San Onofre 3
1Q/2006 Plant Inspection Findings

Initiating Events

Significance: G Oct 15, 2005
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Ensure Procedural Compliance During Unit 3 Heat Treat
A self-revealing finding was identified for the failure of operations personnel to adequately monitor circulating water gates in accordance with Procedure S023-5.1.1, "Heat Treating the Circulating Water System," while performing a heat treat of the Unit 3 intake structure. This failure caused Unit 3 condenser vacuum to degrade, prompting operations personnel to reduce reactor power by approximately 6 percent. Operations personnel were counseled on the importance of maintaining attentiveness while performing evolutions which could upset plant stability. This finding was entered into the licensee's corrective action program as Action Request 051000701.

The finding is greater than minor because it was associated with the human performance attribute of the initiating events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the finding did not contributed to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions were not available. The cause of the finding was related to the crosscutting element of human performance in that operations personnel did not ensure that procedural requirements were followed.
Inspection Report# : 2005005*(pdf)*

Significance: G Aug 02, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Follow Surveillance Procedure Results in Inadvertent Reactivity Addition
A self-revealing, noncited violation of Technical Specification 5.5.1.1 was identified for the failure to follow procedural requirements during surveillance testing of the Unit 3 steam generator blowdown processing system. This failure resulted in the blowdown flow control valve going to the full open position and an inadvertent reactivity addition to Unit 3. The finding had crosscutting aspects in the area of human performance because the failure of instrumentation and control technicians to follow the procedure directly contributed to the cause of the finding.

The finding was determined to be more than minor because it was associated with the human performance attribute of the initiating events cornerstone. It also affected the cornerstone objective of limiting the likelihood of events that upset plant stability. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.
Inspection Report# : 2005004*(pdf)*

Significance: G Jun 26, 2005
Identified By: NRC
Item Type: FIN Finding
Failure to Identify Hydraulic Leak on Main Feedwater Block Valve 3HV4051
The inspectors identified a Green finding for the failure to develop an adequate monitoring plan to timely identify a hydraulic leak on Main Feedwater Block Valve 3HV4051 on April 20, 2005. Specifically, Operations personnel were unaware that the leak existed until notified by the inspectors. This issue involved human performance crosscutting aspects associated with operators failing to identify the leak on shiftly rounds. This issue was entered into the licensee's corrective action program as Action Requests 050401214 and 050401222.

The finding is determined to be greater than minor because it was associated with the human performance attribute of the initiating events cornerstone and affects the cornerstone objective of limiting the likelihood of those events that upset plant stability. Furthermore, if left uncorrected, the finding would become a more significant safety concern in that it would continue to challenge the licensee to promptly identify a hydraulic leak on Valve 3HV4051 in order to prevent a plant transient. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions were not available.
Inspection Report# : 2005003*(pdf)*

Mitigating Systems

Significance: G Dec 31, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Design Controls for Component Cooling Water Heat Exchanger Tube Plugging
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to implement appropriate design controls when plugging component cooling water heat exchanger tubes. Specifically, plugging heat exchanger tubes constitutes a design change. Criterion III requires the licensee to implement design control measures commensurate with those applied to the original design. The licensee entered the issue into their corrective action program as Action Request 051201123.

The failure to implement appropriate design controls when plugging heat exchanger tubes was a performance deficiency. The issue was more than minor because, if left uncorrected, it could result in a more significant safety concern, in that the heat exchanger may not be able to meet licensing basis/design basis heat exchanger capabilities. The inspectors assessed the finding in accordance with the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet and determined the finding was of very low safety significance. Specifically, this design deficiency was confirmed not to result in loss of operability in accordance with "Part 9900, Technical Guidance, Operability Determination Process for Operability and Functional Assessment."

Inspection Report# : 2005005*(pdf)*

Significance: G Aug 17, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Improper Acceptance Limits for Surveillance Testing
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," for the failure to provide procedures that incorporated requirements and acceptance limits for inservice testing. The licensee's use of an inappropriate computer software program resulted in an incorrect determination of acceptability for 14 of 28 surveillance tests. For example, on August 15, 2005, an alert limit was exceeded on charging Pump 3P191 and the issue was not identified until 8 hours after completing the surveillance test. The finding had crosscutting aspects in the area of human performance because the use of the faulty software program by maintenance engineering personnel directly contributed to the cause of the finding. Additionally, this issue had problem identification and resolution crosscutting aspects in that maintenance engineering personnel did not implement timely corrective actions to resolve the software issues.

The finding was determined to be more than minor because it was associated with the human performance attribute of the mitigating systems cornerstone. It also affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. Additionally, if left uncorrected, this issue could have resulted in equipment being considered operable even though testing may have demonstrated the equipment was inoperable. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the finding did not represent an actual loss of a single train of a safety system for greater than its Technical Specification allowed outage time.

Inspection Report# : 2005004*(pdf)*

Significance: G Jun 26, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Properly Implement Maintenance Rule Requirements for SBCS Header Cracks
The inspectors identified a noncited violation of 10 CFR 50.65 (a)(1) for the failure to include component deficiencies of a system important to safety in the maintenance rule program. Specifically, the licensee did not incorporate piping header failures of the Unit 2 and Unit 3 steam bypass control system into the maintenance rule program to ensure appropriate monitoring and goal setting activities were established. This issue was entered into the corrective action program as AR 050200923.

The finding was determined to be greater than minor because it affected the equipment reliability attribute of the mitigating systems cornerstone and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the SBCS did not actually experience a loss of safety function.
Inspection Report# : 2005003*(pdf)*

Barrier Integrity

Significance: G Oct 22, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Procedure Results in Inadvertent Loss of Containment Cooling
A self-revealing noncited violation of Technical Specification 3.6.6.1 was identified for the Unit 3 containment emergency cooling units being inoperable for longer than the allowed outage time of 72 hours. The implementation of inadequate procedures, specifically Procedure SO23-3-3.13, "Containment Cooling/Spray Monthly Tests," resulted in containment fan cooler breakers having improper overcurrent setpoints. The procedures were revised and the containment cooler fan breakers were adjusted to their proper setpoints. This issue has been entered into the licensee's corrective action program as Action Request 051000020.

The finding is greater than minor because it is associated with the procedure quality attribute of the barrier integrity cornerstone. It also affected the cornerstone objective of ensuring the integrity of the reactor containment. The Phase 1 worksheets in Manual Chapter 0609, "Significance Determination Process," were used to conclude that an Appendix H "Containment Integrity Determination Process," analysis was required because the finding involved an actual reduction in defense-in-depth for the atmospheric pressure control of the reactor containment. Table 4.1 of Appendix H of Manual Chapter 0609 indicated that the containment cooling safety function can impact late containment failure and source terms, but not large early release frequency. Based on the results of the Appendix H analysis, the finding is determined to have very low safety significance. The cause of the finding is related to the crosscutting element of human performance in that maintenance personnel did not ensure the correct breaker overcurrent tolerances were incorporated into surveillance and postmaintenance testing procedures.
Inspection Report# : 2005005*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : May 25, 2006