Attachment 6

Examples

1. Failure to implement a required procedure for loss of main condenser vacuum/trip of circulating water pumps The inspectors identified a non-cited violation of Technical Specifications 5.4.1.a for the failure of the licensee to implement the Abnormal Operating Procedure AOP-0005, "Loss of Main Condenser Vacuum/Trip of Circulating Water Pump," following the loss of two of three operating circulating water pumps. Failure to implement this procedure contributed to the loss of condenser vacuum. This finding had cross-cutting aspects of human performance in that the operators did not implement the abnormal operating procedure as required. Additionally, this finding had cross-cutting aspects regarding problem identification and resolution in that a similar event had occurred over a month earlier, and no actions were taken to incorporate that operating experience into the operating procedures or process it through the corrective action program. This finding is greater than minor because it is associated with human performance attribute of the mitigating system cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This finding actually led to the loss of main condenser vacuum and forced the operators to perform a reactor cool down through safety relief valves, reactor core isolation cooling and the suppression pool. This finding is of very low safety significance because it would only affect the plant during this particular situation of partial loss of offsite power and that all mitigating capability was maintained.

Green. A Green, self-revealed, Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for the failure to provide procedural guidance for adjusting service water valve SW-4B, a safety-related valve, which could affect the ability of safety-related mitigating system components to perform their intended function. On October 5, 2005, SW-4B, 'Turbine Building Service Water Train 'B' Header Isolation," failed to meet its inservice testing stroke time requirements during the performance of surveillance procedure SP-02-138B and an associated unplanned entry into a Technical Specification Limiting Condition for Operation occurred. The condition occurred because the licensee made adjustments to SW-4B without procedural guidance to perform such adjustments. Corrective actions taken by the licensee include procedural revisions to strengthen guidance on adjustment of safetyrelated components. The primary cause of this finding was related to the cross-cutting area of human performance because maintenance was performed without required procedures.

Green. The inspector reviewed a self-revealing noncited violation of Technical Specification 6.7.1.a because the licensee failed to control a high radiation area by not barricading and conspicuously posting the area. Specifically, on March 15, 2005, the licensee removed a temporary barrier (scaffold boards) creating an entrance to a high radiation area without the proper radiological controls in place for a high radiation area. It was not until two radiation workers entered the area that a radiation protection technician identified the unposted entry and took appropriate actions to control the area. The finding was entered into the licensee's corrective action program as Condition Report ANO-2-2005-0574.