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L. T. PAPAY
VICE PRESIDENT

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July 14, 1981

Mr. R. H. Engelken, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Region V
Suite 202, Walnut Creek Plaza
1990 North California Boulevard
Walnut Creek, California 94506

Dear Mr. Engelken:

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

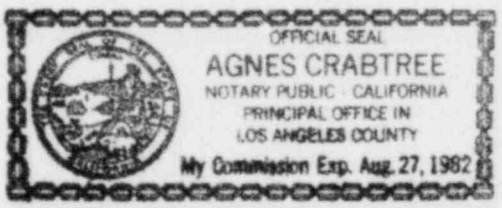
In a letter from your office dated June 16, 1981, we were requested to respond to a Notice of Violation resulting from inspections of San Onofre Unit 2 construction activities which took place during the period March 13 to April 14, 1981. The condition described by the Notice of Violation involved operation of Low Pressure Safety Injection Pump, P016, for San Onofre Unit 2 with valves closed so as to prevent a supply of water to the pump suction.

The actions taken or to be taken to correct and to prevent recurrence of this condition are described in Attachment 1. I trust the attachment responds adequately to all aspects of the Notice of Violation. If you have any questions, or if we can provide additional information, please let me know.

Subscribed on this 14th day of July, 1981 by

L. T. Papay
Vice President
Southern California Edison Company

Subscribed and sworn to before me this 14th day of July, 1981



Agnes Crabtree
Notary Public in and for the
County of Los Angeles, State
of California

Enclosure

cc: R. J. Pate (NRC-San Onofre Units 2&3)

81-114

RESPONSE TO NRC NOTICE OF VIOLATION DATED JUNE 16, 1981

SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2

Response to the Notice of Violation which was identified in Appendix A to IE Inspection Report No. 50-361/81-09, is provided below. A statement of the condition as described by the Notice is given for reference.

NOTICE OF VIOLATION

Southern California Edison Company

Docket No. 50-361

As a result of an NRC inspection on March 13 to April 14, 1981, and in accordance with the Interim Enforcement Policy, 45 FR 66754 (October 7, 1980), the following violation was identified:

Appendix B of 10 CFR 50, Criterion V, states, in part, that, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings,...and shall be accomplished in accordance with these instructions, procedures, or drawings."

SCE Operating Procedure SO23-3-2.6, "Shutdown Cooling," requires in part that valves HV-9339, HV-9337, HV-9377, and HV-9378 be opened to initiate shutdown cooling.

Contrary to the above, the inspector determined that on March 21, 1981 shutdown cooling had been initiated without opening valves HV-9377 or HV-9378. As a result of the above failure to follow an applicable procedure, the Low Pressure Safety Injection Pump, P-016, was operated for at least several minutes with a combination of valves closed, such as to prevent a supply of water to the pump suction.

This is a Severity Level V violation (Supplement II).

RESPONSE

Corrective Steps Taken and Results Achieved

Low Pressure Safety Injection Pump P-016 was given a special retest in accordance with Startup Work Permit 15970 subsequent to the event described above and a determination was made that no damage had been incurred. During the investigation of the administrative aspects it was noted that Station-specific tagging procedures had not been issued at the time of the incident. SO23-0-19, "Use of Caution and Magnetic Tags." has since been issued. In accordance with that procedure, use of a Caution Tag Log has been implemented to strengthen Control over the proper placement of caution tags.

Procedural compliance, already addressed in a February 24, 1981 memorandum to Station employees from the Plant Manager, was formalized by the issuance of Administrative Procedure SO23-0-4, "Station Operations". Station policy makes willful failure to observe procedures a disciplinary problem with severe consequences.

As a result of the incident with the LPSI Pump, the SCE Quality Assurance Organization issued a Corrective Action Request and an NRC Action Item Report. The corrective actions of CAR-SO23-P-22 were reviewed by Quality Assurance and considered complete as of June 10, 1981. The evaluation required by NRCAIR-F-NRC-265 has been completedand the resulting preventive measures are currently in progress.

On-shift training related to this incident has been conducted with Unit 2 operating personnel. Discussions included a review of the cause of the event, the Station Incident Report and the related procedures and administrative policies. The reviews with operations personnel have been documented. The individuals involved directly with the occurrence have been verbally counseled. Although failure to follow procedures is attributed to be the primary cause, there is no indication that deliberate carelessness was a factor in the loss of suction to the LPSI pump.

Supervision is aware of the seriousness of the matter and the potential consequences of poor equipment status control. This subject was the topic of a Units 2 and 3 Operating Supervisor's meeting on April 4, 1981.

There have been no further instances of failure to follow procedures by Unit 2 operating personnel since this incident.

Corrective Steps Which will be Taken to Avoid Further Items of Non-compliance

Procedures currently in effect concerning the control and status of safety-related equipment will be adhered to without exception. Continual reinforcement and emphasis on the necessity for procedural compliance will be directed to all personnel involved by the responsible supervisors.

Members of the Unit 2 operating staff who have not already received the on-shift training and review of the LPSI loss-of-suction incident will be given such instruction by August 1, 1981. The reviews will be documented and available for future NRC inspection.

The existing procedure for operation of the Shutdown Cooling System, SO23-3-2.6, will be revised by August 1, 1981 to include a caution statement on the importance of opening both parallel suction paths.

A procedure covering initial alignment of the Safety Injection System, SO23-3-2.7, will be issued by August 1, 1981. The associated electrical alignment check off list will contain a requirement to ensure that the maintained contact key switches are properly positioned prior to closing the power supply. This will assist in avoiding the undesired valve movement that resulted in the loss of suction to pump P-016 on March 24, 1981.

Additionally, Operating Procedure S023-3-1.4, "Fill and Vent", will be reviewed in parallel with the procedures described above to determine whether any revision is necessary.

Date When Full Compliance will be Achieved

Full compliance will be achieved by August 1, 1981, when training for Unit 2 operations personnel and revisions to the referenced procedures have been completed.