual to develop and implement a checklist (differing from that in the standard operating procedures) to realign the containment spray system without requiring an independent review or verification of the checklist for adequacy and correctness.

Licensee Assertion 2

The NRC letter indicated that two additional recent events, the unplanned operation of the Unit 2 CSS and the failure to reconnect electrical leads on the Unit 3 Plant Protection System following surveillance testing, were the result of failure of licensee's management control system. These two events

are also each the result of individual personnel errors. The fact that the events were recognized, corrected, and reported as soon as they were, in the absence of procedural improvements, rather than remaining undetected for considerably longer periods of time as has occurred at other facilities, reflects positively on the licensee's personnel's diligence in the performance of their duties.

NRC Evaluation

A management control system is those measures established to assure that activities important to nuclear safety are conducted and performed properly. A management control system certainly includes, but is not necessarily limited to, administrative control, training, and supervision. Although procedural improvements shown to be necessary or desirable by initial performance of a procedure or an evolution may not be evidence of inadequate administrative controls, the circumstances associated with the events cited above did evidence an inadequate management control system in that personnel apparently had not received adequate training. In addition, supervision was not appropriately required during the times the activities were performed to assure that weaknesses in the procedures were identified. In the events cited above, had the individuals performing the activity received the appropriate training and had supervision been more involved, the probability of the events occurring would have been less. The fact that the events were repetitive in nature further demonstrates the need for procedural improvements as well as the need for increased management involvement.

NRC Conclusion

The causes were the result of weaknesses in the licensee's management control system.

Licensee Assertion 3

Similarly, improvement in management and administrative controls is not accurately or fairly characterized in the NRC letter which indicated that such controls have not improved as expected over the past year based on evaluation of NRC enforcement actions since January 1983.

Startup periods necessarily represent periods in which new programs and controls (as well as systems and equipment) are exercised and improvements and refinements are sought and implemented. The fact that events during this startup period revealed areas where improvements in administrative control were warranted should not be viewed as evidence that such control has not improved. The fact that corrective actions from these events have prevented recurrence, and that the March 4, 1984 Unit 3 CSS inoperability could not have reasonably been prevented by corrective actions indicated by past events, demonstrates that administrative controls have, in fact, been improved.

Review of NRC enforcement actions against Units 2 and 3 since January 1983, identified as the basis for the NRC conclusion that the licensee's controls have not improved as expected, reveals the fact that enforcement actions have, in fact, been reduced. During each of the two most recent six-month periods (January 1984 - June 1984 and July 1983 - December 1983) items of noncompliance have numbered two or three per six-month period as compared with nine in the prior

six-month period (January 1983 - June 1983) and ten in the next prior six-month period (July 1982 - December 1982). Therefore, on the basis of NRC enforcement actions alone, administrative controls have dramatically improved.

The NRC letter identifies inadequate procedures, failure to follow procedures, and inadequate operator knowledge of regulatory requirements and systems status as being the apparent causes of most violations during the past year. Such causes, so broadly stated, are fundamental to nearly all activities at a nuclear generating station. Therefore, nearly any error could be characterized as resulting from one or more of these causes, regardless of the adequacy of administrative controls. The conclusion that administrative controls are inadequate or unimproved on the basis that these broadly stated causes still result in error is not appropriate.

NRC Evaluation

The NRC Notice of Violation and Proposed Imposition of Civil Penalty dated December 8, 1983 concerning the inoperability of portions of the emergency core cooling system involved the development of a valve lineup checklist by engineering personnel that was not appropriately reviewed and approved prior to implementation by the operations staff. There, as in this case, the status of the plant safety systems was affected without the benefit of a formal documented second review or check by qualified individuals.

The NRC Notice of Violation and Proposed Imposition of Civil Penalty dated March 23, 1983 included violations not assessed civil penalties that involved violations of regulatory requirements designed to assure that temporary changes to systems and procedures are appropriately reviewed and approved.

After each of these events the licensee developed corrective actions that, if properly implemented, appeared adequate to provide additional assurance that the safe operation of the facility would be accomplished in accordance with approved written procedures; and that when changes were made, the changes would be appropriately reviewed, approved and documented.

The number of enforcement actions has not decreased to the degree expected by the NRC, especially in regard to enforcement actions involving the inoperability of ECCS equipment. As evidenced by the stated violation, the controls in place apparently have not improved sufficiently to prevent violations in this area. Thus, corrective actions taken by the licensee were not adequate with regard to both administrative and management controls.

NRC Conclusion

The corrective action in response to the two NRC Notices of Violations and proposed imposition of civil penalties discussed above should have resulted in significant management action to assure that operations involving nuclear safety were accomplished pursuant to approved procedures as prescribed in the Technical Specifications and that personnel involved in these operations understood that a single individual does not have the authority to change a procedure without proper approval.

Licensee Assertion 4

The NRC letter indicates that on at least two occasions on March 2, 1984, there were opportunities for operating personnel to detect isolation of the Unit 3 CSS prior to entering Mode 3 on March 4, 1984. Review of circumstances surrounding each of the evolutions characterized as opportunities reveals that opportunity existed only as a hypothetical possibility and not as a consequence of activities performed in response to procedural or regulatory requirements.

NRC Evaluation

The NRC staff agrees that the opportunities to detect the misposition of the valves did not exist as a consequence of activities performed in response to procedural or regulatory requirements. However, the NRC staff believes that trained, qualified, and properly supervised operations personnel should always be alert to the available instrumentation to monitor operability of equipment and/or abnormal conditions. In this case, the flow-rate meter did not indicate flow and was not checked. In addition, from a practical standpoint, whether equipment is being operated for technical specification compliance or for some other function, it is prudent to monitor system parameters to prevent damaging equipment.

The valve positions verified in the monthly surveillance check are the minimum number acceptable. In performing the walk-down of these valves, the opportunity exists to identify other potentially mispositioned valves that could affect the operability of the systems. The intent of the surveillance should be to ensure that the system is aligned for proper operation, not just to satisfy procedural or regulatory requirements.

NRC Conclusion

Opportunities did exist for reasonable licensee personnel to detect the mispositioned valves between March 4, 1984 and March 17, 1984.

Licensee Assertion 5

Administrative Procedure SO23-0-35, which allowed operations personnel to specify the performance of a portion of a valve alignment checklist prescribed by procedure, was not in violation of Technical Specification 6.8.3 as indicated in the NRC letter and the associated Inspection Report.

Neither regulatory guidance nor the licensee's Technical Specifications require the omission of procedural steps, considered not applicable by an individual authorized and qualified to perform the procedure, to be considered to be a procedure change. Consequently the licensee's administrative controls:

1. permit the identification of procedural steps which are not applicable to a desired procedural evolution,

2. do not require their treatment as procedural changes, and

3. do permit the designation of partial checklists which are not treated as procedural changes.

The licensee's review of administrative controls at several other nuclear power stations revealed that they, too, do not treat authorized procedural step omission or designation of partial checklists as procedure changes. Therefore, although the partial checklist developed and implemented on March 2, 1984 was not properly developed or adequately reviewed, its development and execution did not violate Technical Specification 6.8.3.

NRC Evaluation

The contention that an omission of a portion of an approved procedure required by the facility technical specifications does not constitute "change" if authorized by an individual who holds an NRC Senior Operator's License is without merit.

First, as normally used, the word "change" means to alter, modify, vary or to make different in some particular. Consequently, if a portion of a procedure is omitted, the procedure has been altered and modified to vary from and be different from the original and, therefore, is changed.

Second, the NRC staff recognizes that, on occasion, a need may arise that necessitates an immediate change to a procedure required for the safe operation of the facility. To provide for this contingency, the facility technical specifications permit such changes, provided the change is reviewed and approved by two members of the plant management staff, one of whom is a licensed senior reactor operator, the intent of the procedure is not altered, and a subsequent review by responsible management is performed. These requirements are not only fundamental to quality assurance for operation of a nuclear power plant, but seem to represent only common sense for assuring things are performed properly, i.e., someone does the work, someone checks the work, and then the product of the work is used in the prescribed manner. The NRC does not condone the omission of procedure steps as identified at the San Onofre facility.

Finally, the three Notices of Violation accompanying Notices of Proposed Imposition of Civil Penalties sent to the licensee involving operations of San Onofre Nuclear Generating Stations Units Nos. 2 and 3 during 1983 and 1984 involved the issues of adherence to approved written procedures that were required to perform licensed activities. The regulatory requirements mandating the activities that must be performed in accordance with licensee approved written procedures, and the method whereby changes to such procedures may be made, are clear and appropriately defined.

NRC Conclusion

Omissions of steps from an approved procedure constitute changes in the procedure and must be made in accordance with the provisions of Technical Specification 6.8.3.

Licensee Assertion 6

Factors influencing the magnitude of proposed civil penalties, as established in 10 CFR Part 2, Appendix C, as revised, March 8, 1984, have not been properly assessed.

Clearly, the identified violation was neither willful nor a flagrant NRC-identified violation. CSS inoperability at Unit 3 on March 4, 1984, is not repeated poor performance in an area of concern.

Also, the March 4, 1984 Unit 3 CSS inoperability does not represent a serious breakdown in management controls. The event represents an individual personnel error which does not warrant a conclusion that management controls are inadequate.

The conditions which give cause for the NRC to apply its full enforcement authority are not present in these circumstances and, therefore, calculation of a civil penalty on a per day basis is inappropriate.

A review of past enforcement actions taken by the NRC for similar violations confirms the conclusion that a civil penalty should not be assessed on a per day basis at San Onofre. At Alabama Power Company's Farley Unit 2 Station, the CSS remained valved out for as long as 17 months during which time the reactor was in Modes 1 through 4, based on misinterpretation of valve position. At Consolidated Edison's Indian Point 2 Station, the CSS remained valved out for 36 days while the reactor was made critical five times, based on erroneous initial and independent verification of valve position by two different operators. Enforcement actions at neither Farley nor Indian Point 2 were assessed on a per day basis.

NRC Evaluation

As previously discussed, the NRC has proposed imposition of civil penalties on two occasions in 1983 for the licensee's failure to properly control activities affecting engineered safeguards systems. The apparent underlying cause of these violations, and of the violations under consideration, was inadequate management control of operating activities. To emphasize the concern the NRC places upon these violations, and the apparent cause, the use of daily civil penalties was warranted.

As previously mentioned, a daily civil penalty was proposed at San Onofre because this was the third recent violation at San Onofre in which the apparent underlying cause involved inadequate management controls and the second violation involving containment cooling systems since the beginning of 1983. The other cases had neither a similar enforcement history nor a significant lack of management control in the violation.

NRC Conclusion

Use of NRC enforcement authority was appropriate in this case.

Licensee Assertion 7

10 CFR 2, Appendix C, Section V.B.1, provides for a reduction of up to 50% of the base civil penalty when a licensee identifies the violation and promptly reports the violation to the NRC. In addition, 10 CFR Part 2, Appendix C, Section V.B.2 states, "unusually prompt and extensive corrective action may also result in reducing the proposed civil penalty as much as 50% of the base

value." No reference is made in the Notice of Violation to our prompt reporting, immediate corrective actions, or subsequently developed extensive and effective corrective action.

NRC Evaluation

Although NRC was aware that the licensee was initiating some action to improve the effectiveness of the management and supervisory personnel responsible for operating the nuclear facilities, the full extent of those actions was not fully appreciated until the August 8, 1984 meeting between the NRC and the licensee. The licensee's actions were subsequently set forth in the licensee's supplemental response to the Notice of Violation and Imposition of Civil Penalty dated August 13, 1984.

Conclusion

The licensee's prompt and extensive corrective actions, including the initiatives to improve the effectiveness of the management and supervisory personnel responsible for operating the nuclear facilities warrant mitigation of the proposed civil penalty by 50%.

LICENSEE REQUEST FOR WITHDRAWAL OF VIOLATION II

SCE admits that on March 15, 1984, at approximately 0421, the train B diesel generator was made inoperable (placed in maintenance lockout) while both trains of the CSS were inoperable as described in Item A, above. However, SCE contends this citation should not be considered an independent violation from Item A and should, therefore, be withdrawn. During the period March 15 to March 16, when the condition described above occurred, SCE was not aware, nor was sufficient information available as a consequence of activities performed in response to procedural or regulatory requirements, such that SCE should have been aware of the inoperability of the CSS. Had SCE been aware of the inoperability of the CSS, SCE would have immediately restored the system to operable status, as demonstrated by operator action on March 17 when the condition was discovered, and what has been identified as a separate violation would not have occurred.

Prior to removing Train B Diesel Generator from service at 0421 on March 15, 1984, operators reviewed equipment control records of inoperable equipment to assure all required systems, subsystems, trains, components, and devices that depend on the Train A Diesel were operable. The review did not identify the CSS as being inoperable.

NRC Evaluation

The NRC recognized that the violation was a consequence of not having the CSS operable, but because of the safety significance of the violation, the violation was cited separately without a civil penalty. Under the circumstances of this case, the NRC has concluded that the violation should be withdrawn. However, this action should not be read as a diminished NRC concern with the underlying cause of the inoperability.

NRC Conclusion

The subject violation is withdrawn.

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