

# San Onofre 2

## 4Q/2011 Plant Inspection Findings

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### Initiating Events

**Significance:** SL-III Apr 18, 2011

Identified By: NRC

Item Type: VIO Violation

#### **Inactive SRO Performed Licensed Duties as Refueling SRO Supervisor**

The inspector identified one violation of 10 CFR 55.53(f) which states, in part, that the facility licensee is required to certify that the qualifications and status of a Senior Reactor Operator (SRO) are current and valid prior to the operator resuming activities authorized by their license. Specifically, on October 21, 2010, and October 27, 2010, an SRO performed licensed activities (core alterations) as Refueling SRO Supervisor while his license was INACTIVE.

Additionally, the SRO was on a temporary medical hold from licensed activities on the dates identified. On October 27, 2010, the SRO's license restrictions were questioned by on-shift operations personnel and the SRO was relieved from his watch station. The licensee has entered this violation into their corrective action program as NN 201174957. The corrective actions taken and planned to correct the violation and prevent recurrence and the date when full compliance will be achieved is considered adequate.

Failure of the facility licensee to maintain electronic programs used to verify licensed operator qualifications and to schedule licensed operator watch stations up-to-date with licensed operator worker qualifications and license restrictions could potentially impede the regulatory process by not providing complete and accurate information to NRC inspectors. NRC Enforcement Policy, Section 6.4, Licensed Reactor Operators, Item c.1.(c) states, in part, that if a licensed operator, or a senior operator actively performing the functions covered by that position, is determined to be in noncompliance with a condition stated on the individual's license, then a Severity Level III violation exists.

Inspection Report# : [2011012](#) (pdf)

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### Mitigating Systems

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Maintain Emergency Core Cooling System Valves in Required Positions**

The inspectors identified a noncited violation of Technical Specification 5.5.1.1.a for the failure of operations personnel to maintain valves in positions required by procedures. The inspectors observed a drain valve, required to be closed by procedure, to be less than fully closed during a partial walk down of the Unit 2 high pressure safety injection system. Specifically, prior to August 17, 2011, operations personnel failed to implement instructions for filling, venting, draining, startup, shutdown, and changing modes of operation for emergency core cooling systems as written to ensure that high pressure safety injection system suction line drain valve 1204MR096 was in the required position. A plant equipment operator verified that the valve was returned to the required position and promptly informed the control room of the out-of-position valve. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201608017. The performance deficiency is more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern and is therefore a finding.

Specifically, if seismic class I valves continue to be mispositioned, safety-related plant systems may be unable to accomplish their safety functions after an accident. This finding is associated with the Mitigating Systems Cornerstone. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the inspectors determined this finding to be of very low safety significance because it did not result in the loss of a system safety function, did not represent the loss of safety function of a single train for greater than its allowed outage time, did not result in the loss of safety function of any non-technical specification equipment, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events. This finding has a crosscutting aspect in the area of human performance associated with the resources component because the licensee

failed to ensure procedures for operation of Keratest valves were adequate [H.2(c)](Section 1R04).

Inspection Report# : [2011004](#) (pdf)

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Provide Adequate Flood Protection for the Auxiliary Feedwater Steam Supply Piping**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for failure to translate applicable regulatory requirements and the design basis into specifications, drawings, procedures, and instructions. The Updated Final Safety Analysis Report, states, in part that, "In the extreme event that the thunderstorm PMP occurs, no safety-related equipment will be impacted by flooding," since, "Drainage water in the structures which entered from other areas (e.g. from roofs, open areas) will not reach safety-related equipment." Specifically, from original construction until adequate compensatory measure were implemented on May 5, 2011, the steam supply piping to the auxiliary feedwater pump turbine was not adequately protected from all postulated flood levels and conditions, such that, in the extreme event that the thunderstorm probable maximum precipitation occurs, water could have reached the steam supply pipe resulting in steam condensation inside the pipe which could impact auxiliary feedwater pump operability. The compensatory measures will remain in place until the design nonconformance is resolved. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201448584. The performance deficiency is more than minor and therefore a finding because it is associated with the protection against external events attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using NRC Inspection Manual 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the finding screened to a Phase 2 significance determination because it involved a potential loss of safety function. A Phase 2 was not appropriate for this external event. The Senior Reactor Analyst determined that the finding had very low significance. This was based on information received from the licensee indicating that the precipitation intensity required to render the turbine-driven auxiliary feedwater pump non-functional had a return frequency well below 1.0E-6/yr. In the case of clogged drains, less intense rain could affect the function of the pump, but would likely not cause a transient. A bounding risk estimate indicated that the delta core damage frequency of this scenario was less than 1.0E-7/yr. No crosscutting aspect was identified because this issue is not reflective of current performance, since this condition has existed since construction (Section 1R15).

Inspection Report# : [2011004](#) (pdf)

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Incorporate Calculation Results into Plant Procedures**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of engineering personnel to ensure that procedures for preventing unacceptable gas accumulation included appropriate qualitative or quantitative acceptance criteria to ensure that this important activity had been satisfactorily accomplished. Specifically, from July 2008 through August 2011, after performing Calculation M-0013-005, "Safety Injection Tank Fluid Nitrogen Evolution," which determined the maximum permissible back-leakage from the safety injection tanks into the emergency core cooling systems pump discharge headers to preclude unacceptable gas accumulation, engineering personnel failed to incorporate the results of this calculation into plant procedures. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201606472. The performance deficiency is more than minor because it is associated with the procedure quality attribute of the Mitigating Systems Cornerstone objective and to ensure the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences, and is therefore a finding. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the inspectors determined the finding to be of very low safety significance because it did not represent the loss of safety function of any system or train and was not potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance associated with the decision making component because, when confronted with conservatively calculated information, engineering personnel failed to incorporate these conservative assumptions into plant procedures to ensure accumulating gas was identified before reaching an unacceptable volume, instead deciding to use informal trending mechanisms to track safety injection tank leakage [H.1(b)](Section 4OA5).

**Significance:** G Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Perform Plant Modification in Accordance with Applicable Specifications**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure of licensee personnel to perform a modification to the Unit 3 high pressure safety injection system in accordance with the seismic requirements of the applicable construction specification. Specifically, in March 2010 (Unit 2) and February 2011 (Unit 3), licensee personnel failed to ensure that modifications per Engineering Change Packages NECP 800194395 (Unit 2) and NECP 800229823 (Unit 3) were either accomplished in accordance with Construction Specification CS-P206, "Design Guide for Supporting Small Piping (2 Inch and Under)," Revision 14, as required by the design change packages, or that deviations from the construction specification were controlled. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201608558. The performance deficiency is more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, and is therefore a finding. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the inspectors determined the finding to be of very low safety significance because it did not represent the loss of safety function of any system or train, and because during a seismic event, the absence of seismic supports on the subject pipe would not cause a plant trip or other initiating event, would not degrade two or more trains of a multi-train safety system or function, and would not degrade one or more trains of a system that supports a safety system or function. This finding has a crosscutting aspect in the area of human performance associated with the work practices component because licensee personnel failed to define and effectively communicate expectations regarding procedural compliance and to ensure that personnel followed procedures [H.4(b)](Section 4OA5).

Inspection Report# : [2011004](#) (pdf)

**Significance:** G Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Assessment of Seismic Qualification of Emergency Diesel Generator Buried Fuel Oil Tanks**

The team identified a Green noncited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states in part: "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, from initial construction until July 22, 2011, the licensee had not properly evaluated the seismic qualification of the buried emergency diesel generator fuel oil storage tanks, to ensure that the tank's structures would not fail during a seismic event. The calculation did not accurately reflect the actual installed condition of the fuel oil tanks. The team determined that failure of the tanks to remain intact would impact the capability of the safety related emergency diesel generators to perform their design function following the event. This finding was entered into the licensee's corrective action program as Nuclear Notification NN-201548802.

The team determined that the failure to have an adequate seismic calculation for emergency diesel generator fuel oil storage tanks was a performance deficiency. The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of design control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the inadequate design analysis of these components could have resulted in structural failure, preventing continued operation of the emergency diesel generators after an earthquake. In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding was of very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, the licensee performed a preliminary re-evaluation of the tank shell stresses due to the concrete structures, and determined that the tank stresses were still within the American Society of Mechanical Engineers (ASME) Code allowable stresses following a Safe Shutdown Earthquake (SSE). The team reviewed the evaluation, and concurred that the stresses were below those allowed by ASME Boiler and Pressure Vessel Code. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section

1R21.2.9).

Inspection Report# : [2011010](#) (*pdf*)

**Significance:**  Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Evaluate that Sufficient Voltage would be Available at the Emergency Diesel Generator Air Start Solenoid**

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states in part: "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, as of July 22, 2011, the licensee failed to evaluate that the voltage available at the emergency diesel generator diesel engine air start solenoid would be sufficient to ensure starting the diesel engine under design basis conditions. The licensee failed to incorporate the required minimum operating voltage for the emergency diesel generator air start solenoids into Calculation E4C-017. This finding was entered into the licensee's corrective action program as Nuclear Notifications NN-201513266 and NN-201566686.

The team determined that the failure to incorporate the required minimum operating voltage for the emergency diesel generator air start solenoids into Calculation E4C-017 was a performance deficiency. The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of design control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding was of very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, the licensee performed subsequent analyses and actual tests of the air start solenoids, which demonstrated that the emergency diesel generator air start solenoids would function as required to mitigate an accident. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section 1R21.2.13).

Inspection Report# : [2011010](#) (*pdf*)

**Significance:**  Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Incorporate Design Requirements into Procedures and Instructions**

The team identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states in part: "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, as of July 22, 2011, the licensee did not incorporate the vendor required amperage limit, identified in engineering change package ECP-040201281-2, for bus load limit requirements, into 480 Volt Switchgear Operating Instructions SO23-6-3. This finding was entered into the licensee's corrective action program as Nuclear Notification NN201570846.

The team determined that the failure to incorporate the vendor required amperage limit, identified in engineering change package ECP-040201281-2, for bus load limit requirements, into 480 Volt Switchgear Operating Instructions SO23-6-3 was a performance deficiency. The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of design control, to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, the licensee had never implemented 480 Volt Switchgear Operating Instructions SO23-6-3 for the purpose of cross tying busses in an emergency, where the limiting load on the bus may have been exceeded. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section 1R21.2.14).

Inspection Report# : [2011010](#) (*pdf*)

**Significance:**  Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Maintain Equipment Important to Safety**

The team identified a Green noncited violation of 10 CFR 50.65, “Requirements for monitoring the effectiveness of maintenance at nuclear power plants,” which states in part: “Each holder of a license to operate a nuclear power plant shall monitor the performance or condition of structures, systems, or components, against licensee-established goals, in a manner sufficient to provide reasonable assurance that such structures, systems, and components, are capable of fulfilling their intended functions, and when the performance or condition of a system, structure, or component, does not meet established goals, appropriate corrective actions shall be taken.” Specifically, as of July 22, 2011, the licensee failed to adequately monitor the condition of the Flood Level Detecting system in a manner to provide reasonable assurance the system could perform its intended function. The licensee failed to properly evaluate Maintenance Rule Functional Failures and take appropriate corrective actions to improve system performance. These level switches are connected to control room annunciation to warn the control room of flooding in a space that has safety-related or important to safety components. This has been entered into the licensee’s corrective action program as Nuclear Notifications NN-201567315 and NN-201570575.

The team determined that the failure to properly maintain the flood level sensors which are used for control room annunciation to warn the control room of flooding of a space that has safety related or important to safety components, was a performance deficiency. The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of design control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee did not maintain flood level sensors appropriately to provide reasonable assurance that the components would be capable of fulfilling their intended function. In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding represented the degradation of equipment and functions specifically designed to provide notification to the control room of flooding of spaces with safety related or important to safety equipment and components. Therefore, the finding was potentially risk significant and a Phase 3 analysis was required. The preliminary significance determination was based on Inspection Manual Chapter 0609, Appendix M, “Significance Determination Process Using Qualitative Criteria.” The senior reactor analyst determined qualitatively that the risk was very low for the following reasons: (1) the frequency of internal flooding is very low, (2) floods in most of the problem areas would not cause a transient, (3) redundant indications of flooding exist, including fire and sump pump operations, and (4) none of the potentially flooded areas would likely affect more than one train of safety equipment. This finding involved a cross-cutting aspect in the area of Human Performance, Resources, because the licensee failed to assure that equipment and other resources were available and adequate to assure nuclear safety. Specifically, the licensee was not able to maintain the flood level switches adequately to assure nuclear safety due to long-standing equipment issues [H.2(a)](Section 1R21.3.2).

Inspection Report# : [2011010](#) (*pdf*)

**Significance:**  Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Adequately Control Document Changes**

The team identified a Green non-cited violation, with multiple examples, of 10 CFR 50, Appendix B, Criterion VI, “Document Control,” which states in part: “Measures shall be established to control the issuance of documents, such as instructions, procedures, and drawings, including changes thereto, which prescribe all activities affecting quality. These measures shall assure that documents, including changes, are reviewed for adequacy and approved for release.” Specifically, on June 23, 2011, the team identified numerous drawing inconsistencies where changes to certain components were not changed on all affected drawings and procedural errors where changes were not made to all affected documents. The licensee has entered the errors into their corrective action program under numerous Nuclear Notifications listed in section 4AO2.

The team identified that collectively, from a program perspective, the failure to properly incorporate design changes of components in the plant to all affected drawings, procedures, or instructions, was a performance deficiency. The finding was more than minor because if left uncorrected, the performance deficiency had the potential to lead to a

more significant safety concern. In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding was of very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, none of the documents with the identified errors had been used in response to any events or plant perturbations. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section 40A2).

Inspection Report# : [2011010](#) (*pdf*)

**Significance:**  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Compensatory Measures for a Design Nonconformance**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure of operations personnel to establish adequate compensatory measures to restore or maintain operability as required by Procedure SO123-XV-52, "Operability Determination and Functionality Assessments," Revision 18. Specifically, on November 12, 2010, although engineering identified measures were required to maintain water level below the steam line in the auxiliary feedwater trenches, no measures had been taken to stage pumps or limit flows into the trenches. On May 5, 2011, as a result of the inspectors' questions, the licensee established additional compensatory measures including blocking storm drains that flow into the trench and staging sump pumps. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201448584.

The performance deficiency is more than minor, and therefore a finding, because it is associated with the protection against external events attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. During a design basis flooding from a probable maximum precipitation event, the auxiliary feedwater pump could be rendered inoperable. Using NRC Inspection Manual 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the finding screened to a Phase 2 significance determination because it involved a potential loss of safety function. A Phase 2 was not appropriate for this external event. The senior reactor analyst determined that the finding had very low significance. This was based on information received from the licensee indicating that the precipitation intensity required to render the turbine-driven auxiliary feedwater pump non-functional had a return frequency well below 1.0E-6/yr. In the case of clogged drains, less intense rain could affect the function of the pump, but would likely not cause a transient. A bounding risk estimate indicated that the delta core damage frequency of this scenario was less than 1.0E-7/yr. The finding was determined to have a cross-cutting aspect in the area of human performance associated with the decision-making component because operations personnel failed to verify the validity of underlying assumptions for operability decision-making [H.1(b)](Section 1R01).

Inspection Report# : [2011003](#) (*pdf*)

**Significance:**  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Work Instructions to Ensure Environmentally Qualified Configuration**

The inspectors identified that work instructions to replace a safety-related steam generator differential pressure transmitter did not contain adequate instructions to ensure that the scope of work was defined and the installed configuration would satisfy environmental qualification requirements. This involved multiple examples of a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings." The inspectors also identified that the licensee had failed to maintain procedures intended to address previous problems damaging delicate insulation needed to maintain environmental qualification, and had failed to plan modifications needed to implement a planned improvement to the environmental qualification configuration, challenging maintenance workers during transmitter replacement. The licensee has entered this issue into their corrective action program as Nuclear Notification NN 201477774.

Failure to provide adequate work instructions to replace a safety-related steam generator differential pressure transmitter to ensure that the scope of work was defined and the installed configuration would satisfy environmental qualification requirements is a performance deficiency. The performance deficiency affected the procedure quality attribute of the Mitigating Systems Cornerstone. This finding is more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern in that inadequate work instructions could result in a

failure to meet the environmental qualification in systems needed to mitigate accidents. This finding was determined to have very low safety significance during a Phase 1 significance determination because it involved a qualification deficiency that was confirmed not to result in loss of operability or functionality. This finding has a cross-cutting aspect in the resources component in the human performance area because the licensee failed to ensure that procedures and other resources were adequate to assure nuclear safety. Specifically, the licensee did not ensure that complete, accurate, and up-to-date design documentation, procedures, and work packages were provided to support replacement activities for generator differential pressure transmitter 2PDT-0979-2 [H.2(c)](Section 1R12).

Inspection Report# : [2011003](#) (pdf)

**Significance:**  Jun 30, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Failure to Appropriately Assess and Manage Risk for Work in Unit 3 Intake**

A self-revealing noncited violation of 10 CFR 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified for the failure of work control and operations personnel to adequately assess and manage the increase in risk associated with maintenance on the Unit 3 fish elevator.

Specifically, on March 29, 2011, a stop log was installed in the Unit 3 intake structure without informing the Unit 2 control room operators or establishing measures to maintain adequate Unit 2 saltwater flow to ensure the operability of the component cooling water system. Immediate corrective actions included verifying and monitoring Unit 2 train A component cooling water operability and taking actions to restore saltwater cooling flow and component cooling water/saltwater cooling heat exchanger differential pressure to normal. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201395115.

The performance deficiency is more than minor and therefore a finding because it is associated with the operating equipment configuration control 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 Manual Chapter 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," Flowcharts 1 and 2, the finding was determined to have very low safety significance because the incremental core damage probability deficit was less than 1E-6 and the incremental large early release probability deficit was less than 1E-7. This finding has a cross-cutting aspect in the area of human performance associated with the decision-making component because work control and operations personnel did not communicate decisions and the basis for decisions to individuals that needed to know the information in order to perform work safely and take appropriate risk management actions [H.1(c)](Section 1R13).

Inspection Report# : [2011003](#) (pdf)

**Significance:**  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Provide Adequate Long-Time Over-Current Protection for the Cables for Charging Pumps 2P190 and 2P191**

The inspectors identified that the licensee did not provide adequate long-time over-current protection for charging pumps 2P190 and 2P191 feeder cables. The finding involved a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control", for failure to translate applicable regulatory requirements and the design basis into specifications, drawings, procedures, and instructions. The licensee entered this issue into their corrective action program as Nuclear Notification NN 201443248.

Failure to provide adequate long-time over-current protection for the feeder cables for charging pumps 2P190 and 2P191 is a performance deficiency. The performance deficiency affected the Mitigating Systems Cornerstone. The performance deficiency is more than minor and therefore a finding, because if left uncorrected, it would have the potential to lead to a more significant safety concern in that possible mechanical problems with the pump or motor could cause the affected cables to exceed their current limit and cause cable damage without tripping the associated breaker. The finding was determined to have very low safety significance during a Phase 1 significance determination because it involved a design deficiency that was confirmed not to have resulted in a loss of operability or functionality. No crosscutting aspect was identified because this issue is not reflective of current performance, since this condition has existed since construction (Section 1R17).

Inspection Report# : [2011003](#) (pdf)

**Significance:**  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Follow Procedure Requirements for a Failed Surveillance**

The inspectors identified a noncited violation of Technical Specification 5.5.1.1, "Procedures," for the failure of operations personnel to follow the surveillance program requirements for control element assembly testing, when a satisfactory verification of control element assembly movement was not obtained. Specifically, on May 8, 2011, operations personnel failed to refer to the abnormal procedure and the applicable action statement for Technical Specification 3.1.5, "Control Element Assembly (CEA) Alignment," as required by Procedure SO23-3-3.5, "CEA/Reactor Trip Circuit Breaker Operability Testing," Revision 18, when a satisfactory verification of control element assembly movement was not obtained. The licensee assumed the inability to move a control element assembly was due to a control rod drive mechanism control system failure without establishing a technical basis. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201474804.

The performance deficiency is more than minor and therefore a finding, because, if left uncorrected, it would have the potential to lead to a more significant safety concern since using presumptions of operability with inadequate factual basis could result in a condition prohibited by technical specifications. The finding is associated with the Mitigating Systems Cornerstone. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets, the finding was determined to have very low safety significance because the finding: (1) was not a design or qualification issue confirmed not to result in a loss of operability or functionality; (2) did not represent an actual loss of safety function of the system or train; (3) did not result in the loss of one or more trains of nontechnical specification equipment; and (4) did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding has a cross-cutting aspect in the area of human performance associated with the decision-making component because operations personnel failed to use conservative assumptions in decision-making when evaluating test results to determine an appropriate course of action [H.1(b)](Section 1R22).

Inspection Report# : [2011003](#) (*pdf*)

**Significance:**  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Lack of Adequate Procedures to Respond to the Inability to Drive Control Rods**

The inspectors identified a noncited violation of Technical Specification 5.5.1.1, "Procedures," for the licensee's failure to establish procedures for the inability to drive control rods. Specifically, from initial licensing to May 2011, Abnormal Operating Instruction SO23-13-13, "Misaligned or Immovable Control Element Assembly," did not contain guidance to address an immovable control element assembly. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201497724.

The performance deficiency is more than minor and therefore a finding, 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 to prevent undesirable consequences. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheets, the inspectors determined the finding to have very low safety significance because the finding: (1) was not a design or qualification issue confirmed not to result in a loss of operability or functionality; (2) did not represent an actual loss of safety function of the system or train; (3) did not result in the loss of one or more trains of nontechnical specification equipment; and (4) did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The inspectors reviewed this finding for cross-cutting aspects and none were identified since the deficiency has existed since initial licensing and is not reflective of current performance (Section 1R22).

Inspection Report# : [2011003](#) (*pdf*)

**Significance:**  Mar 31, 2011

Identified By: NRC

Item Type: FIN Finding

**Failure to Follow Station Procedures for Seasonal Readiness**

The inspectors identified a finding for the failure of license personnel to follow procedure SO23-XX-29.1, "Seasonal Readiness." Specifically, licensee personnel failed to implement, as seasonal weather conditions dictated, the appropriate preventative maintenance program for roof drains associated with the emergency diesel generator

buildings. As a result of the recurring degraded and clogged roof drains, rainwater was allowed to accumulate on the roof which resulted in water intrusion into the Unit 2 building and over energized electrical equipment. A plastic tent was installed by maintenance personnel to protect the electrical equipment. Based on the inspectors' concerns, licensee personnel completed a walkdown of the other emergency diesel building to identify whether similar rainwater intrusion was occurring. Maintenance personnel corrected the condition by removing debris which had clogged the Unit 2 roof drains. This issue was entered into the licensee's corrective action program as Nuclear Notifications NN 201393414 and NN 201174566.

The performance deficiency is more than minor and is therefore a finding because it is associated with the protection against external events attribute of the Mitigating Systems cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to have very low safety significance because it did not represent a loss of system safety function, nor actual loss of safety function of a single train, and it did not screen as potentially risk significant due to flooding or severe weather because the potentially degraded equipment was not specifically designed to mitigate flooding or severe weather nor would it contribute to external event initiated accident sequences. The finding was determined to have a crosscutting aspect in the area of human performance associated with the component of work control because the licensee did not plan and coordinate work activities consistent with nuclear safety. Specifically, the licensee did not plan or implement preventative maintenance for roof drains to support long-term equipment reliability by limiting reliance on manual actions, such as plastic tents to protect plant equipment during the winter rainy season. Maintenance scheduling was more reactive than preventative [H.3(b)](Section 1R01).  
Inspection Report# : [2011002](#) (pdf)

**Significance:**  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Procedures to Establish Compensatory Measures**

The Inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instruction, Procedures, and Drawing," for the failure of operations personnel to follow the requirements of station procedure to perform an adequate operability determination and establish compensatory measures associated with an emergency diesel generator. Specifically, on February 23, 2011, operations personnel failed to follow procedures to establish compensatory measures associated with an emergency diesel generator when an immersion heater was removed from service. On March 18, interim corrective actions were taken that included operator required reading (priority 2 reading) to ensure that on-shift licensed operators use conservative decision making regarding compensatory measures. Planned corrective actions will be part of a root cause evaluation. These issues have been entered into the licensee's corrective action program as Nuclear Notifications NNs 201365616, 201348283 and 201378245. The performance deficiency was determined to be more than minor and is therefore a finding because it was associated with the Mitigating Systems Cornerstone attribute of procedure quality and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding is determined to have very low safety significance because it did not result in the loss of safety function of any technical specification required equipment. The finding was determined to have a crosscutting aspect in the area of human performance associated with the decision-making component because the licensee failed to verify the validity of underlying assumptions for operability decision-making.  
Inspection Report# : [2011002](#) (pdf)

**Significance:**  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Comply with Technical Specifications**

The inspectors identified a noncited violation of Technical Specification 3.5.4, "Refueling Water Storage Tank," for the failure of licensee personnel to enter the technical specification or complete the associated required action prior to the appropriate completion time when the refueling water storage tank (RWST) was inoperable. Specifically, the licensee did not enter the appropriate technical specification for an inoperable RWST when it was potentially not capable of performing its specified safety function while aligned to non-seismic spent fuel pool cooling and

purification system for cleanup. On October 8, 2010, operations personnel placed administrative controls on system isolation valves to prevent the RWST from being aligned to non-seismic systems. This issue was entered into the licensee's corrective action program as Nuclear Notifications NNs 201133936 and NN 201135761.

The performance deficiency was determined to be more than minor and is therefore a finding because it is associated with the design control attribute of the Mitigating Systems Cornerstone and affects the associated cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the inspectors determined that a Phase 2 evaluation was required because the finding involved the potential loss of safety function. A Phase 2 significance determination was performed using the pre-solved worksheet from the "Risk Informed Inspection Notebook for the San Onofre Nuclear Generating Station," Revision 2.01a. Assuming both trains of high pressure injection were inoperable, the finding was Yellow, which warranted further review. Therefore, the analyst performed a bounding Phase 3 significance determination. Based on the licensee's PRA calculation, consultation with licensee PRA personnel, and an understanding of the bounding and conservative assumptions incorporated in the analysis, the analyst determined that the licensee's delta-CDF result of  $7.6E-7$ /yr was clearly bounding, that the large early release frequency was negligible, and that the significance of the issue was very low. Since the apparent root cause determined the cause was due to weaknesses in the design change processes early in plant operations (between 1982 and 1995), and the licensee's program has improved with respect to performing design changes, the inspectors determined that this finding was not reflective of current performance and therefore did not have a crosscutting aspect associated with it.

Inspection Report# : [2011002](#) (*pdf*)

**Significance:**  Aug 16, 2010

Identified By: NRC

Item Type: VIO Violation

### **Failure to Ensure At Least One Train of Equipment Necessary to Achieve Hot Shutdown Conditions Is Free of Fire Damage**

The team identified a cited violation of License Condition 2.C(14), "Fire Protection," for failure to correct a noncompliance. Specifically, Inspection Report 05000361;362/2007008 documented a noncompliance involving the failure to ensure that at least one train of safe shutdown equipment would remain free from fire damage in each fire area. The NRC exercised discretion not to cite this violation at that time because the licensee met the criteria described in Enforcement Guidance Memorandum 98-002, Revision 2, and Supplement 2 to that revision. Enforcement Guidance Memorandum 07-004 superseded Enforcement Guidance Memorandum 98-002 and required licensees to complete corrective actions for noncompliances related to post-fire operator manual actions by March 6, 2009. This violation is being cited due to the failure to complete corrective actions and restore compliance within the required time. This finding was entered into the licensee's corrective action program as Notification NN 200940265.

The failure to promptly restore adequate fire protection and/or separation of required safe shutdown systems was a performance deficiency. This performance deficiency was more than minor because it was associated with the protection against external factors (fire) attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events in order to prevent undesirable consequences. Because the violation involved multiple fire areas, the team could not evaluate this issue using Phase 2 of Inspection Manual Chapter 0609, Appendix F, and a Phase 3 significance determination process risk assessment was performed by a senior reactor analyst. The finding was determined to have very low risk significance (Green), with a delta-CDF of  $3.2E-8$ /yr, because of a combination of the availability of long recovery times for feasible operator manual actions and low-probability fire damage scenarios in the nine fire areas with fire sources which could potentially damage cables of required safe shutdown components. This finding involved a cross-cutting aspect in the decision-making component in the human performance area because the licensee failed to make a risk-significant decision using a systematic process when considering the scheduling of corrective actions.

Inspection Report# : [2010007](#) (*pdf*)

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## **Barrier Integrity**

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# Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## 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.

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## Miscellaneous

Last modified : March 02, 2012