

San Onofre 2

4Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Mar 24, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Two Examples of Failure to Follow Procedures for Control of Corrosion Related Maintenance

The inspectors identified a Green non-cited violation of Technical Specification 5.5.1.1 for the failure by licensee personnel to follow Procedure SO23-XX-30, "Nuclear Maintenance Order (NMO) Generation, Screening and Classification," Revision 9 EC1, and Procedure SO23-XX-36, "Toolpouch Maintenance Program," Revision 1 EC1. Specifically, prior to March 5, 2013, the licensee's Nuclear Maintenance Order Screening Committee failed to assign the appropriate job type and priority to seven corrosion-related nuclear maintenance orders in accordance with Procedure SO23-XX-30, "Nuclear Maintenance Order (NMO) Generation, Screening and Classification," Revision 9 EC1. Additionally, between February 9, 2012, and February 19, 2013, the Nuclear Maintenance Order Screening Committee failed to ensure the required conditions were met prior to assignment of toolpouch maintenance tasks for four nuclear notifications in accordance with Procedure SO23-XX-36, "Toolpouch Maintenance Program," Revision 1 EC 1. This issue has been entered into licensee's corrective action program as Nuclear Notifications 202346546 and 202351959.

The inspectors determined that the failure by the licensee's personnel to follow Procedure SO23-XX-30, "Nuclear Maintenance Order (NMO) Generation, Screening and Classification," to assign the appropriate job types and priority for corrosion-related nuclear maintenance orders, and the failure to follow Procedure SO23-XX-36, "Toolpouch Maintenance Program," for the conduct of toolpouch maintenance were performance deficiencies. These performance deficiencies were more than minor, and therefore a finding, because they were associated with the Initiating Events Cornerstone attribute of equipment performance and adversely affected the associated cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors determined that Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process," was appropriate based on the plant conditions present when most of the examples of this performance deficiency occurred. The finding did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the finding screened as having very low safety significance (Green). This finding had a crosscutting aspect in the area of human performance, decision-making component, because the Nuclear Maintenance Order Screening Committee failed to use conservative assumptions in decision making when assigning inappropriate job types and tool pouch maintenance tasks for nuclear notifications. [H.1(b)] (Section 40A5)

Inspection Report# : [2013002](#) (*pdf*)

Significance: G Mar 24, 2013

Identified By: NRC

Item Type: FIN Finding

Failure to Follow Procedure for Plant Preservation Rust Grading

The inspectors identified a Green finding for failure to follow the requirements of the Plant Preservation Rust Grading and Budget Preparation Guide. Specifically, prior to February 28, 2013, licensee personnel failed to initiate nuclear notifications for plant areas that received a rust grade of 4 or higher. This issue has been entered into the licensee's corrective action program as Nuclear Notification NN 202341172.

The inspectors determined that the failure to initiate nuclear notifications for the areas assigned a rust grade of 4 as required by the Plant Preservation Rust Grading and Budget Preparation Guide was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the Initiating Events Cornerstone attribute of equipment performance and adversely affected the associated cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors determined that Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process," was appropriate based on the plant conditions present when most of the examples of this performance deficiency occurred. The finding did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the finding screened as having very low safety significance (Green). This finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because the licensee failed to implement a corrective action program with a low threshold for identifying issues. [P.1(a)] (Section 40A5)

Inspection Report# : [2013002](#) (pdf)

Mitigating Systems

Significance:  Jun 23, 2013

Identified By: NRC

Item Type: FIN Finding

Failure to Properly Scope All the Pertinent External Flood Protection Features into the Walkdown List in Accordance with Industry Guidance NEI 12-07

The inspectors identified one finding of very low safety significance for the licensee's failure to follow procedures regarding the Fukushima event response for flood protection to comply with NRC endorsed NEI 12-07, "Guidelines for Performing Walkdowns of Plant Flood Protection Features." Specifically, the licensee failed to perform an evaluation of the aggregate effect on a failure on the five locations of inaccessible waterstops included in the flooding walkdown scope; failed to evaluate the conduits beneath the grating of the diesel generator building for inclusion in the walkdown scope; and failed to establish adequate procedures that included accurate assessment of the Available Physical Margin of flooding protection features included in the flooding walkdown scope. This finding was entered into the licensee's corrective action program as Nuclear Notifications NN 202367435, NN 202369978, and NN 202375161.

The performance deficiency is greater than minor, and therefore a finding, because it is associated with the Mitigating Systems Cornerstone attribute of Protection Against External Factors (Flood Hazard) and it adversely affects the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding could be evaluated using the significance determination process in accordance with IMC 0609, "Significance Determination Process," and conducted a Phase 1 characterization and initial screening. Phase 1 initial screening determined that IMC 0609 Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," should be used. Because the finding did not involve the loss or degradation of equipment or function specifically designed to mitigate a seismic, flooding, or severe weather initiating event (e.g., seismic snubbers, flooding barriers, tornado doors), the finding screened as Green. The finding has a cross-cutting aspect in the area of human performance, associated with the decision-making component, because the licensee did not verify the validity of the underlying assumptions and identify possible unintended consequences.

Inspection Report# : [2013003](#) (pdf)

Significance:  Mar 24, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Completely Inspect and Maintain PMF Berm

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for failure to accomplish activities in accordance with procedures. Specifically, prior to March 4, 2013, the licensee failed to accomplish inspections and maintenance of the downstream face of the probable maximum flood berm in accordance with Attachments 1 and 3 of Procedure SO123-XVIII-35, "Inspection and Maintenance of Seawall, Offsite Probable Maximum Flood Berm and Channel, and Related Drainage Facilities."

These issues have been entered into the licensee's corrective action program as Nuclear Notifications NN 202346674, NN 202354058, and NN 202359197.

The inspectors determined that the licensee's failure to accomplish inspections and maintenance in accordance with Procedure SO123-XVIII-35, "Inspection and Maintenance of Seawall, Offsite Probable Maximum Flood Berm and Channel, and Related Drainage Facilities," was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because, if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, the licensee routinely failed to maintain and inspect the downstream face of the berm for vegetation overgrowth, structural integrity, and animal burrows, resulting in identified degradation conditions during subsequent inspections. Using NRC Inspection Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," the finding screened as potentially risk important, affecting the Mitigating Systems cornerstone attribute for external events mitigating systems, because the finding resulted in the degradation of equipment and functions specifically designed to mitigate a flooding initiating event. Therefore, a Region IV senior reactor analyst performed a detailed risk evaluation using NRC Inspection Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." Based on the inspector's observation of the condition of the berm, the senior reactor analyst determined that even though the berm was degraded, it remained functional. Since the probable maximum flood berm remained functional, there was no quantifiable change to the core damage frequency or the large early release frequency. Therefore, the finding was of very low safety significance (Green). This finding had a crosscutting aspect in the area of human performance, resources component, because the licensee did not ensure personnel were available and adequate to assure nuclear safety. [H.2(b)] (Section 1R01)

Inspection Report# : [2013002](#) (pdf)

Significance: G Mar 24, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Screen Nuclear Notifications Results in Missed Operability Determinations and Functionality Assessments

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure by operations personnel to implement procedures associated with evaluating the impact of degraded or non-conforming conditions on the operability of equipment required by technical specifications. Specifically, between December 2010 and February 2013, the inspectors identified fourteen examples where operations personnel failed to follow Procedure SO123-XV-50.CAP-2, "SONGS Nuclear Notification Screening," Attachment 3, step 6.2.9, resulting in the failure to complete the immediate operability determination or the immediate functionality assessment as required. This issue has been entered into licensee's corrective action program as Nuclear Notification NN 202337603.

The inspectors determined that the failure of operations personnel to follow Procedure SO123-XV-50.CAP-2, "SONGS Nuclear Notification Screening," for screening nuclear notifications was performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it is associated with the Mitigating Systems Cornerstone attribute for equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the inspectors determined that this was a significant programmatic deficiency that would lead to worse errors, if left uncorrected. The inspectors determined that Manual Chapter 0609, Appendix G,

“Shutdown Operations Significance Determination Process,” was appropriate based on the plant conditions present when most of the examples of this performance deficiency occurred. The finding did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the finding screened as having very low safety significance (Green). This finding had a cross-cutting aspect in the area of human performance, decision-making component, because operations personnel failed to make decisions demonstrating that nuclear safety was an overriding priority. [H.1(b)] (Section 1R15)

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 24, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Write Nuclear Notifications for Degraded or Non-Conforming Conditions

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure of licensee to implement procedures associated with entry of degraded or non-conforming issues into the corrective action program. Specifically, the NRC staff identified seven examples of problems that were not documented in a nuclear notification until prompted by NRC many days or years after they were known to the licensee between June 2009 and January 2013. This issue has been entered into licensee’s corrective action program as Nuclear Notification NN 202364842.

The inspectors determined that the failure by licensee personnel to write nuclear notifications in accordance with Procedure SO123-XV-50.CAP-1 was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the Mitigating Systems Cornerstone attribute for equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that Manual Chapter 0609, Appendix G, “Shutdown Operations Significance Determination Process,” was appropriate based on the plant conditions present when most of the examples of this performance deficiency occurred. The finding did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the finding screened as having very low safety significance (Green). This finding had a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because the licensee failed to implement a corrective action program with a low threshold for identifying issues. [P.1(a)] (Section 4OA2)

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 24, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Corrective Actions for Nitrogen Gas Accumulation in the Auxiliary Feedwater System

The inspectors identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Actions,” associated with the licensee’s failure to take appropriate and prompt corrective actions regarding nitrogen gas accumulation in safety related auxiliary feedwater system. Specifically, from March 2012 until January 2013, a condition adverse to quality related to the accumulation of gas, from steam generator nitrogen purge, into piping and safety related pumps in the auxiliary feedwater system was not promptly identified and corrected until a gas binding event occurred during a start of an auxiliary feedwater pump in Unit 3 in January 2, 2013. This issue has been entered into the licensee’s corrective action program as Nuclear Notifications NN 202268941 and NN 202382092. The inspectors determined the failure to take prompt corrective actions for nitrogen gas accumulation in the safety-related auxiliary feedwater system as required by 10 CFR Criterion XVI was a performance deficiency. The finding was more than minor because it was associated with the Mitigating Systems Cornerstone attribute for equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, the finding was more than

minor because not promptly correcting gas accumulation on safety related system used to support decay heat removal would have the potential to lead to a more significant safety concern. The inspectors determined that Manual Chapter 0609, Appendix G, “Shutdown Operations Significance Determination Process,” was appropriate based on the plant conditions present when most of the examples of this performance deficiency occurred. The finding did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the finding screened as having very low safety significance (Green). The inspectors determined the finding had a cross cutting aspect in the area human performance area, decision-making component, because the licensee did not make safety-significant or risk-significant decisions using a systematic process when they identified a degraded condition of gas accumulation in the auxiliary feedwater system. [H.1(a)] (Section 4OA2)
Inspection Report# : [2013002](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

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