

November 12, 1999

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

**Subject: Docket Nos. 50-361 and 50-362
Response to An Apparent Violation in Inspection Report No.
50-361/99-12; 50-362/99-12
San Onofre Nuclear Generating Station, Units 2 and 3**

Reference: Letter, Mr. Ken E. Brockman (USNRC) to Mr. Harold B. Ray
(SCE), dated October 15, 1999

Gentlemen:

The Reference letter transmitted the results of NRC Inspection Report No. 50-361/99-12 and 50-362/99-12, conducted August 8 through September 18, 1999, at Southern California Edison's (SCE), San Onofre Nuclear Generating Station (SONGS), Units 2 and 3. The letter identified an apparent violation of Unit 3 Technical Specifications 3.8.1 and 3.0.3, that is being considered for escalated enforcement, and provided SCE the opportunity to either: 1) respond within 30 days, or 2) request a predecisional enforcement conference. On October 22, 1999, Mr. A. E. Scherer, SONGS' Manager of Nuclear Regulatory Affairs, contacted Ms. L. J. Smith, NRC Region IV, Division of Reactor Projects, Project Branch E, Acting Chief, and informed her that SCE did not request a predecisional enforcement conference and would respond within 30 days. The enclosure to this letter provides SCE's response to the violation.

The Reference letter requested SCE confirm on the license docket that the corrective actions previously described to the staff have been or are being taken. This will confirm that the corrective actions previously described have been completed.

The enclosure also provides our perspective of the regulatory significance of the apparent violation. Although SCE acknowledges the apparent violation occurred, SCE notes that SONGS never actually operated Unit 3 outside of the TS limiting conditions for operation. Specifically, the TS 3.8.1 violation occurred because SONGS failed to verify the operability of required offsite electrical sources; the required sources were in fact operable throughout this event. The TS 3.0.3 violation occurred because SCE failed to administratively declare a battery charger inoperable. The battery charger was in fact available and functional throughout the event.

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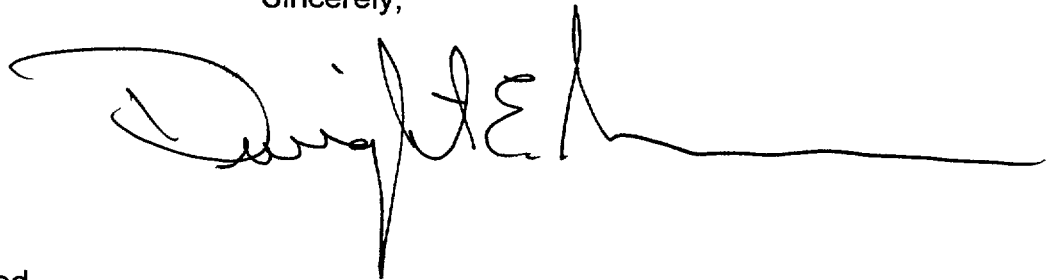
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As noted in Inspection Report 99-12, SCE evaluated the risk significance of this event, and determined the incremental risk increase was $7.4E-7$ for core damage, and $1.5E-8$ for large early release. Thus, this event was determined to be of very small risk significance. Based on our assessment, SCE concludes it would be appropriate to disposition this violation as a severity level IV violation. If the apparent violation is dispositioned as a severity level IV violation, it would appear to meet the criteria for a noncited level IV violation.

In any event, the inspection report noted that a civil penalty may not be warranted. SCE concurs with this conclusion.

If you have any further questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Douglas E. H.", with a long horizontal flourish extending to the right.

Enclosure: As stated

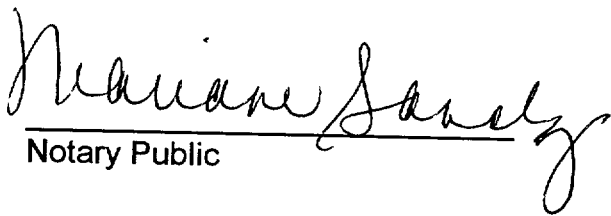
cc: E. W. Merschoff, Regional Administrator, NRC Region IV
L. J. Smith, Acting Chief, Branch E, Division of Reactor Projects
J. A. Sloan, NRC Senior Resident Inspector, San Onofre Units 2 and 3
L. M. Raghavan, NRC Project Manager, San Onofre Units 2 and 3

State of California
County of San Diego

Dwight E. Nunn, being duly sworn, hereby deposes and says that he is Vice President of Southern California Edison, San Onofre Nuclear Generating Station; that as such he is duly authorized to sign and file with the Nuclear Regulatory Commission the attached information concerning the response to an Apparent Violation; that he is familiar with the content thereof; and that the matters set forth therein are true and correct to the best of his knowledge, information, and belief.

By: 
Dwight E. Nunn
Vice President
Engineering and Technical Services

Subscribed and sworn before me this 12th day of November 1999


Notary Public



A. RESPONSE TO APPARENT VIOLATION

APPARENT VIOLATION

The enclosure to Mr. K. E. Brockman's letter dated October 15, 1999, states, in part:

"An apparent violation of Technical Specifications 3.0.3 and 3.8.1 occurred because operators did not recognize that they had aligned Emergency Diesel Generator 3G003 to an inoperable automatic voltage regulator. Subsequently, when the opposite-train battery charger was taken out of service, the Technical Specifications required that the same-train battery charger be declared inoperable. Because these conditions were not recognized, the operators did not perform the Technical Specification-required actions for the inoperable emergency diesel generator or for the two inoperable battery chargers, which included shutting down Unit 3. The program to control equipment status was inadequate in that it failed to prevent the alignment of the emergency diesel generator to the inoperable automatic voltage regulator, which was known to perform erratically. Additionally, operators on several shifts failed to observe the control board indication of the inappropriate alignment (EA 99-242)."

SCE accepts the apparent violation.

1. Reason for the Violation

The root cause of the apparent violation was an inadequate equipment status control program. Procedure SO123-0-13, "Technical Specification LCO Action Requirements (LCOAR) and Equipment Deficiency Mode Restraints (EDMR)," was deficient in that it did not require placing an information and/or warning tag at equipment control locations outside of the Control Room. There was no information available at the Emergency Diesel Generator (EDG) 3G003 local control panel, where the automatic voltage regulator (AVR) circuit selector switch is located, to warn operators that AVR "B" was inoperable. As a result, a Plant Equipment Operator, in following the procedure for a return-to-service test and at the direction of a Control Operator (CO), unknowingly aligned EDG 3G003 to an inoperable AVR, thus rendering EDG 3G003 inoperable.

A contributing cause to the apparent violation was that Control Room Operators were not adequately knowledgeable of equipment status and did not recognize the condition of AVR "B" during routine board monitoring. The CO who directed placing AVR "B" in-service was not cognizant of the condition of AVR "B," and several Control Room Operators failed to recognize the improper condition during subsequent shift turnover control board walkdowns.

2. Corrective Actions Taken and the Results Achieved

The following corrective actions have been implemented:

On June 25, 1999, the Unit 3 Control Room Supervisor identified that EDG 3G003 was aligned to an inoperable AVR. Operators realigned EDG 3G003 to the operable AVR "A," and performed the monthly surveillance test, thus restoring EDG 3G003 to an operable condition.

A "Caution Tag" was placed on the local AVR selector switch to warn operators that AVR "B" was inoperable. Additionally, the EDMR tag on the control room board was revised to clearly state that AVR "B" was inoperable.

A board walkdown was conducted to ensure other tags clearly specified applicable restrictions.

The LCOAR/EDMR Procedure, SO123-0-13, Revision 8, was issued on September 28, 1999. The revised procedure directs operators to install equipment tags at both Control Room control boards, and at equipment local control points.

The event was discussed with Operators involved in the event.

An Operations' Pre-Shift Brief/Priority 2 reading (required reading for all operators) was generated on June 30, 1999, describing the event and the errors that occurred.

A formal presentation on this event was included in the Operator Training Requalification Program. All five Control Room Operating Crews have completed this training.

SO23-3-3.23, "Diesel Generator Monthly Test," was revised on October 1, 1999. The revised procedure no longer directs operators to switch AVRs, unless they are performing a scheduled surveillance test.

The LCOAR/EDMR program was enhanced such that LCOARs/EDMRs over 30 days old are reviewed to identify if any additional actions are needed to minimize potential challenges to Operators.

3. Corrective Actions That Will be Taken

There are no other planned corrective actions.

4. Date When Full Compliance Will be Achieved

Full compliance was achieved on June 25, 1999, when Operators realigned and tested EDG 3G003 with AVR "A," and returned EDG 3G003 to operable status.

B. LICENSEE PERSPECTIVE OF APPARENT VIOLATION

SCE reviewed the apparent violation against the criteria provided in NUREG-1600, Revision 1, "General Statement of Policy and Procedure for NRC Enforcement Actions." SCE concludes this event would be more appropriately dispositioned as a severity level IV violation based on the following: 1) the Technical Specification (TS) noncompliance appears to be more consistent with the severity level IV example provided in NUREG-1600, Revision 1, and 2) there was very small risk significance associated with this event.

APPLICATION OF NUREG-1600, REVISION 1

The apparent violation involved a failure to comply with the action statement for a TS Limiting Condition for Operation. NUREG-1600, Revision 1, Appendix B, Supplement I, includes this type of violation as an example of both a severity level III violation and a severity level IV violation, depending on the significance of the failure to comply:

Severity Level III Example

A significant failure to comply with the Action Statement for a Technical Limiting Condition for Operation where the appropriate action was not taken within the required time, such as:

- (a) In a pressurized water reactor, in the applicable modes, having one high-pressure safety injection pump inoperable for a period in excess of that allowed by the action statement.

Severity Level IV Example

A less significant failure to comply with the Action Statement for a Technical Specification Limiting Condition for Operation where the appropriate action was not taken within the required time, such as:

- (a) In a pressurized water reactor, a 5% deficiency in the required volume of the condensate storage tank.

Response To An Apparent Violation
In Inspection Report
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ENCLOSURE

SCE acknowledges the apparent violation occurred, and that SCE failed to comply with the applicable TS 3.8.1 and TS 3.0.3 action statements, after unknowingly causing EDG 3G003 to be inoperable. However, SCE notes that SONGS' Unit 3 was never actually operated outside of the TS limiting conditions for operation. Therefore, this event could be considered a less significant failure to comply with a TS action statement. The basis for this conclusion is described below:

SONGS' TS allow one inoperable EDG for up to 14 days. In this event, EDG 3G003 was inoperable for approximately 55 hours. The TS 3.8.1 violation occurred when operators failed to verify the operability of required offsite circuits after EDG 3G003 was unknowingly rendered inoperable. Although this verification was not performed within the required time frame, the offsite circuits were in fact operable throughout the event.

The TS 3.0.3 violation occurred when battery charger 3B001 was removed from service for planned maintenance. With EDG 3G003 inoperable and 3B001 removed from service, TS 3.8.1 required that battery charger 3B002 be declared inoperable. SONGS' TS allow only one inoperable battery charger. With two battery chargers inoperable (3B001 due to maintenance, and 3B002 administratively inoperable), SCE should have entered TS 3.0.3 but failed to do so. Although 3B002 should have been declared inoperable in accordance with TS 3.8.1, 3B002 was in fact functional and available to perform its intended safety function throughout the duration of the EDG 3G003 inoperability.

In addition, when 3B001 was removed from service for maintenance, a spare battery charger (non-1E power source) was placed in-service. Although this spare battery charger did not have a Class 1E power source, if necessary, it could have been manually realigned, by procedure, to 3B001's Class 1E power source before the battery was exhausted.

RISK ANALYSIS

SCE evaluated this event using a plant-specific Probabilistic Risk Analysis. As noted in LER 99-006 and Inspection Report 99-12, SCE determined that, for the period of time that Unit 3 should have entered TS 3.0.3 until the time that EDG 3G003 operability was restored, the incremental risk increase was $7.4E-7$ for core damage, and $1.5E-8$ for large early release. Thus, this event was determined to be of very small risk significance. As a result, this violation appears to meet the threshold for a severity level IV violation.

Based on the above, SCE concludes this violation should be dispositioned as a severity level IV violation. Since the violation was identified and corrected by SCE, the violation appears to meet the NRC Enforcement Policy criteria for a noncited level IV violation.