

## San Onofre 2

### 4Q/2003 Plant Inspection Findings

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#### Initiating Events

**Significance:** N/A Oct 10, 2003

Identified By: NRC

Item Type: FIN Finding

##### **95001 for Green to White**

During this supplemental inspection, performed in accordance with Inspection Procedure 95001, the inspector determined that the licensee performed a comprehensive and thorough evaluation in which specific problems were identified, an adequate root cause evaluation was performed and corrective actions were taken or planned to prevent recurrence.

Inspection Report# : [2003011\(pdf\)](#)

**Significance:**  Feb 01, 2003

Identified By: Self Disclosing

Item Type: FIN Finding

##### **Loss of generator excitation trip - Unit 2**

The licensee failed to have an adequate preventive maintenance procedure to conduct functional testing of the Unit 3 main transformer/generator protective relays. As a result, a maintenance technician inadvertently caused a reactor trip of Unit 2.

This self-revealing finding was considered to be more than minor because it resulted in an unnecessary challenge to the reactor protective system and upset plant stability. However, the finding was considered to have very low safety significance because the reactor trip was uncomplicated; operations personnel quickly placed the plant in a stable shutdown condition; and mitigating equipment responded as designed.

Inspection Report# : [2003002\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Dec 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

##### **High pressure safety injection header isolation valve failure to open during testing**

The inspectors determined that the licensee implemented an inadequate procedure that did not ensure that electrical leads in safety-related circuitry were properly landed.

A inspector-identified noncited violation of Technical Specification 5.5.1.1 was identified. The finding was considered to be more than minor because the reliability and capability of a portion of the safety injection system was compromised when high pressure safety injection header Isolation Valve 2HV9323 failed to open on a simulated safety injection actuation signal. However, the finding was determined to have very low safety significance because the other

three Train B high pressure safety injection header isolation valves were operable and capable of opening on a safety injection actuation signal to allow injection into the reactor coolant system. As a result, the actual safety function of the Train B safety injection system remained intact because only two of the four valves were needed.

Inspection Report# : [2003002\(pdf\)](#)



**Significance:** Jul 11, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to promptly identify and correct linestarter degradation**

A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, was identified as a result of inadequate corrective actions in response to the improper use of trichloroethane-based cleaners during linestarter maintenance. This resulted in unnecessary degradation of safety-related linestarter auxiliary contacts.

This issue was considered more than minor because the damage caused by improper maintenance practices to safety-related linestarters, if left uncorrected, could lead to a more significant safety concern in that a risk-significant valve could fail to perform its safety function. The finding was characterized under the Significance Determination Process as having very low safety significance because there was no actual impact on the safety-related function of any Unit 3 valve. Additionally, the results of the inspection of the remaining Unit 2 risk dominant valves, completed on July 11, 2003, did not result in any additional test failures.

Inspection Report# : [2003004\(pdf\)](#)



**Significance:** Mar 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Incorrect lubricating oil used in AFW Pump 2P504**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, because the licensee implemented inadequate corrective actions to address several instances where incorrect oil was used in safety-related equipment. The inadequate corrective actions resulted in the introduction of incorrect bearing lubricating oil in Auxiliary Feedwater Pump 2P504 during an oil change.

The inspectors determined that the finding had a credible impact on the mitigating systems cornerstone because it resulted in an unnecessary extension of the unavailability of Auxiliary Feedwater Pump 2P504. The issue was determined to be more than minor because, if left uncorrected, the availability and reliability of a portion of the auxiliary feedwater system could be compromised in that excessive pump bearing temperatures could have been reached. Furthermore, the inadequate corrective actions could increase the likelihood of incorrect oil being introduced in safety-related equipment. The finding was determined to have very low safety significance because Auxiliary Feedwater Pump 2P504 was restored to operable status within its Technical Specification allowed outage time.

Inspection Report# : [2003003\(pdf\)](#)

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## Barrier Integrity

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## Emergency Preparedness

**Significance:** SL-IV Apr 01, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Change to EAL C3 resulting in decrease in effectiveness of EP in violation of 10 CFR 50.54(q)**

Between March 3 and April 25, 2003, the licensee implemented a change to Emergency Action Level C3 which constituted a decrease in effectiveness of the emergency plan because two conditions which would previously have resulted in site area emergency classification would not be classified by the revised emergency action level.

Implementation without prior NRC approval of changes to the emergency plan which constitute reduction in the effectiveness of the plan was a noncited violation of 10 CFR 50.54(q).

The finding was evaluated using NUREG-1600, "General Statement of Policy and Procedure for NRC Enforcement Actions," Section IV, because licensee reductions in the effectiveness of its emergency plan impact the regulatory process. The finding had greater than minor significance because deletion of conditions indicative of a site area emergency has the potential to impact safety. The finding was determined to be a noncited Severity Level IV violation because the emergency action level change constituted a failure to implement an emergency planning standard and did not constitute a failure to meet an emergency planning standard as defined by 10 CFR 50.47(b). This finding has been entered into the licensee's corrective action program as Action Request 030400514.

Inspection Report# : [2003003\(pdf\)](#)

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

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## Miscellaneous

Last modified : March 02, 2004