SOUTHERN CALIFORNIA EDISON
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U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Gentlemen:

Subject: Docket Nos. 50-361 and 50-362
Reply to Notices of Violation 9615-01 and 9617-01
San Onofre Nuclear Generating Station, Units 2 and 3

References: (1) Letter from Mr. J. E. Dyer (USNRC:RIV) to Mr. Harold B. Ray (SCE), dated December 17, 1996 (Inspection Report 50-361/362 96-15)

(2) Letter from Mr. T. P. Gwynn (USNRC:RIV) to Mr. Harold B. Ray (SCE), dated December 16, 1996 (Inspection Report 50-361/362 96-17)

Reference 1 transmitted the results of NRC Inspection Report No. 50-361/96-15 and 50-362/96-15, and included a Notice of Violation (NOV) for operators failing to correctly align a Unit 3 volume control tank inlet diversion valve (3LV0227A) handswitch. Reference 2 transmitted the results of NRC Inspection Report No. 50-361/96-17 and 50-362/96-17, and included a Notice of Violation for operators failing to properly verify the closure of a Unit 3 reactor coolant vent gas system orifice gate valve (3MU995).

Because both violations involved the failure of operators to ensure the correct position of valves and Edison believes both violations have similar root causes, a single response is being provided. To facilitate your review, Enclosures 1 and 2 provide the specific causes and corrective actions for the respective violations.

As discussed in a December 11, 1996, conference call with Region IV Management, Edison believes additional attention in this area is warranted, and has already focused additional management attention in this area, as described below:

Improvements to Ensure Correct Valve Position

Edison has undertaken several initiatives in response to the valve and component mispositioning events. As noted in Reference 1, our Nuclear Oversight Division (NOD) identified examples of valve and/or component mispositionings, and issued Corrective

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Action Request CAR-011-96 to Station Management to address the concern. Each respective Station Division has been required to respond to the individual specifics of the NOD report. However, since most of the events involved the Operations Division, Operations has already 1) evaluated their respective events, and 2) implemented a number of immediate corrective actions, discussed below. Additional long term corrective actions are being planned or implemented. The immediate corrective actions are:

1. Operations Management has provided interactive training to the operating crews on self-checking.

2. Operations Procedure SO23-0-4.1, "Professional Operator Development and Evaluation Program," outlines a set of fundamental good operating practices (GOP) and observable standards, which represent the attributes of operators who avoid mistakes, and effectively supervise. The Operations Manager is stressing his expectation that the GOPs be diligently followed in his discussions with the operators individually and at shift briefings.

3. Operators have been assigned required readings on the errors, and the GOPs and observable standards.

4. The appropriate level of disciplinary actions was taken for the personnel involved in the specific events. In addition, operators involved in the events were required to demonstrate to supervision expected implementation of the GOPs, prior to resuming full watchstation duties.

5. NOD has formed a team to perform a root cause and common cause analysis on component mispositioned events. The team will identify organizational, programmatic, and human performance issues related to these events, and recommend performance enhancements to lower operator error rate while positioning components. NOD expects to complete this effort by January 31, 1997.

Edison believes there was no safety significance associated with these valve/component mispositioning events. For Violation 1, the alignment of the 3LV0227A handswitch to the "Auto" position did not pose a challenge to safety systems. For Violation 2, because the item met all criteria for exclusion of pipe breaks, Edison believes this event had no safety significance.

Although Edison believes the component mispositioning events had no safety significance, we recognize the need for a higher level of performance in this area. We believe the above completed and planned actions will identify areas for needed improvement and appropriate corrective actions to address this concern.

In summary, we expect continued diligence on the part of our staff while performing their duties to ensure SONGS program and procedural requirements are met.

If you have any further questions, please contact me.

Sincerely,

Enclosures

cc: L. J. Callan, Regional Administrator, NRC Region IV
J. E. Dyer, Director, Division of Reactor Projects, NRC Region IV
K. E. Perkins Jr., Director, Walnut Creek Field Office, NRC Region IV
J. A. Sloan, NRC Resident Inspector, San Onofre Units 2 and 3
M. B. Fields, NRC Project Manager, San Onofre Units 2 and 3

ENCLOSURE 1

Mispositioned Letdown Valve Handswitch NOV Response

Reference 1 provided the results of NRC inspection (50-361/96-15 and 50-362/96-15) conducted by NRC Residents Messrs. Jim Sloan, John Russell, and David Solorio, from October 20, 1996, through November 30, 1996, at the San Onofre Nuclear Generating Station, Units 2 and 3. The enclosure to Reference 1 transmitted a Notice of Violation. This attachment provides Edison's reply to the subject Notice of Violation.

Violation

"Unit 3 Technical Specification 5.5.1.1.a states that 'Written procedures shall be established, implemented, and maintained covering the . . . applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978.' Regulatory Guide 1.33, Appendix A, Section 3, recommends, in part, procedures for the operation of the chemical and volume control system.

"Procedure SO123-O-23, Revision 1, Attachment 2, 'Abnormal Alignment/Evolution,' Log Number 3-96-34, directs in Step 2 to 'maintain 3LV0227A in 'Manual/VCT' except when diverting to radwaste.'

"Contrary to the above, on October 18, 1996, the NRC inspector identified that volume control tank inlet diversion Valve 3LV0227A was in 'auto' when no diversion to radwaste was in progress.

"This is a Severity Level IV violation (Supplement 1) applicable to Unit 3 (Violation 50-362/96015-01)."

Reasons For The Violation

The reason for the violation was personnel error and programmatic weakness.

On the morning of October 18, 1996, the night shift performed a Technical Specification required Reactor Coolant System (RCS) Leak Rate test (SO23-3-3.37, "Reactor Coolant System Water Inventory Balance," Attachment 1, "Leak Rate Calculation"), which required the level in the Volume Control Tank (VCT) to be within a specific range prior to beginning the test. If the level of the VCT was outside the range, then the level was to be adjusted; in this case lowered. Abnormal Alignment 3-96-34, required VCT inlet diversion valve 3LV0227A's manual down stream isolation valve MU924 to be closed, and 3LV0227A's handswitch to be placed in the 'Manual/VCT' position, unless diverting RCS letdown to radwaste.

The abnormal alignment had been previously initiated because 3LV0227A leaked-by, and would allow a small amount of RCS letdown to divert to radwaste. With Abnormal Alignment 3-96-34 in place, the normal practice of lowering VCT level was to open MU924 and place 3LV0227A's handswitch in the "Auto/Radwaste" position. This alignment diverted RCS letdown to radwaste allowing VCT level to lower.

The operators properly aligned the system (opened MU924 and placed 3LV0227A's handswitch in the 'Auto/Radwaste' position) and diverted letdown to radwaste until an acceptable level in the VCT was achieved. When they realigned the system to perform the leak rate test, they properly closed S31901MU924 per the alignment requirements; however, they failed to place the handswitch for 3LV0227A back to "Manual/VCT" position as required by Abnormal Alignment 3-96-34. When the system was restored to its normal system line-up, the alignment requirements of Abnormal Alignment 3-96-34 should have been reviewed to ensure proper implementation. Also, it is believed this event would have been avoided if the abnormal alignment requirements had been incorporated into the procedure once it was recognized as a frequent (every 72 hours) challenge to the operators.

The night shift crew turned over to the day shift crew at approximately 0600, on October 18, 1996, and neither crew recognized the mispositioned handswitch for 3LV0227A. The duration of the misalignment, and the method of discovery, indicates that both crews involved were inadequate in their Control Board walk-downs. Control Room Operators are expected to perform thorough board walk-downs during turnovers, and the Assistant Control Room Operator (ACO) is expected to perform two additional walk-downs during the shift.

The failure to properly align 3LV0227A handswitch to the "Auto" position did not pose a challenge to plant safety systems. Operators do not normally rely on the automatic VCT water level control capability, and valve 3LV0227A would not normally shift position automatically without a plant transient causing an approximate eight degree elevation in RCS temperature, or a control system failure. Therefore, Edison believes there was no safety significance to this event.

Corrective Steps That Have Been Taken And The Results Achieved

The Control Operator who failed to place the handswitch for 3LV0227A in "Manual/VCT" was coached by Operations management on conformance with procedural requirements and rigid adherence to the Good Operating Practices.

Operations management reiterated to all Operations on-shift supervisors the necessity to perform thorough and timely control board walkdowns.

Corrective Steps That Will Be Taken To Avoid Further Violations

Abnormal alignment documents are now being evaluated by Operations to determine their possible impact to operators in following existing procedures. Those abnormal alignment documents that are determined to challenge operators will be incorporated into the appropriate existing procedures.

Date When Full Compliance Was Achieved

Full compliance was achieved on October 18, 1996, when the handswitch for 3LV0227A was returned to the "Manual/VCT" position.

ENCLOSURE 2

Failure To Close Reactor Head Vent NOV Response

Reference 2 provided the results of an NRC inspection (50-361/96-17 and 50-362/96-17) conducted by Messrs. Mike Runyan and Mel Fields from November 18-22, 1996, at the San Onofre Nuclear Generating Station, Units 2 and 3. The enclosure to Reference 2 transmitted a Notice of Violation. This attachment provides Edison's reply to the subject Notice of Violation.

Violation

"Unit 3 Technical Specification 6.8.1 stated, that, 'Written procedures shall be established, implemented, and maintained covering the activities . . . recommended in Appendix A of Regulatory Guide 1.33, Revision 2.' Regulatory Guide 1.33, Appendix A, Section 3, recommends, in part, procedures for filling and venting the reactor coolant system.

"Procedure SO23-3-1.4, Attachment 3, Temporary Change Notice 15-2, 'RCS Post Fill Valve Alignment,' states in Step 1.3 that 'All unbracketed steps will be performed now . . . unbracketed steps may be marked 'N/A' after verifying completion during the previous fill.'

"Contrary to the above, on September 12, 1995, a senior control operator, directed unbracketed steps to be marked 'N/A' without verifying completion of these steps during the previous fill. The unbracketed steps were marked 'N/A,' causing Unit 3 valve S31201MU995, reactor coolant gas vent system orifice gate valve, required to be locked closed in Modes 1 through 4, to be left open for approximately 1 year while Unit 3 was operated in Mode 1."

"This is a Severity Level IV violation (Supplement 1) (50-362/9617-01)."

Reasons For The Violation

The misposition was caused by personnel error in the incorrect completion of the Reactor Coolant System (RCS) post-fill valve alignment procedure. Operations procedure SO23-3-1.4, "Filling and Venting The Reactor Coolant System," Attachment 3, step 2.1.3, requires the operator to verify the locked closed position of S31201MU995. The operator marks N/A in this step if he verifies this was accomplished during a previous RCS fill. In this case, the operator marked N/A without properly verifying the valve was closed during the previous RCS fill evolution.

Because the item met all criteria for exclusion of pipe breaks, Edison believes this event had no safety significance.

Corrective Steps That Have Been Taken And The Results Achieved

As an immediate corrective action, Edison confirmed by a review of plant records that the corresponding Unit 2 head vent valve MU995 was closed. The following Unit 3 safety significant systems were walked down outside of containment to ensure proper valve alignment: High Pressure Safety Injection (HPSI); Low Pressure Safety Injection (LPSI); Containment Spray; Auxiliary Feedwater (AFW); and, Component Cooling Water (CCW). No misalignments were identified.

Edison took appropriate disciplinary action with the senior control operator involved in this event. Additionally, a pre-shift briefing was provided to all operators on the misalignment and its root cause. An Action Request (AR 960901287) was generated to document this incident. The AR included an Event Report (ER) which evaluated this event, determined the cause, and recommended appropriate corrective actions.

Operations procedure SO123-0-20, "Use of Procedures," was revised such that when multiple steps, or entire sections are to be marked 'N/A' or left blank, the decision to not perform the steps is to be reviewed by a second Operations supervisor. Also, Operations procedure SO23-3-2.34, "Containment Access Control, Inspections and Airlocks Operation," was revised to include a new Attachment 13, "Containment Close-out Critical Valve Verification," to be performed at the end of refueling outages. This procedural revision provides for an independent verification to ensure important containment valves with no remote position indication are properly aligned.

Corrective Steps That Will Be Taken To Avoid Further Violations

Per the AR 960901287 Event Report recommendations, Edison is reviewing major alignment procedures to ensure that suitable second-checking of alignment decisions is implemented. This will be accomplished by February 28, 1997.

Date When Full Compliance Was Achieved

Full compliance was achieved on September 25, 1996, when Unit 3 reached Mode 5, and the reactor head vent system was no longer required to be in service per Licensee Controlled Specification 3.4.102 requirements.