Southern California Edison Company

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RICHARD M. ROSENBLUM
VICE PRESIDENT

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August 5, 1994

U. S. Nuclear Regulatory Commission
Attention: L. J. Callan, Regional Administrator
NRC Region IV
611 Ryan Plaza Drive, Suite 400
Arlington, TX 76011-8064

Dear Joe:

Subject: **Docket No. 50-361**
Interim Corrective Action
San Onofre Nuclear Generating Station
Unit 2

On Thursday August 4, 1994, Edison identified that on August 3, 1994, an out-of-service high pressure safety injection (HPSI) pump had been operated for approximately two hours without cooling water flow to the motor. The pump run was the latest in a series of inservice test runs being conducted to evaluate and resolve anomalous pump vibration readings. Edison immediately initiated an investigation of the event, and today implemented several immediate actions including removing the responsible Control Room Supervisor from shift responsibilities for an indefinite period, and conducting a safety standdown for each operating crew in which the Operations Manager personally instructs all on-shift personal to emphasize the significance of this event. Additional corrective actions will occur as the investigation continues.

Although the safety significance of the event is reduced because the pump was administratively inoperable and aligned as a third of a kind component at the time of testing, and because both trains of high pressure safety injection were operable at the time, we are nevertheless extremely concerned about the overall significance of the incident. It represents the most recent of several similar events in which performance is far below the standard we expect of the operations organization. In particular, we are troubled by these events since they seem to be significantly out of character with otherwise very good performance by the operations organization when faced with challenges such as the recent minor control room fire and other similar events cited in the SALP report.

My initial conclusion is that these events represent an over reliance by on-shift personnel on staff organizations during seemingly routine evolutions. This over reliance has produced a consequential reduced sense of personal responsibility and accountability on the part of the on-shift operators. We strongly believe that our consistently strong performance in response to challenging operational incidents is an indication that this weakness does not extend to our ability to manage more safety significant events.

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I have empaneled a group of senior division managers to participate in the investigation of this and the other similar events. The panel includes the managers of the Operations, Maintenance, Nuclear Oversight and Site Technical divisions and myself. Ray Waldo, the Operations Manager, will chair this panel. The panel will report their findings to Mr. Harold B. Ray, Senior Vice President, Power Systems. We anticipate being prepared to discuss our initial findings and corrective actions with the you at the SALP meeting on August 18, 1994. I will keep you advised of other corrective actions as they occur.

Very truly yours,

cc: Document Control Desk
K. E. Perkins, Jr., Director, Walnut Creek Field Office, NRC Region IV
J. A. Sloan, NRC Senior Resident Inspector, San Onofre Units 2 & 3
M. B. Fields, NRC Project Manager, San Onofre Units 2 and 3