

**From:** Kathleen O'Donohue, R2  
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- TBD. A finding was identified for failure to protect the control circuit of motor operated valve (MOV) MOV-4-626, RCP thermal barrier component cooling water return isolation valve, to prevent spurious operation during a fire in FA U (FZ 67). The inspectors found an error in the SSA Essential Equipment List, in that, MOV-4-626 was not properly classified as being required to assure SSD. As a result, the fire response procedure failed to include MOV-4-626 as part of the mitigation strategy against spurious valve operation.

The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. The performance deficiency is assumed to degrade the defense-in-depth for fire protection. This finding is applicable to FZ 67 and is unresolved pending completion of a significance determination. (Section 1R05.01.b.1)

- TBD. A finding was identified for failure to ensure that local manual operator actions used to verify correct alignment of RCP seal package thermal barrier cooling valves were completed in a timely manner for fires in either FA T (FZ 63) or FA U (FZ 67). When evaluating the feasibility of the manual actions using the guidance in the inspection manual, the inspectors identified that 0-ONOP-016.10 allowed 20 minutes to complete the operator actions for verification of thermal barrier cooling valve alignment. However, industry analyses [Westinghouse Direct Work No. DW-94-011; Westinghouse WCAP-10541, Revision 2; and Westinghouse WCAP-15603, Revision 1-A] have determined that seal package damage could occur within 13 minutes of loss of all seal package cooling.

The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. The performance deficiency is assumed to degrade the defense-in-depth for fire protection. The finding is applicable to FZ 63 and FZ 67 and is unresolved pending completion of a significance determination. (Section 1R05.01.b.2)

- TBD A finding was identified for failure to evaluate and mitigate the effects of loss of security card key access to rooms where local manual operator actions are performed for a fire in FA U (FZ 67). The inspectors questioned whether failure of the security card key reader in FZ 67 would impede operator access to other rooms during performance of SSD local manual operator actions. The licensee had not analyzed the routing of security system cables. However, investigation revealed that security card key readers for FZ 68 (4A 4160 V switchgear room) and for FZ 93/94 (Unit 4, 480 V Load Centers A and B Room and Unit 4, 480 V Load Centers C and D Room, respectively) could potentially lose card key function as a result of a fire in FZ 67; thus impeding operator access to these rooms.

The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. The performance deficiency is assumed to degrade the defense-in-depth for fire protection. The finding is applicable to FZ

67 and is unresolved pending completion of a significance determination.  
(Section 1R05.01.b.3) ]

- TBD A finding was identified for failure to protect the control circuit for level control valve (LCV) LCV-3/4-115B, RWST to charging pump valve, to prevent spurious operation during a fire. If valve LCV-3/4-115B spuriously closes due to a fire-induced thermal insult, loss of the RWST as a suction source could lead to charging pump damage. This finding is applicable to FA T (FZ 63) on Unit 3 and FA U (FZ 67) on Unit 4.

The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. The performance deficiency is assumed to degrade the defense-in-depth for fire protection. This finding is applicable to FZ 63 and FZ 67 and is unresolved pending completion of a significance determination. (Section 1R05.03)

- TBD A finding was identified for failure to ensure local manual operator actions to verify correct alignment of MOV-3-716A and MOV-4-716A, Unit 3 and Unit 4 RCP thermal barrier component cooling water supply isolation valves, were completed in a timely manner for a fire in FA MM (FZ 106, 106R, or 97). The inspectors identified that 0-ONOP-105, Attachment 7 (Unit 3) and Attachment 8 (Unit 4) allowed 20 minutes to complete the operator actions for verifying that MOV-3-716A and MOV-4-716A were open. However, industry analyses [Westinghouse Direct Work No. DW-94-011; Westinghouse WCAP-10541, Revision 2; and Westinghouse WCAP-15603, Revision 1-A] have determined that seal package damage could occur within 13 minutes of loss of all seal package cooling. Thus, the operator guidance provided in 0-ONOP-105 does not provide timely action and could possibly result in an RCP seal LOCA.

The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. The performance deficiency is assumed to degrade the defense-in-depth for fire protection. This finding is applicable to FA MM and is unresolved pending completion of a significance determination.  
(Section 1R05.05.b.1)

- TBD A finding was identified for local manual operator actions that may not be timely due to reliance on security support to bring a vital area security key to access normally locked rooms which do not have a security card key readers. Operators do not carry vital access security keys with them and 0-ONOP-105 does not require vital access security keys be brought when the MCR is evacuated. Instead, security support is required to bring access keys to the operator. However, operator access to key-locked rooms is not ensured because security support could be diverted to higher priority activities. Consequently, local manual operator actions may be delayed and may not be completed in a timely manner to ensure that safe shutdown is achieved.

The finding is greater than minor because it is associated with the protection

against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. The performance deficiency is assumed to degrade the defense-in-depth for fire protection. This finding is applicable to FA MM and is unresolved pending completion of a significance determination.

- NCV A Green non-cited violation (NCV) was identified for failure to provide full area fire detection and a fixed suppression system in the Unit 3 and 4 mechanical equipment room for fires in FA MM (FZ 97). As part of FA MM, the FPPR identified the room as an alternative SSD area [along with the MCR (FZ 106) and the control room roof (FZ 106R)]. The inspectors observed that no full area detection system existed on the ceiling areas or within beam pockets above the emergency filter unit or air handling supply fans. Additionally, the room did not have a full area fixed suppression system.

The finding adversely affected the fire detection and suppression capability defense-in-depth elements. The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. Because the finding is of very low safety significance and because it has been entered into the CAP (CR 04-0688), this violation is being treated as an NCV, consistent with Section VI.A of the NRC Enforcement Policy: NCV 05000250,251/ 2004007-009, Failure to Install Full Area Wide Detection and Fixed Suppression Systems in the Unit 3 and 4 Mechanical Equipment Room. (Section R05.10.b.2)