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SUBJECT: Responds to nonconformance condition noted in insp of facility.

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April 2, 1990

HAROLD B. RAY  
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714-458-4400

Mr. Dennis F. Kirsch, Chief  
Reactor Safety Branch  
U. S. Nuclear Regulatory Commission, Region V  
1450 Maria Lane, Suite 210  
Walnut Creek, California 94596-5368

Dear Mr. Kirsch:

Subject: **Docket No. 50-361**  
**Failure to Properly Identify Nonconforming Condition**  
**San Onofre Nuclear Generating Station, Unit 2**

During an NRC inspection conducted at San Onofre the week of March 19, 1990, by Mr. Clifford Clark, he identified and questioned the status of Southern California Edison (SCE) Nonconformance Report (NCR) 2R0139. The purpose of this letter is to summarize the results of our subsequent evaluation of the circumstances related to this NCR, as well as their implications for our policies and programs for identification and correction of nonconforming conditions.

1. The Nonconforming Condition On Unit 2

Valve 2HV9303 is a nominal 24-inch, motor-operated butterfly valve in the Safety Injection System which is installed in the recirculation suction line to the containment emergency sump. It is normally closed, located outside containment and fails as-is. Although it is identified as a containment isolation valve, it is not subject to leakrate testing because it is within a closed, Seismic Class I system outside containment, returning to the Reactor Coolant System.

Three taper pins are normally installed to secure the valve disc to the stem. These pins transfer in shear the valve operating forces from the stem to the disc. The nonconforming condition which exists is that only two taper pins are presently installed.

SCE has determined that operation with two taper pins, instead of three as intended, does not reduce the margin for operation of the valve. This is because in both cases the highest stress levels during operation, under normal and accident conditions, are in the valve stem itself and not in the

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taper pins. Also, the highest stress levels, which are developed when valve "break-away loads" are applied, are well below allowable limits with two taper pins in place.

2. Initial Identification of the Nonconforming Condition by Station Maintenance

In September 1989, while Unit 2 was shutdown for refueling, a check valve adjacent to 2HV9303 was disassembled for inservice inspection. A loose taper pin was discovered adrift inside the valve body and removed. This was documented on the Maintenance Order (MO) controlling the work on the check valve. Since the taper pin did not come from the check valve itself, maintenance personnel speculated that it had come from 2HV9303 or its companion butterfly valve located inside containment.

No NCR was created at this time to provide for assessment of the nonconforming condition represented by the loose taper pin. Based on an interview with the cognizant maintenance planner (now employed by another utility), it appears that he believed the NCR would be created by an engineer in Station Technical with whom he discussed the discovery. The engineer states that he does not now recall this discussion.

Later, in December 1989 the check valve MO was reviewed by a Maintenance supervisor, but no action was taken in response to the notation concerning the loose taper pin.

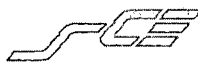
3. Subsequent Identification of the Nonconforming Condition by Station Technical

An engineer in Station Technical reviewed the MO in October 1989 and recognized the need for an NCR to be issued concerning the loose taper pin. However, instead of creating the NCR himself, he discussed doing so with other engineers whom he believed to be cognizant in this case. Again, no NCR was created, and the engineers state that they do not now recall this discussion.

Finally, in February 1990, during review of the MO for other reasons, a maintenance planner questioned whether an NCR had been issued concerning the loose taper pin. As a result of this inquiry, NCR 2R0139 was issued by Station Technical on February 28, 1990.

4. Processing of the NCR by Station Technical

The NCR that was issued was a so-called "root-cause" NCR which was intended by the Station Technical engineer as a vehicle to determine



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where the loose taper pin had come from. Following this, it was intended to create a normal NCR, specific to the affected component, for evaluation. However, no action had been taken in response to this NCR prior to March 21, 1990, when it was questioned by the NRC inspector. (Note: With the information that was available at the time the "root-cause" NCR was written, its use was inappropriate and a normal NCR should have been created instead at that time.)

Thus, from the time of its initial discovery by Maintenance in September 1989 until action was taken to verify the origin of the loose taper pin in March 1990, SCE did not properly identify the nonconforming condition which it represented. As a result, no assessment was made of its possible effect on the operability of the affected valve, 2HV9303.

5. Prior Failure to Promptly Identify Nonconforming Condition On Unit 1

In a letter to the NRC dated March 9, 1989, SCE responded to a Notice of Violation concerning the failure to promptly document an apparent nonconforming condition on Unit 1. Corrective action included issuance by the Station Manager of a memorandum to all site personnel reminding them of the requirement for timely initiation of NCRs whenever the quality of an item is unacceptable or indeterminate. A copy of this memorandum dated April 10, 1989, is attached for your information.

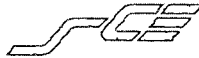
6. Evaluation of Prior Corrective Action Effectiveness

Clearly the attached memorandum did not have the intended result with respect to the nonconforming condition represented by the loose taper pin discussed above. As it stated, "Anyone can identify a perceived nonconforming condition through initiation of an NCR." However, both Maintenance and Station Technical personnel in this case apparently believed they could informally transfer responsibility for documentation of recognized nonconforming conditions to others, with no follow up on their part. This is contrary to our policy and procedures.

In addition, processing of the "root-cause" NCR clearly did not comply with direction in the attached memorandum concerning timeliness, in that its safety implications were not promptly determined and assessed.

Because the attached memorandum was not effective, a special training module is being developed and will be implemented, with required attendance by all engineering and other technical personnel who will be held responsible for assuring timely creation of NCRs wherever appropriate. Management will participate in the presentation of this

Mr. Dennis F. Kirsch



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training, to ensure effective communication of its policy. The training will include a thorough review of the failure to properly identify and process the nonconforming condition described above. This training will be completed within the next 60 days.

In addition, in order to make easier and more thorough the task of initiating and processing an NCR, and to reduce the incentive to transfer this responsibility to others, the NCR process is being implemented using electronic media, similar to that used for MOs currently. Electronic initiation and processing of NCRs will be effective by April 16, 1990.

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

Sincerely,

Enclosure

cc: John B. Martin, NRC Regional Administrator, Region V  
C. W. Caldwell, NRC Senior Resident Inspector, San Onofre

April 10, 1989

ALL SITE PERSONNEL

SUBJECT: Timely Initiation of Nonconformance Reports (NCRs)

The U. S. Nuclear Regulatory Commission (NRC) recently issued a Notice of Violation (NOV) to SCE, which cited a failure to initiate an NCR in a timely fashion. This memo is written to emphasize the policy on this subject.

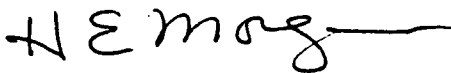
In the event which prompted the NOV, information was available to SCE on January 5, 1989, which indicated the possibility that a portion of residual heat removal (RHR) piping wall was not of the required thickness. Cognizant personnel noted that the information originated with an unverified test. In addition, plant conditions were such that the integrity of the pipe would not have been challenged until mode elevation, even if the information had been credible. For these reasons, cognizant personnel elected not to write an NCR until additional, verifying tests were conducted. This was an incorrect judgement.

General Procedure S0123-XV-5, "Nonconforming Materials, Parts or Components," provides a program for the identification and disposition of materials, parts or components in which the quality of the item is unacceptable or indeterminate. The NCR is used to document the condition and its resolution. In order to ensure that affected materials, parts and components are not inadvertently used or installed, an NCR must be initiated in a timely fashion anytime information becomes available which indicates that quality is unacceptable or indeterminate. The NCR must be initiated in a time frame which is commensurate with the safety significance of the potentially nonconforming condition in light of existing plant conditions.

As previously stated, plant conditions were such that the piping was not in danger of failing. Notwithstanding this fact, there was sufficient basis for writing an NCR because there was reasonably credible information to indicate that the quality of the piping was indeterminate.

Anyone can identify a perceived nonconforming condition through initiation of an NCR. Initiation is considered complete when the originator of the NCR fills out blocks 2 through 15 of the NCR and submits it to Station Technical Division, through the Technical Information Management Center on the second floor of the AWS Building. Validation of the NCR by Station Technical normally should occur within 24 hours. However, the complexity of the issue and current workload may occasionally delay validation. For this reason, the NCR originator must notify supervision if he or she feels that a significant safety hazard exists. Supervision is then responsible for advising Station Technical Division of the condition.

Your compliance with the provisions of S0123-XV-5 is essential for the timely identification and correction of nonconforming conditions.

  
H. E. MORGAN

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