



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
612 EAST LAMAR BLVD, SUITE 400
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October 7, 2010

Mr. James J. Sheppard
Senior Vice President and
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Southern California Edison Company
San Onofre Nuclear Generating Station
P.O. Box 128
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SUBJECT: ERRATA - SAN ONOFRE NUCLEAR GENERATING STATION –
NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION
REPORT 05000361/2010006; 05000362/2010006 AND NOTICE OF VIOLATION

Dear Mr. Sheppard:

Please replace page 10 of the Summary of Findings section as well as page 38 of the Report Details in NRC Inspection Report 05000361/2010006; 05000362/2010006, dated July 30, 2010, with the enclosed revised pages. These changes are needed to correct a typographical error listing the crosscutting aspect of the finding involving inadequate procedures for radiation monitoring of the component cooling water. Specifically, the error is that the crosscutting aspect is listed as [P.1(c)], when it should be [P.1(a)]. The description of the crosscutting aspect is correct.

Sincerely,

/RA/ Dale A. Powers for

Michael C. Hay, Chief
Technical Support Branch
Division of Reactor Safety

Dockets: 50-361; 50-362
Licenses: NPF-10; NPF-15

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ADAMS: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		<input checked="" type="checkbox"/> SUNSI Review Complete	Reviewer Initials:
		<input checked="" type="checkbox"/> Publicly Available	<input checked="" type="checkbox"/> Non-Sensitive
		<input type="checkbox"/> Non-publicly Available	<input type="checkbox"/> Sensitive
DRS:TSB	C:TSB		
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10/4/2010	10/7/2010		

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Notification 200871387, and actions were implemented to require periodic grab sampling of the train which was not being monitored.

The inspectors determined that this finding was more than minor because this issue impacted the Public Radiation Protection Cornerstone and its objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain as a result of routine civilian nuclear reactor operation. Specifically, the radiation monitors for component cooling water were not sufficient to ensure adequate release measurements. The inspectors evaluated the significance of this finding using Phase 1 of Inspection Manual Chapter 0609.04 and determined that the finding screened to Inspection Manual Chapter 0609, Appendix D, "Public Radiation Safety Significance Determination Process." The inspectors evaluated the significance of this finding using Inspection Manual Chapter 0609, Appendix D, and determined that the finding was of very low safety significance (Green) because dose did not exceed Appendix I criteria. This finding was determined to have a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program in that the plant operators did not have a low threshold for identifying deficiencies in procedures. [P.1(a)](Section 4OA2.5g)

Cornerstone: Miscellaneous

- Severity Level IV. The inspectors identified a Severity Level IV noncited violation of 10 CFR 50.73, "Licensee Event Report System," in which the licensee failed to submit a licensee event report within 60 days following discovery of an event meeting the reportability criteria. On January 26, 2010, the valve which isolates nonseismic piping from condensate storage tank T-120 failed its in-service test when the hand wheel stem snapped after a leveraging device was used in an attempt to close the valve. This isolation valve, 2HV5715, must be closed within 90 minutes of an operating basis earthquake in order to prevent the loss of condensate storage tank T-120 water inventory from a line break in the nonseismic portion of the condensate system. The failure of this valve resulted in a condition prohibited by Technical Specification 3.7.6 and therefore was reportable. This finding was entered into the licensee's corrective action program as Nuclear Notification 200888616, and the licensee was taking actions to send a licensee event report to the NRC for this event.

The inspectors determined that traditional enforcement was applicable to this issue because the NRC's regulatory ability was affected. Specifically, the NRC relies on the licensee to identify and report conditions or events meeting the criteria specified in regulations in order to perform its regulatory function. The inspectors determined that this finding was not suitable for evaluation using the significance determination process, and

sufficient to ensure adequate release measurements. The inspectors evaluated the significance of this finding using Phase 1 of Inspection Manual Chapter 0609.04 and determined that the finding screened to Inspection Manual Chapter 0609, Appendix D, Public Radiation Safety Significance Determination Process. The inspectors evaluated the significance of this finding using Inspection Manual Chapter 0609, Appendix D, and determined that the finding was of very low safety significance because dose did not exceed Appendix I criteria. This finding was determined to have a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program in that plant operators did not have a low threshold for identifying deficiencies in procedures. [P.1(a)]

Enforcement. Technical Specification 5.5.1.1.a. requires, in part, that written procedures be established, implemented, and maintained covering the activities specified in Appendix A, "Typical Procedures for Pressurized Water Reactors and Boiling Water Reactors," of Regulatory Guide 1.33, "Quality Assurance Program Requirements (Operations)," dated February 1978; Section 7.g requires procedures for radiation monitoring operation. Contrary to the above, prior to April 22, 2010, the licensee failed to establish procedures for component cooling water system alignments that would prevent unmonitored leakage to the environment through leakage into the Salt Water Cooling system. Because the violation was of very low safety significance and was entered into the corrective action program as Nuclear Notification 200871387, this violation is being treated as noncited violation, consistent with the NRC Enforcement Policy VI.A: NCV 05000361/2010006-07, "Failure to Establish Component Cooling Water Radiation Monitoring Procedures."

h. Failure to Revise Procedures with Known Technical Errors

Introduction. The inspectors identified a cited violation of Technical Specification 5.5.1.1a for the failure to maintain written procedures covered in Regulatory Guide 1.33. Specifically, as of April 2010, the licensee failed to properly control procedure changes associated with plant modifications resulting in procedures with known technical deficiencies being used at the facility.

Description. On April 8, 2010, the inspectors reviewed corrective actions from two previous noncited violations for the licensee's failure to maintain procedures. The first noncited violation was 05000361:05000362/2009003-02 and was associated with the licensee's failure to implement controls over its backlog of procedure change requests such that procedures with known technical deficiencies were in use in the field (before being revised). The second noncited violation was 05000361:05000362/2009009-02 and also involved the licensee's failure to implement controls over its backlog of procedure change requests such that procedures with known technical deficiencies were in use in the field.

During this inspection, the inspectors identified that the backlog of procedure change requests had increased to 3,389. The inspectors identified that most of these procedure changes were appropriately classified according to the "TEAM"