

*Southern California Edison Company*

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VICE PRESIDENT

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June 13, 1995

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

Dear Sir:

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


Reference: Letter, Mr. A. Bill Beach (USNRC) to  
Mr. Harold B. Ray (Edison), dated May 3, 1995

The referenced letter provided the results of a routine resident inspection (50-361/95-02 and 50-362/95-02) by Messrs. J. Sloan, J. Russell, and D. Solorio for January 29 - March 11, 1995, at the San Onofre Nuclear Generating Station, Units 2/3. The enclosure to the reference transmitted a Notice of Violation. The enclosure to this letter provides Edison's reply to the subject Notice of Violation.

As discussed with Mr. Brad Olson, NRC Region IV, on June 8, 1995, the NOV Response due date was extended to June 13, 1995, in order to provide a complete response.

If you have any further questions, please contact me.

Sincerely,



Enclosure

cc: L. J. Callan, Regional Administrator, NRC Region IV  
A. B. Beach, Director, Division of Reactor Projects,  
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 and 3  
M. B. Fields, NRC Project Manager, San Onofre Units 2 and 3

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ENCLOSURE

Reply to a Notice of Violation

1. Violation A

Violation A involved operators rendering a feedwater isolation valve inoperable when it was required to be operable during the refueling outage shutdown. The violation occurred when plant operators soft seated the main feedwater isolation valves (MFIV) in Mode 3. The operators did not recognize (cognitive error) that soft seated MFIVs would be inoperable.

Edison has counseled the individuals involved to ensure their full understanding that soft seating these valves (i.e. MFIVs and MFBVs) renders them inoperable, and has revised the procedure for MFIV operation to clearly state that soft seated valves are inoperable. Additionally, the other operators have been reminded of the MFIV operability requirements.

Full compliance was achieved on February 12, 1995, when the Unit entered Mode 5 and the MFIVs were no longer required to be operable.

2. Violation B

Violation B involved operators who engaged in a potentially distracting activity. The violation occurred as an NRC inspector observed an onshift control room operator showing another operator three 45-rpm phonograph records in the Unit 3 control room. The operators knew of the procedural requirements prohibiting distracting non-work related activities in the control room. They misjudged the appropriateness of looking at the phonograph records for a few moments.

Edison expects an appropriate level of decorum in the control room at all times. The control room operator who brought the records into the control room was coached on this error. Operators have been assigned a priority reading assignment which reemphasizes proper control room decorum. The Shift Superintendents have discussed the control room decorum incidents with their respective operating crews. In addition, Edison is placing more emphasis on control room formality, and will continue to monitor control room decorum to judge the effectiveness of our corrective actions.

Full compliance was achieved on February 27, 1995, when the phonograph records were put away.

### 3. Violation C

Violation C involved placing a spent fuel assembly into the wrong location in the spent fuel pool. The violation occurred when personnel failed to properly execute procedure SO23-X-7, "Nuclear Fuel Movement for Refueling Cycles," as a result of inadequate communications. Information exchanges between the Spent Fuel Handling Machine (SFH) operator and the Control Room Engineer (CRE) were not clear or complete enough to effectively communicate the SFH machine bridge coordinates. Edison expects meticulous handling of fuel assemblies in full compliance with written, approved procedures.

In addition, initial on-shift communications were inadequate, in that the shift superintendent and other appropriate management were not promptly notified. When management became aware of the event later that same shift, fuel movements were stopped and the crew was assembled for a debrief.

As corrective action, management has reemphasized the following to all refueling crews:

- the importance of safety,
- the expectations of management,
- the importance of complete, clear, and concise communication,
- the importance of the self-check concept (STOP),
- the importance of procedural compliance, and
- the importance of the CRE repeating back the complete coordinates.

Refueling training will be modified to emphasize the importance of complete and formal communications. In addition, the complete coordinates will be recorded on the Fuel Movement Sequence Data Sheet.

Edison evaluated the safety significance of mispositioning a spent fuel assembly in the spent fuel pool. The evaluation determined that at the Technical Specification required minimum boron concentration of 1850 ppm, there was no potential for a misplaced fuel assembly to lead to a criticality accident. The K-eff would have remained less than or equal to 0.95, including all uncertainties.

Full compliance was achieved on February 25, 1995, when the mispositioned fuel assembly was placed in the correct location.

#### 4. Violation D

Violation D involved the failure to promptly document and correct a condition adverse to quality. The violation occurred when Edison personnel failed to generate a nonconformance report (NCR) in a timely manner. The NCR should have been written to document the operability basis for the Amerace relay auxiliary contacts and mounting configurations on July 13, 1993.

On May 28, 1993, Edison's Procurement Engineering (PE) department discovered an Amerace (the Agastat relay manufacturer) Certificate of Compliance, for relays supplied directly to SONGS, did not encompass auxiliary contacts and relay orientation. The same relays had been supplied to SONGS by various original equipment manufacturers as sub-components of equipment which had been seismically qualified as a whole such as switchgear and electrical control panels.

Because this model relay had been previously supplied as part of original, seismically-qualified equipment, Edison believed the relays would perform their design function, and the absence of Amerace seismic qualification of certain component aspects did not imply a functional inability to perform as required. In order to make certain such was the case, Edison developed a program to confirm the seismic qualification of the replacement relays, and to determine if any replacement relays had been installed in the plant in safety-related applications. In summary, the fact that the Amerace Certificate of Compliance did not encompass auxiliary contacts and relay orientation was initially considered to be an administrative documentation problem.

During execution of the program on July 13, 1993, Edison determined several replacement Agastat relays were being utilized in plant safety-related applications. In retrospect, Edison should have written an NCR at that time to document that replacement relays with incomplete seismic qualification documentation had been installed in the plant and to document our judgment that the replacement relays were capable of performing their safety function.

It is Edison's policy to initiate a station NCR to address operability and disposition actions promptly upon determining a nonconforming condition impacts components installed in plant applications, such as the qualification issue in this case. In this instance, that was not done until a station NCR was issued in February 1994.

As corrective action, appropriate procedural revisions were made to provide a timely, formal mechanism for NEDO's involvement in such problem resolution. In addition, on June 9, 1995, a second example of untimely NCR issuance was identified during an NRC inspection (Report No. 50-361 & 362/95-12). As a result of the June 9 finding, Edison has expanded the proposed NEDO and PE training on these procedure changes and the requirements for timely issuance of NCRs to include Station Technical,

Maintenance, and Quality Control personnel.

Full compliance was achieved on February 1, 1994, when an NCR was issued to document the Agastat relay discrepancies.