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

Gentlemen:

Subject: Docket Nos. 50-361 and 50-362
Reply to Notices of Violation
San Onofre Nuclear Generating Station, Units 2 and 3

- References: (1) Letter from Mr. A. Bill Beach (NRC:RIV) to Mr.
Harold B. Pay (SCE), dated July 12, 1994
(Inspection Report 50-361/362 94-12)
- (2) Letter from Mr. Thomas P. Gwynn (NRC:RIV) to
Mr. Harold B. Ray (SCE), dated July 12, 1994
(Inspection Report 50-361/362 94-16)

Reference 1 transmitted the results of NRC Inspection Report No. 50-361/362-94-12, and included a Notice of Violation for failing to follow procedures. Reference 2 transmitted the results of NRC Inspection Report No. 50-361/362-94-16, and included one Notice of Violation for failing to follow procedures and for inadequate procedures. The Enclosure to this letter provides the Southern California Edison reply to the subject Notices of Violation.

Additionally, the transmittal letters of both References 1 and 2 solicited Edison's review and comment on specific management performance aspects. Those concerns will be provided in a separate letter.

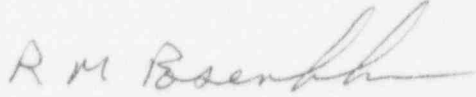
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If you have any further questions, please contact me.

Sincerely,



R. M. Rosenblum
Vice President
Engineering and Technical Services

Enclosure

cc: L. J. Callan, Regional Administrator, NRC Region IV
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

ENCLOSURE

Reply to a Notice of Violation.

1. Violation A (362/94-12-01) - Letter, A. Bill Beach (NRC:RIV) to Mr. Harold B. Ray (SCE), dated July 12, 1994

The violation involved the failure of a Chemistry Technician to wear a lab coat as required by the Radiation Exposure Permit (REP) when "reaching in" a potentially contaminated area to obtain a sump sample.

The reason for the violation was a personal error by the Chemistry Technician. The Chemistry Technician failed to recognize that lowering a sample beaker into the sump constituted a "reach in", and therefore that the REP requirement to wear a lab coat should have been followed.

As corrective actions, the Chemistry Technician, as well as other personnel involved, have been re-instructed on the definition of "reach in" as intended in the REP. Further, a reminder is being issued to all affected personnel regarding contaminated area boundaries and the REP requirements that control penetrating them.

Full compliance was achieved on June 9, 1994, when applicable personnel were re-instructed.

2. Violation B (362/94-12-02) - Letter, A. Bill Beach (NRC:RIV) to Mr. Harold B. Ray (SCE), dated July 12, 1994

The violation indicated maintenance performed steps out of sequence and failed to stop and process a procedure change, as required, prior to completing CCW inboard and outboard bearing inspection work in a different sequence from that specified in the procedure.

Edison has concluded that the work was, in fact, performed in compliance with requirements. Edison personnel were slow in investigating the incident, and as a result, Edison Maintenance management and supervision failed to inform the NRC inspectors that approval, in accordance with SONGS administrative procedures, had been obtained to deviate from the procedure sequence, simultaneously work both the inboard and outboard bearings, and apply RTV (Step 6.4.3.15) out of sequence at the end of the job.

Approval was obtained prior to deviation, and was documented in the work done section of Maintenance Order (MO) 93120491 which states, "Procedure Steps 6.4.3.15 through 6.4.3.18 can be worked simultaneously". Such approval is authorized in SO123-I-1.7, "Maintenance Order Preparation, Use, and Scheduling", Section 6.15.1.2.2.4.

Station management has been sensitized to the necessity of performing more thorough and timely investigations and of the need to ensure Edison affords the inspector a full understanding of events. Full compliance was in effect at all times. Because Edison was slow to investigate this incident, no withdrawal of the violation is being requested.

3. **Violation A (362/94-16-01)-Letter, Thomas P. Gwynn (NRC:RIV) to Mr. Harold B. Ray (SCE), dated July 12, 1994**

The violation involved a failure to complete a prerequisite step ("HPSI 3P019 aligned per SO23-3-2.7") in the abnormal alignment procedure, SO123-O-23, resulting in damage to HPSI pump 3P019. The reason for the violation was the operators did not comply with the requirements of the abnormal alignment procedure, SO123-O-23.

At the time of the incident, Operators intended to perform two activities: (1) prepare HPSI 3P019 for operation, and (2) utilize the pump to drain the RWST (to less than 5% level to enable repair work on a cross-tie valve) and refill the refueling cavity. Because there is no single procedure to cover these activities, in accordance with SO123-O-23, "Control of System Alignments", Operators prepared a plan to utilize two procedures in sequence. First, prepare the pump using SO23-3-2.7, Attachment 8; and then align HPSI 3P019 discharge to the refueling cavity using procedure SO23-3-2.8, Attachment 19.

Procedure SO23-3-2.7, Attachment 8, provides for starting the pump, opening the mini-flow orifice bypass valve, and verifying pump operation. At the completion of Attachment 8, the mini-flow orifice bypass valve is closed (Step 2.1.17) and the pump is turned off (Step 2.1.19). During the first evolution, Operators decided to prematurely enter SO23-3-2.8, Attachment 19, without completion of Attachment 8, Step 2.1.17. The Operators deviated from the original work plan without understanding the potential for pump runout when operating the pump with the mini-flow bypass valve open, in addition to opening the injection valves as called for in SO23-3-2.8, Attachment 19.

As corrective action, Edison has taken appropriate disciplinary action with the individuals involved. Also, Edison issued a required reading assignment alerting the operators to the possibility of HPSI pump run-out, and prohibiting operation of a HPSI pump with an open isolation valve while the pump mini-flow orifice bypass valve is also open. In addition, Operations Division Experience Report (ODER) 3-94-11, which evaluated the 3P019 event and proposed

corrective actions, was issued to all operators for required reading and will be incorporated into operator re-qualification training.

Full compliance was achieved on May 20, 1994, when Operations issued a priority reading assignment to all operators alerting them to the potential for HPSI pump run-out.

4. Violation B (362/94-16-02)-Letter, Thomas P. Gwynn (NRC:RIV) to Mr. Harold B. Ray (SCE), dated July 12, 1994

The violation identified two instances where procedures for operating the HPSI pumps were inadequate in that: (1) the procedure did not have provisions for monitoring pump discharge pressure; and (2) the procedure did not have quantitative acceptance criteria for monitoring pump flow rate. While Edison agrees that including additional pump performance acceptance criteria into the procedures can, under some circumstances, provide useful information for the operator to better understand pump performance, we have concluded that the absence of such information did not contribute to the cited events.

There are limitations to providing monitoring provisions on pump acceptance criteria. Specifically, SONGS does not have flow meters to monitor total flow and using a combination of control room and local flow indications to monitor total flow is not considered practical; therefore, inclusion of pump flow quantitative acceptance criteria would not have avoided the cited event since total flow could not reliably have been determined. We have also concluded that monitoring pump motor amperage cannot provide a viable indication of pump performance in all circumstances. For instance, our review of the HPSI pump data during the November 3, 1993 HPSI 3P019 event showed that motor amperage remained constant at approximately 60 amps, even during run-out conditions (normal operating range is between 50 and 65 amps); therefore, monitoring pump motor amperage would not have provided information which would have precluded the cited event.

Due to the limitations noted above, Edison has not included pump motor amperage or total flow as quantitative acceptance criteria in the procedure, but has included precautions in the HPSI procedures to ensure discharge pressure is less than 1525 PSIG and alignment restrictions to ensure calculated combined flow does not exceed 900 GPM once the pump is started and the flow path is established. The procedure provides specific direction to the operators to stop the HPSI pump if acceptance criteria are not met.

As described in response to violation 3, full compliance was achieved on May 20, 1994, when Operations issued a priority reading assignment to all operators alerting them to the possibility of HPSI pump run-out.