

## San Onofre 3

### 2Q/2004 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\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Apr 10, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Auxiliary Feedwater Pump Oil Leak Not Promptly Identified or Corrected**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, because the licensee failed to adequately correct an identified oil leak from the inboard bearing of the motor to Auxiliary Feedwater Pump 3P504 and subsequently failed to promptly re-identify the leak during subsequent routine inspections of the pump.

This finding is greater than minor because it had a credible impact on the mitigating systems cornerstone in that, if left uncorrected, it would have become a more significant safety concern. Specifically, the unidentified accelerated oil leak would have likely continued to the point where Auxiliary Feedwater Pump 3P504 would have been rendered inoperable. The finding was determined to have very low safety significance (Green) because Auxiliary Feedwater Pump 3P504 remained operable.

Inspection Report# : [2004002\(pdf\)](#)

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**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\(pdf\)](#)

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#### Barrier Integrity

#### Emergency Preparedness

## Occupational Radiation Safety

**Significance:**  Apr 10, 2004  
Identified By: NRC  
Item Type: NCV NonCited Violation

### Failure to Post a Radiological Hazard

Green. On March 10, 2004, the inspector identified a non-cited violation of Technical Specification 5.5.1.1a because the licensee failed to post a radiological hazard (hot spot). A survey performed by the licensee on February 17, 2004, identified a hot spot, with radiation levels of 350 millirem per hour on contact and 50 millirem per hour at 30 centimeters, on the 17-foot elevation of the Unit 2 containment building.

The failure to post a hot spot is a performance deficiency. The finding was greater than minor because it was associated with the Occupational Radiation Safety cornerstone attribute of Program and Process and affected the cornerstone objective to ensure the adequate protection of a worker's health and safety from exposure to radiation. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was determined to be of very low safety significance because it was not associated with as low as is reasonably achievable planning or work controls, there was no overexposure or a substantial potential for overexposure, and the ability to assess dose was not compromised. The finding was entered into the licensee's corrective action program as Action Request 040201480.

Inspection Report# : [2004002\(pdf\)](#)

## Public Radiation Safety

**Significance:**  Jan 30, 2004  
Identified By: NRC  
Item Type: NCV NonCited Violation

### The licensee failed to have all the required effluent monitors channels operable or implement auxiliary sampling requirements as specified in the Offsite Dose Calculation Manual.

The licensee failed to have all the required effluent monitors channels operable or implement auxiliary sampling requirements as specified in the Offsite Dose Calculation Manual

A self-revealing, non-cited violation of Technical Specification 5.5.2.1 was reviewed by the team because the licensee failed to have all the required effluent monitors channels operable or implement auxiliary sampling requirements as specified in the Offsite Dose Calculation Manual. Specifically, the Unit 3 condenser air ejector monitor (3-7870) was declared inoperable on May 26, 2003, at 5:40 p.m. and auxiliary sampling equipment was initially put in place. However, from 8:00 p.m. on May 27, 2003, until 9:55 a.m. on May 28, 2003, continuous particulate and iodine samples were not obtained via the compensatory sampling device because a chemistry technician did not install the necessary filters. The situation was discovered during the successive, routine filter change out.

The finding was greater than minor because it was associated with cornerstone attributes (radiation monitoring and chemistry technician performance) and affected the associated cornerstone objective (to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain). The finding involved an occurrence in the licensee's radiological effluent monitoring program that was contrary to Offsite Dose Calculation Manual requirements; therefore, it was evaluated using the Public Radiation Safety Significance Determination Process. The finding had very low significance because the finding was not a radioactive material control findings, but it was an effluent release program finding. The finding impaired the licensee's ability to assess dose; however, the licensee was able to assess dose to the public through use of an operational noble gas monitor (3RT-7818) in the condenser evacuation system and the dose did not exceed 10 CFR Part 50 Appendix I values .

Inspection Report# : [2004006\(pdf\)](#)

**Significance:**  Jan 30, 2004  
Identified By: NRC  
Item Type: NCV NonCited Violation

### The licensee failed to follow radiation protection procedures related to the release of radioactive material from the protected area-magenta-painted hose with total fixed activity of 40 nanocuries

The licensee failed to follow radiation protection procedures related to the release of radioactive material from the protected area - magenta-painted hose with total fixed activity of 40 nanocuries.

A self-revealing, non-cited violation of Technical Specification 5.5.1 was reviewed by the team because the licensee failed to follow radiation protection procedures related to the release of radioactive material from the protected area. Specifically, on November 6, 2003, the licensee discovered one magenta-painted hose in a 55 gallon drum which had been stored in the Mesa rea (outside the protected area) since January 1998. The licensee surveyed the hose and determined that it contained a total fixed activity of 40 nanocuries.

The finding was greater than minor because it is associated with the cornerstone attribute (material release) and it affected the associated cornerstone objective (to ensure adequate protection of public health and safety from exposure to radioactive material released into the public domain). The finding

involved an occurrence in the licensee's radioactive material control program that was contrary to licensee procedures. This finding was evaluated as having very low safety significance using the Public Radiation Safety Significance Determination Process because the finding was a radioactive material control issue, was not a transportation issue, public exposure was not greater than 5 millirem, and there were less than 5 occurrences over the past rolling 8 quarters.

The finding was greater than minor because it is associated with the cornerstone attribute (material release) and it affected the associated cornerstone objective (to ensure adequate protection of public health and safety from exposure to radioactive material released into the public domain). The finding involved an occurrence in the licensee's radioactive material control program that was contrary to licensee procedures. This finding was evaluated as having very low safety significance using the Public Radiation Safety Significance Determination Process because the finding was a radioactive material control issue, was not a transportation issue, public exposure was not greater than 5 millirem, and there were less than 5 occurrences over the past rolling 8 quarters.

Inspection Report# : [2004006\(pdf\)](#)

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## Physical Protection

[Physical Protection](#) information not publicly available.

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## Miscellaneous

Last modified : September 08, 2004