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 MARTIN, J. B. Region 5, Ofc of the Director

SUBJECT: Responds to NRC 871015 ltr re concerns noted during Sept
 insp of 870831 event. Corrective actions: training programs
 will be revised & Health Physics Procedure SO123-VII-9.9
 will be revised.

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November 6, 1987

HAROLD B. RAY
VICE PRESIDENT & SITE MANAGER
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TELEPHONE
714-368-9470

Mr. John B. Martin, Regional Administrator
U. S. Nuclear Regulatory Commission, Region V
1450 Maria Lane, Suite 210
Walnut Creek, CA 94596

Dear Mr. Martin:

Subject: Docket No. 50-361
San Onofre Nuclear Generating Station, Unit 2

Mr. F. A. Wenslawski's letter dated October 15, 1987, forwarded to us a report of a special inspection conducted at San Onofre in September. The letter identified a concern with certain plant procedures related to emergency conditions and the implementation of 10 CFR 50.54(x). It requested that we evaluate issues identified in the report and identify any actions that we will take. The purpose of this letter is to respond to this request.

The special inspection was directed at an event that occurred on August 31, 1987, which involved leakage of primary coolant due to failure in Mode 5 of the packing for valve 2HV-9378. Our report of this event is provided in Licensee Event Report (LER) No. 2-87-14. Revision 1 of the LER was submitted by letter dated October 26, 1987, and it indicated that a separate, informational LER would be provided to address the health physics aspects of the event. Preparation of that LER has been completed, and it is being submitted as LER No. 2-87-20.

In summary, we agree with the concern identified in Mr. Wenslawski's letter. The need to have clear, well understood requirements to ensure that radiation protection requirements are met is always important, but it is particularly so in circumstances where people are suddenly faced with unanticipated conditions and where prompt action is required. Our evaluation of the August 31 event has concluded that a number of changes are required in our programs and training.

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Mr.. John B. Martin

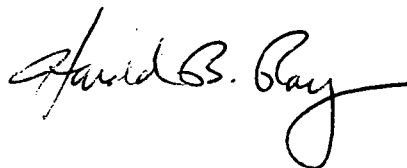
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November 6, 1987

Our response to the concern identified in Mr. Wenslawski's letter is provided as an attachment hereto. Additional information concerning our evaluation of the health physics aspects of the event may be found in LER No. 2-87-20.

If you have any questions or comments, or if you would like additional information, please let me know.

Sincerely,



HBR:bam

Attachment

cc: David J. Fogarty

Kenneth P. Baskin

Mr. F. R. Huey, USNRC Senior Resident Inspector, SONGS

Mr. F. A. Wenslawski, Region V

Attachment

RESPONSE TO NRC CONCERN

The following summarizes the SCE evaluation of the Health Physics (HP) actions and controls which were implemented in response to the packing leak which developed for valve 2HV-9378 on August 31, 1987. This summary is provided in response to the concern identified in Mr. Wenslawski's letter dated October 15, 1987, and additional information concerning the event is provided in LER Nos. 2-87-14 and 2-87-20.

With respect to the identified NRC concern, our evaluation consists of a number of findings and corrective actions, as follows:

Finding 1

No condition of emergency was declared by the Shift Superintendent as a result of the packing leak from 2HV-9378.

Problem

The HP Foreman believed he was authorized, under the circumstances as he understood them, to deviate from approved procedures in providing support to personnel who had been directed to take steps to reduce or stop the leak.

Discussion

As indicated in the NRC inspection report, provisions of plant procedures which authorize deviation from approved procedures in accordance with 10 CFR 50.54(x), in order to protect the public health and safety, were not implemented for this event. This was because there was no need for such deviation.

Nevertheless, as discussed in LER No. 2-87-20, the HP Foreman did deviate from the approved procedures. Although the radiological protection actions taken were appropriate under the circumstances, and they would have been the actions taken even if all provisions of the procedures had been followed, the HP Foreman had not been authorized to deviate from the approved procedures. Such unauthorized deviation is not acceptable and could result in a hazard, as noted in the inspection report.

Corrective Action

All training programs will be reviewed, and revised as necessary, to ensure that the circumstances under which personnel may be authorized to deviate from approved procedures, and the means of obtaining such authorization, are clearly addressed. In addition, this aspect of the August 31 event will be discussed in a special notice to all personnel who hold unescorted access to the Protected Area. This notice will be issued by November 13, 1987.

Finding 2

HP procedures are unclear, with respect to the intent of a provision which concerns deviations under certain circumstances.

Problem

As indicated in the NRC inspection report, there is a provision in HP procedure SO123-VII-9.9 that refers to deviations which are permitted under declared emergency conditions or HP Supervisor-approved special conditions. The scope of the deviations might be subject to misunderstanding.

Discussion

As discussed above, the event on August 31 did not involve any condition of declared emergency, and no special condition was approved by a HP Supervisor.

The context in the procedure for the reference to deviations was itself intended to limit the scope of the deviations. The reference appears in Subsection 6.1.1.2. Section 6.1.1 describes the process for an initiator to obtain a Radiation Exposure Permit (REP). Subsection 6.1.1.1 states that an REP must be requested at least 24 hours in advance of the need for its use. Subsection 6.1.1.2 gives the exception to this as follows:

"Deviations are permitted for Operations Shift Supervisor-declared emergency conditions or Health Physics Supervisor-approved special conditions.

NOTE: Health Physics will attempt to service late requests but timely requests will be given priority."

Hence, the intent of this provision in the procedure was not to provide for deviations from the HP Program generally, but only from the requirement to request an REP 24 hours in advance of the need for its use.

Corrective Action

Although the intent of the statement concerning deviations is limited by its context in the procedure, in order to ensure that it is not a source of misunderstanding, the statement will be revised to simply say that exceptions to the 24 hour requirement may be approved in certain specified circumstances.

Also, use of the term "emergency" in this subsection of the procedure is improper and was not intended to describe conditions referred to in 10 CFR 50.54(x) or in the Emergency Plan Implementing Procedures (EPIPs). Use in this case was generic, and such generic usage will be replaced with more precise terms wherever it appears in HP procedures.

These actions will be completed by December 31, 1987.

Finding 3

HP procedures should provide for actions to be taken in non-declared-emergency circumstances when non-shift HP supervision and management may not be immediately available to authorize expedited actions.

Problem

Existing procedures require approval above the level of HP shift supervision, in order to use defined, expedited procedural steps for issuance of an REP. Under certain circumstances, obtaining such approval may unnecessarily delay REP issuance.

Discussion

Subsection 1.1.1.4 of HP procedure SO123-VII-9.9 provides for expedited action as follows:

"For certain conditions where work must be performed in an expedient manner and pre-job surveys cannot be obtained in the time frame required (such as for SSAM or ALARA considerations, etc.) the following will apply."

One of the required steps is to obtain approval of the HP Manager or a HP Supervisor, including by phone if necessary. This was not done during the event on August 31.

Corrective Action

HP procedures will be revised by November 30, 1987, to include provisions for HP shift supervision to provide expedited support to plant activities, under specified circumstances. The requirements for providing such support will be defined in the procedures so that approval of higher levels of supervision and management prior to implementation will not be required.

Finding 4

In principle, the emergency conditions addressed by 10 CFR 50.54(x) could include conditions which do not result in declaration of an emergency under the EIPs.

Problem

The NRC inspection report indicated a concern in that the provisions of HP procedure SO123-VII-9.9 and Operations procedure SO123-O-1 recognize an emergency and authorize departure from established requirements without necessarily being in an emergency classification as defined by EPIP SO23-VIII-1.

Discussion

As discussed above, SO123-VII-9.9 used the term, emergency, in a generic sense, and the intended use was only with respect to the 24 hour requirement for REP issuance. This will be corrected.

SO123-O-1 uses the term, emergency, in the sense that it is used in 10 CFR 50.54(x). It is our understanding that the NRC does not intend the emergency conditions addressed by 10 CFR 50.54(x) to be limited to those which are addressed by EIPs. EIPs are prepared in response to 10 CFR 50, Appendix E, and related guidance, whereas 10 CFR 50.54(x) (and therefore SO123-O-1) are intended to address circumstances in which no action consistent with license conditions and technical specifications that can provide adequate protection to the public health and safety is immediately apparent.

With respect to the event on August 31, as discussed above and in the NRC inspection report, it was not an emergency defined either by SO123-O-1 or SO23-VIII-1. As regards HP procedure SO123-VII-9.9, the Shift Superintendent did not declare an emergency. If he had, the deviation permitted by the procedure was only with respect to the 24 hour REP requirement.

Corrective Action

We conclude that all personnel who may have to provide expedited support to unanticipated plant conditions should receive training which clarifies their authorities, duties and responsibilities and those of others who may be involved. Currently, such training is generally limited to conditions addressed by EIPs.

Because of the potentially broad scope of this needed training, and the possibility that some changes in procedures may also be required, an action plan and schedule will first be developed. This will be completed by December 31, 1987.

Finding 5

Telephone communication between the Shift Superintendent and the HP Foreman resulted in incorrect understanding of the direction provided.

Problem

The Shift Superintendent believed he was speaking on the telephone to a maintenance mechanic when he provided general direction to take the steps necessary to stop the packing leak. It appears that he was instead speaking to the HP Foreman who interpreted the direction as authorization to deviate from his approved procedures.

Discussion

The Shift Superintendent does not recall speaking to the HP Foreman, and he certainly did not declare an emergency or authorize deviation from HP procedures. He does recall having a telephone conversation with a person he thought to be the mechanic assigned to work on valve 2HV-9378. What would be appropriate direction to the mechanic to urgently take steps to stop the packing leak, was evidently provided to the HP Foreman in error. This led the foreman to believe he had direction that would permit him to deviate from his procedures.

Corrective Action

As discussed under Finding 1 above, this event will be formally reviewed with all personnel who hold unescorted access to the Protected Area. Mis-communication of this kind can lead to very serious consequences and must not occur. There is an established training program for Control Room operators which is designed to prevent this kind of error. This training for Control Room personnel will be enhanced to explicitly apply to their communications with others who may be outside the Control Room.