

## San Onofre 3 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 10, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

#### **Thermocouple packing not replaced in accordance with procedural requirements**

The licensee failed to ensure that packing material for a heated junction thermocouple penetration on the Unit 3 reactor vessel head was installed in accordance with procedural requirements. A human performance deficiency in the compliant use of procedures directly contributed to this violation.

A self-revealing noncited violation of Technical Specification 5.5.1.1 was identified. This issue had a credible impact on safety because, if left uncorrected, the finding would become a more significant safety concern in that reactor coolant system inventory would be lost and boric acid would be introduced to the reactor vessel head. However, the finding was determined to have very low safety significance because the leak was small, did not affect any plant mitigating equipment, and was discovered and repaired while the plant was in a shut down and cooled down condition with primary system pressure equal to or less than 150 psig.

[In addition to the noncited violation, an ALARA finding was also identified (Inspection Report 50-362/2003005, Section 4OA5). A finding was identified because the corrective actions associated with the above human performance deficiency failed to maintain collective doses ALARA. Specifically, the rework exceeded 5 person-rem and the dose estimate by more than 50 percent. The ALARA aspects of this finding were found to have no more than very low safety significance because the finding was an ALARA work control issue and the licensee's three-year rolling average collective dose was less than 135 person-rem.]

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

**Significance:**  Jan 28, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

#### **Inadequate procedure results in reactor vessel lining damage**

An inadequate procedure was implemented to remove the core barrel from the Unit 3 reactor vessel during the Unit 3 Cycle 12 refueling outage. The use of the inadequate procedure resulted in a small amount of damage to the stainless

steel reactor vessel lining.

A self-revealing noncited violation of TS 5.5.1.1 was identified. The issue had a credible impact on safety because, if left uncorrected, it could become a more significant safety concern in that it could result in the inadvertent introduction of foreign material into the reactor coolant system and unnecessary personnel exposure to implement repairs. The issue is therefore more than minor. However, the finding was determined to have very low safety significance because the damage to the reactor vessel lining did not affect its operability and did not contribute to the likelihood of an initiating event.

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

 **Significance:** Jan 17, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

### **Reactor coolant pump gasket not installed in accordance with procedural requirements**

The licensee failed to ensure that a reactor coolant pump vapor stage gasket had been properly installed in accordance with procedural requirements. A human performance deficiency in the compliant use of procedures directly contributed to this violation.

A self-revealing noncited violation of Technical Specification 5.5.1.1 was identified. The issue had a credible impact on safety because, if left uncorrected, the leak could become a more significant safety concern in that corrosive boric acid could have degraded a reactor coolant pump casing and reactor coolant system piping. The issue is therefore more than minor. However, the finding was determined to have very low safety significance because the leak was very small, did not contribute to the likelihood of a loss of coolant accident or a reactor trip, did not affect the likelihood that mitigation equipment functions would not be available, and did not increase the likelihood of fire or flooding.

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

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## **Mitigating Systems**

 **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:** Apr 08, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

### **Pressurization of U3 LPSI header**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, because the licensee failed to implement adequate corrective actions following the identification of a leaking check valve in the Unit 3 low pressure safety injection system in May 2001, which resulted in the unnecessary pressurization of the Unit 3 low pressure safety injection header and challenged its associated relief valve.

The inspectors determined that the issue had a credible impact on the mitigating systems cornerstone because it resulted in the unnecessary pressurization of the Unit 3 low pressure safety injection header and the cycling of its associated relief valve. The issue was determined to be more than minor because, if left uncorrected, it would become a more significant safety concern in that the licensee would continue to unknowingly pressurize the low pressure safety injection header and challenge its associated relief valve. As a result, the reliability of the relief valve and hence the low pressure safety injection header could be compromised. The finding was determined to have very low safety significance because the relief valve maintained the low pressure safety injection header pressure below the American Society of Mechanical Engineers code pressure limit and the safety function of the low pressure safety injection header was maintained.

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**

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