San Onofre 2
3Q/2008 Plant Inspection Findings

Initiating Events

Significance: G Aug 26, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Follow Procedure to Move Fuel in the Spent Fuel Pool
Two examples of a self-revealing noncited violation of 10 CFR 50, Appendix B, Criterion V, were identified for the failure of engineering personnel to follow procedures for the movement of nuclear fuel in the spent fuel pool. Specifically, on July 3, 2008, and again on August 26, 2008, spent fuel assemblies were placed into storage locations that were different than the evaluated and approved locations specified on Procedure SO23-X-7.2, Attachment 4. This finding was entered into the licensee's corrective action program as Nuclear Notification 200116680.

The finding is greater than minor because it would become a more significant safety concern if left uncorrected in that nuclear fuel could be inadvertently placed in an unanalyzed location. Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria," was used since the Significance Determination Process methods and tools were not adequate to determine the significance of the finding. This finding affects the initiating events cornerstone and is determined to have very low safety significance by NRC management review because the incorrect fuel storage locations were determined to be acceptable storage locations for the fuel assemblies in question. This finding has a crosscutting aspect in the area of human performance associated with work practices because engineering personnel failed to use human error prevention techniques commensurate with the risk of the assigned task, such that work activities were performed safely.

Inspection Report# : 2008004 *(pdf)*

Significance: G Jun 03, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Properly Monitor and Execute a Unit 2 Reactivity Manipulation.
A self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion V, (Procedures) was identified for the failure of operations personnel to understand, monitor and perform a Unit 2 reactivity manipulation in accordance with procedural requirements. This failure contributed to the overfeeding of both steam generators as well as the inadvertent addition of positive reactivity during a planned startup. Specifically, on June 3, 2008, operations personnel failed to follow Procedure SO123-0-A1, "Conduct of Operations," Revision 14, step 6.5.2.7, which requires, in part, that all reactivity manipulations are to be identified and fully understood and shall be closely monitored to verify the expected magnitude, direction, and effects are realized. This finding was entered into the licensee's corrective action program as Action Request 0080600073.

The finding is greater than minor because it is associated with the human performance attribute of the Initiating Events Cornerstone and affects the cornerstone objective to limit the likelihood of events that upset plant stability. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets, the finding is determined to have very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment or functions would not be available. The finding has a crosscutting aspect in the area of human performance associated with work practices because operations personnel proceeded in the face of uncertainty or unexpected circumstances [H.4(a)].

Inspection Report# : 2008003 *(pdf)*

Significance: G Apr 10, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Implement Procedural Requirements for Planned Unit 2 Power Reduction.
A self-revealing noncited violation of Technical Specification 5.5.1.1 was identified associated with the failure to implement procedural guidance to ensure a Unit 2 power reduction was properly performed. Lack of supervisory oversight resulted in an uncoordinated power reduction, resulting in a steam generator low pressure pre-trip annunciator. Specifically, on April 10, 2008, operations personnel failed to implement appropriate procedures to properly perform a power reduction from full power to 65 percent in support of a planned repair of a main feedwater pump. This finding was entered into the licensee's corrective action program as Action Request 80400544.

The finding is greater than minor because it is associated with the human performance attribute of the Initiating Events Cornerstone and affects the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge the critical safety functions during shutdown as well as power operations. Using Manual Chapter 0609, "Significance Determination Process," Phase 1

Worksheets, the finding is determined to have very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment or functions would not be available. The finding has a crosscutting aspect in the area of human performance associated with work practices because supervisory operations personnel did not ensure that the work activity was properly supervised to ensure the support of nuclear safety [H.4(c)].

Inspection Report# : 2008003 *(pdf)*

Significance: G Mar 24, 2008
Identified By: NRC
Item Type: FIN Finding
Unit 2 Main Feedwater Pump Trip Results in Inadvertent Power Reduction
The inspectors identified a Green self-revealing finding for the failure of maintenance personnel to adequately adjust bearing oil pressure to a Unit 2 main feedwater pump. This caused the main feedwater pump to trip, which subsequently caused an unplanned power reduction. The overhaul procedure used by the machinists, SO23-I-8.165, "Feed Pump Drive Turbine Internal, Bearing, and Valve Inspection," Revision 11, only stated to "adjust pressures as required." This finding was entered into the licensee's corrective action program as AR 080101431.

The finding was more than minor because it affects the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Using Manual Chapter 609, Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance (Green) 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. The finding had a crosscutting aspect in the area of human performance associated with the work practices (H.4(a)) in that human error prevention techniques, such as proper documentation, were not implemented, and that maintenance personnel proceeded with the work activity when faced with uncertainty.

Inspection Report# : 2008002 *(pdf)*

Significance: G Oct 11, 2007
Identified By: Self-Revealing
Item Type: FIN Finding
Ineffective Corrective Actions for Instrument Air Header Ruptures
The inspectors reviewed a self-revealing Green finding involving ineffective corrective actions taken in response to site and industry operating experience with instrument air header ruptures. Specifically, contrary to Section 6.2.3 of Procedure SO-123-I-1.42, "Maintenance Division Experience Report," Revision 0, the licensee failed to implement corrective actions to prevent recurrence for an equipment failure with the potential to cause a significant plant transient, and failed to appropriately consider previous industry and plant experience similar to the event. Additionally, licensee personnel failed to properly evaluate and take corrective actions based on industry operating experience through 2006 involving improperly made soldered joints in instrument air systems. As a result, an additional failure of an improperly made instrument air header joint occurred at SONGS on June 20, 2007. The licensee entered this issue in their corrective action program as Action Request AR 070600867.

This finding was more than minor since it was associated with the equipment reliability attribute of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. This finding required a Phase 2 analysis per the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets since the loss of instrument air is a transient initiator resulting in the loss of the feedwater system which is part of the power conversion system which can be used to mitigate the consequences of an accident. Based on the results of the Phase 2 analysis and a subsequent Phase 3 analysis, the finding was determined to be of very low safety significance (Green) because of the availability of the diverse auxiliary feedwater system and the ability of the operators to depressurize the steam generators and utilize the condensate system for heat removal. These results were evaluated by a senior reactor analyst. This finding has a crosscutting aspect in the area of problem identification and resolution associated with operating experience in that the licensee failed to effectively implement changes to station processes, procedures, and equipment in response to operating experience involving improperly made instrument air system joints [P.2(b)].
Inspection Report# : 2007013 *(pdf)*

Significance: G Oct 11, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
Failured to Follow Abnormal Operating Instruction in Response to a Loss of Instrument Air
The inspectors identified a Green noncited violation of Technical Specification 5.5.1.1 involving the failure to meet procedural requirements following a loss of instrument air. Specifically, operators failed to monitor nitrogen tank levels or take precautions for the possibility of oxygen-deficient areas in the plant following actuation of the low pressure backup nitrogen system. The licensee entered this issue in their corrective action program as Action Request AR 070700291.

This finding was more than minor since it was associated with the human performance attribute of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. This finding required a Phase 2 analysis in accordance with the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets

since the loss of instrument air is a transient initiator resulting in the loss of the feedwater system which is part of the power conversion system which can be used to mitigate the consequences of an accident. Based on the results of the Phase 2 analysis, the finding was determined to be of very low safety significance because of the low likelihood of a complete loss of instrument air and the availability of the auxiliary feedwater system. The cause of this finding has a crosscutting aspect in the area of human performance associated with resources because licensee personnel were not adequately trained on the operation of the low pressure nitrogen system to effectively implement the abnormal operating instruction [H.2(b)].
Inspection Report# : 2007013 *(pdf)*

Mitigating Systems

Significance: G Jun 18, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Air Supply Equalizing Valve Not Secured Closed Due To Failure To Follow Procedure
The inspectors identified a noncited violation of Technical Specification 5.5.1.1 for the failure of operations personnel to follow Procedure SO23-2-8.1,"Saltwater Cooling System Alignments," Revision 7. Specifically, on June 17, 2008, inspectors identified air equalizing supply Valve HV6200 not secured closed, contrary to procedural requirements. These valves were required to be secured closed as a corrective action to Apparent Cause Evaluation 060100377. This finding was entered into the licensee's corrective action program as Nuclear Notification 200038227.

The finding is greater than minor because it would become a more significant safety concern if left uncorrected, in that air equalizing supply valves could be inadvertently opened rendering their associated air-operated valves unable to perform their safety function. The finding affected the Mitigating Systems Cornerstone. Using Manual Chapter 0609 "Significance Determination Process," Phase 1 Worksheets, the finding is determined to have very low safety significance because it did not result in the actual loss of system safety function. The finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program, because the licensee did not thoroughly evaluate problems such that resolutions address causes and extent of condition [P.1(c)].

Inspection Report# : 2008003 *(pdf)*

Significance: G Jun 03, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Properly Implement the Operability Determination Process.
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," for the failure of operations and engineering personnel to follow procedures and adequately evaluate degraded, nonconforming, and unanalyzed conditions to support operability decision-making. Specifically, on June 3, 2008, operations and engineering personnel failed to adequately evaluate the operability of the Unit 2 component cooling water system Train A when unexpected, rapid heat exchanger fouling occurred during low tide conditions. This finding was entered into the licensee's corrective action program as Action Request 080600438.

The finding is greater than minor because the degraded component cooling water heat exchanger is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets, the finding is determined to have very low safety significance because the finding did not result in a loss of safety function of component cooling water Train A for greater than the Technical Specification allowed outage time. This finding has a crosscutting aspect in the area of human performance associated with decision-making because the licensee did not make safety-significant decisions using a systematic process when faced with uncertain and unexpected conditions [H.1(a)].

Inspection Report# : 2008003 *(pdf)*

Significance: G Jan 12, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Operability Procedure
The inspectors identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of operations personnel to meet operability determination procedural requirements following unexplained load swings on Emergency Diesel Generator 3G002. Specifically, operations personnel failed to evaluate the operability of the diesel, per procedure, once a degrading condition had been identified. The licensee entered this issue in their corrective action program as Action Request AR 071201393.

The inspectors determined that the failure to follow SONGS's Procedure SO123 XV 52, Revision 7, "Functionality Assessments and Operability Determinations," constituted a performance deficiency and a violation. The inspectors determined that the violation was more

than minor because it is associated with the mitigating systems cornerstone attribute of human performance and it affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The failure to identify the degraded condition associated with Emergency Diesel Generator 3G002 led to operation of Unit 3 with an inoperable diesel for approximately 9 days. Furthermore, the inspectors determined that the cause of the violation is related to the crosscutting area of problem identification and resolution because the licensee did not thoroughly evaluate the problem, including not properly classifying, prioritizing, and evaluating for operability a condition adverse to quality [P.1(c)].

In accordance with Inspection Manual Chapter 0609, “Significance Determination
Process,” Attachment 4, “Phase 1 – Initial Screening and Characterization of Findings,” the inspectors concluded the violation was of very low safety significance (Green) because it did not represent an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time

Inspection Report# : 2008006 *(pdf)*

Significance: G Jan 12, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Surveillance Test Procedure
The inspectors identified a Green noncited violation of Technical Specification 5.5.1.1 for an inadequate monthly Surveillance Test Procedure SO23-3-3.23, “Diesel Generator Monthly and Semi-Annual Testing,” Revision 30. The licensee failed to provide adequate guidance for evaluating momentary transients while performing emergency diesel generator surveillance testing. The licensee entered this issue in their corrective action program as Action Requests AR 071201393.

The failure to have a proper procedure in place for emergency diesel generator surveillance testing was considered a performance deficiency. The inspectors determined that the violation was more than minor because it is associated with the mitigating systems cornerstone attribute of human performance and it affected the cornerstone objective of ensuring availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The failure to fully understand the statement regarding momentary transients contributed to the delayed identification of a degraded condition associated with the Emergency Diesel Generator 3G002. The inspectors determined that the cause of the violation is related to the crosscutting area of human performance because operations personnel did not use conservation assumptions in decision making. Specifically, the operations personnel did not understand what the reference to momentary transients meant and failed to evaluate the statement in the procedure further in the face of uncertainty. The procedure indicated that momentary transients might be acceptable and operations personnel made the decision to accept the guidance without proper investigation [H.1(b)].

In accordance with Inspection Manual Chapter 0609, “Significance Determination Process,” Attachment 4, “Phase 1 – Initial Screening and Characterization of Findings,” the inspectors concluded the violation was of very low safety significance (Green) because it did not represent an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time

Inspection Report# : 2008006 *(pdf)*

Significance: G Dec 31, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Properly Implement Maintenance Rule Requirements for EDG AVRs
Green. The inspectors identified a Green noncited violation of 10 CFR 50.65(a)(1) for the failure to include Units 2 and 3 emergency diesel generator automatic voltage regulator deficiencies as functional failures in the maintenance rule program. The inspectors noted that the voltage regulator deficiencies should have placed the emergency diesel generators into maintenance rule 10 CFR 50.65(a)(1) status approximately six months after the failure occurred. This caused a lapse in the determination of appropriate system monitoring and goal setting to maintain system reliability. This issue was entered into the licensee's corrective action program as Action Request 070300161.

The finding was determined to be more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and it affected the cornerstone objective by challenging the availability and capability of safety-related components. Based on the results of the Significance Determination Process Phase 1 evaluation, the finding was determined to have very low safety significance because it did not result in an actual loss of a system safety function, a loss of a single train of safety equipment for greater than its technical specification allowed outage time, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events. This finding also had crosscutting aspects in the area of problem identification and resolution associated with the corrective action program (P.1(c)) because the licensee failed to thoroughly evaluate the cause and extent of condition of the failed EDG AVRs.
Inspection Report# : 2007005 *(pdf)*

Significance: G Dec 31, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish Procedural Requirements for Draining the Auxiliary Feedwater Steam Supply Trench

Green. The inspectors identified a Green noncited violation of Technical Specification 5.5.1.1 for the failure of operations personnel to have adequate procedural guidance in place to ensure the proper application for use of a submersible pump to prevent wetting of the steam supply to the Unit 2 turbine driven auxiliary feed pump to maintain operability. The inspectors noted during a plant walk-down on October 5, 2007, that a submersible pump and hose was in use in a pipe trench in the Unit 2 auxiliary feedwater pump building without sufficient procedural guidance to ensure that the trench would not fill up with water and render the Unit 2 auxiliary feedwater pump inoperable. This issue was entered into the licensee's corrective action program as Action Request 071000309.

The finding was determined to be more than minor because, if left uncorrected, it could become a more significant safety concern due to degradation of safety-related equipment. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance (Green) because it did not result in a loss of safety function and did not affect the risk of external initiators. The finding had a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program (P.1(c)) in that the licensee did not thoroughly evaluate the problem such that resolutions address causes and extent of conditions, as necessary
Inspection Report# : 2007005 *(pdf)*

Significance: G Dec 31, 2007
Identified By: NRC
Item Type: VIO Violation
Failure to Prevent Recurrence of Premature Tripping of Square D Thermal Overloads
Green. A self revealing Green violation of 10 CFR Part 50, Appendix B, Criterion XVI, was identified for the failure to prevent recurrence of premature tripping of Square D thermal overloads used for equipment protection on safety-related equipment. The licensee failed to scope the thermal overloads associated with the Unit 3 saltwater cooling pump room because they had previously determined that it had sufficient margin such that it would not be susceptible to failure. The licensee has since replaced all 75 susceptible thermal overloads that were previously scoped out of the corrective action process. This issue was entered into the licensee's corrective action program as Action Request 070800454.

The finding was determined to be more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and it affected the cornerstone objective by challenging the availability and capability of safety-related components. The inspectors also noted that this a repetitive problem in implementing corrective actions. Based on the results of the Significance Determination Process Phase 1 evaluation, the finding was determined to have very low safety significance because it did not result in an actual loss of a system safety function, a loss of a single train of safety equipment for greater than its technical specification allowed outage time, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events. This finding also had crosscutting aspects in the area of problem identification and resolution associated with the corrective action program (P.1(c)) because the licensee failed to thoroughly evaluate the extent of condition of insufficient solder material on safety-related thermal overloads.
Inspection Report# : 2007005 *(pdf)*

Significance: G Oct 11, 2007
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Evaluation Results in CCW Pump Runout
A self-revealing, Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified when Unit 2 experienced a loss of instrument air due to the failure of a soldered joint. Specifically, the loss of instrument air resulted in component cooling water (CCW) Pump 024 being in a runout condition for approximately 75 minutes due to a previous system modification. The licensee entered this issue in their corrective action program as Action Requests AR 070700051 and 070600872.

This finding was greater than minor because it was associated with the mitigating systems cornerstone attribute of design control and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding did not affect the initiating events cornerstone functions of the component cooling water system because the condition would only have existed given a loss of instrument air initiator had already occurred. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "Significance Determination Process (SDP) Phase 1 Screening Worksheet for the Initiating Events, Mitigating Systems, and Barriers Cornerstones," this finding was determined to be of very low safety significance because the finding was a design deficiency confirmed not to result in a loss of operability per "Part 9900, Technical Guidance, Operability Determination Process for Operability and Functional Assessment."
Inspection Report# : 2007013 *(pdf)*

Significance: G Oct 11, 2007
Identified By: Self-Revealing
Item Type: FIN Finding
Ineffective Corrective Actions for a Failed Control Room Annunciator
The inspectors reviewed a self-revealing Green finding involving the failure to take effective corrective actions for a failed control room annunciator. Specifically, after the annunciator for actuation of the backup nitrogen supply to the instrument air system failed to function on demand on several occasions from 1994 through 2007, the corrective actions taken by the licensee to restore the annunciator to service were inadequate and narrowly focused. The annunciator subsequently failed to function during the loss of instrument air event on June 20, 2007.

The licensee entered this issue in their corrective action program as Action Request AR 070601250.

This finding was more than minor since it was associated with the human performance attribute of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. This finding required a Phase 2 analysis in accordance with the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets since the loss of instrument air is a transient initiator resulting in the loss of the feedwater system which is part of the power conversion system which can be used to mitigate the consequences of an accident. Based on the results of the Phase 2 analysis, the finding was determined to be of very low safety significance because of the low likelihood of a complete loss of instrument air and the availability of the auxiliary feedwater system. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program in that the licensee failed to thoroughly evaluate the failed annunciator such that the resolution appropriately addressed the causes [P.1(c)].
Inspection Report# : 2007013 *(pdf)*

Significance: G Oct 11, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedure for Loss of Instrument Air
The inspectors identified a Green noncited violation of Technical Specification 5.5.1.1 involving the failure to maintain an adequate abnormal operating instruction for a loss of instrument air event. The licensee entered this issue in their corrective action program as Action Request AR 070801151.

This finding was more than minor because it was associated with the procedure quality attribute of the mitigating systems cornerstone and affected the cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events, in that a less than adequate abnormal operating procedure could have prevented operators from promptly tripping the reactor, allowing conditions to continue to degrade and resulting in a demand on the reactor protection system. Using the Significance Determination Process Phase 1 Screening Worksheet in Appendix A of Inspection Manual Chapter 0609, the inspectors determined this finding had very low safety significance because it did not result in an actual loss of safety function per "Part 9900, Technical Guidance, Operability Determination Process for Operability and Functional Assessment." This finding has a crosscutting aspect in the area of human performance associated with resources in that the licensee failed to provide operators with complete, accurate, and up-to-date procedures [H.2(c)].
Inspection Report# : 2007013 *(pdf)*

Significance: G Oct 11, 2007
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Simulator Incorrectly Modeled Plant Response to Loss of Instrument Air
A self-revealing, Green noncited violation of 10 CFR Part 55.46(c)(1) was identified involving the licensee's failure to incorporate a design change in modeling plant response for the plant-referenced simulator. Specifically, during operator training in the plant-referenced simulator, the controlled bleedoff valves for the reactor coolant pumps were modeled to fail closed on a loss of instrument air, whereas the valves in the plant remained open during an actual loss of instrument air event on June 20, 2007. The licensee entered this issue in their corrective action program as Action Requests AR 070600873 and 070900160.

This finding was greater than minor because it was associated with the mitigating systems cornerstone attribute of human performance and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated this finding using the Appendix I, "Licensed Operator Requalification Significance Determination Process" worksheets of Manual Chapter 0609 because the finding is a requalification training issue related to simulator fidelity. The finding is of very low safety significance because the discrepancy did not have an adverse impact on operator actions such that safety related equipment was made inoperable during normal operations or in response to a plant transient. This finding has a crosscutting aspect in the area of human performance associated with resources in that the licensee did not provide operators with adequate facilities and equipment for use in operator training [H.2(d)].
Inspection Report# : 2007013 *(pdf)*

Significance: G Oct 11, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Procedure for an Impaired Annunciator
The inspectors identified a Green noncited violation of Technical Specification 5.5.1.1 involving the failure to meet procedural requirements governing impaired annunciators. Specifically, after the identification of a failed annunciator, operators did not enter the annunciator in the failed annunciator log or mark the affected annunciator window with an annunciator compensatory action flag. The licensee entered this issue in their corrective action program as Action Request AR 070700291.

This finding was more than minor since it was associated with the human performance attribute of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. This finding required a Phase 2 analysis in accordance with the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets

since the loss of instrument air is a transient initiator resulting in the loss of the feedwater system which is part of the power conversion system which can be used to mitigate the consequences of an accident. Based on the results of the Phase 2 analysis, the finding was determined to be of very low safety significance because of the low likelihood of a complete loss of instrument air and the availability of the auxiliary feedwater system. This finding has a crosscutting aspect in the area of human performance associated with resources because the operators were not sufficiently trained to consistently implement the annunciator operating procedure [H.2(b)].
Inspection Report# : 2007013 *(pdf)*

Significance: G Oct 11, 2007
Identified By: Self-Revealing
Item Type: FIN Finding
Inadequate Implementation of Corrective Actions for Air Operated Valve Regulators
A Green self-revealing finding was identified associated with the failure of the reactor coolant pump controlled bleed off valve to shut during a loss of instrument air event. The licensee failed to adequately implement corrective actions from previously evaluated industry operating experience for new valve regulators that were installed in the unit. The licensee entered this issue in their corrective action program as Action Request AR 070600873.

The finding was greater than minor because it was associated with the mitigating systems cornerstone attribute of design control and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheet, the finding is determined to have very low safety significance because the condition only affected the mitigation systems cornerstone and it was confirmed not to result in loss of operability per “Part 9900, Technical guidance, Operability Determination Process for Operability and Functionality Assessment”
Inspection Report# : 2007013 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Last modified : November 26, 2008