

**NRC Inspection Findings related to "Closed Cooling" Water Systems**

**(1/1/2004 to 6/22/2011)**

This data supports an NRC Information Notice, see ADAMS ML11150135.

**ROP PIM Reports - Event Dates: 01/01/2004 - 06/22/2011 - Generated on 06/22/11  
By Types, Cornerstones, Event Dates, Sites  
Key Word Search on **closed cooling water** ,  
Significance: All  
14 *Open/Closed Final* items selected - All Regions**

Findings - **Green** 2  
Non-Cited Violations - **Green** 12

Cross Cutting Areas:

SCWE - *Safety Conscious Work Environment*

HP - *Human Performance*

PIR - *Problem Identification and Resolution*

Finding						
<b>Initiating Events</b>	10/08/2004	DRESDEN	<b>Green</b>	*SCWE: N	*HP: N	*PIR: N
Docket/Status: , 05000237 (C)						
Open: <a href="#">2004010</a>						
(PIM) Performance Issues Which Resulted in the Initiation of a Manual Scram on Unit 2 Due to Failure of the 2A Recirculation Pump Motor						
<p>A self-revealed finding of very low safety significance was identified involving several performance issues which resulted in the initiation of a Unit 2 manual scram on April 24, 2004, due to failure of the 2A recirculation pump motor. The performance issues included an inadequate process for rewinding the 2A recirculation pump motor when it was installed in 1999, an inadequate evaluation of the testing of the motor before installation, and the failure to perform post maintenance testing of the reactor building <b>closed cooling water</b> system piping to identify leakage. This failure resulted in the deposit of a conductive substance inside the motor. The licensee identified a number of corrective actions including replacing the 2A recirculation pump motor and revising Exelon Nuclear Engineering Standard NES-EIC-40.01 to include enhanced testing requirements. The finding was more than minor because it affected the initiating events cornerstone objective to limit the likelihood of an initiating event. The finding was determined to be of very low safety significance because all equipment and systems operated as designed during the scram.</p>						

<b>Mitigating Systems</b>	09/30/2006	VERMONT YANKEE	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
Docket/Status: 05000271 (C)						
Open: <a href="#">2006004</a>						
(PIM) Entergy Did Not Incorporate Industry Operating Experience into the Preventive Maintenance Strategies for the “A” RBCCW Pump Motor						
<p>A self-revealing finding of very low safety significance was identified because Entergy did not effectively incorporate existing industry operating experience into the preventive maintenance (PM) strategy for the “A” reactor building <b>closed cooling water</b> (RBCCW) system pump motor as required by Entergy’s PM program. As a result, conditions that ultimately resulted in the failure of the “A” RBCCW pump motor went unrecognized. The finding is greater than minor because it is associated with the Equipment Performance attributes of both the Initiating Events and Mitigating Systems Cornerstones and because it affects the associated Cornerstone objectives to limit the likelihood of those events that upset plant stability and to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors conducted a Phase 1 screening of the finding in accordance with IMC 0609, Appendix A, and determined that a Phase 2 screening was required since the finding affected two or more Cornerstones. The inspectors conducted a Phase 2 screening and determined that the finding was of very low safety significance (Green) since no solved accident sequences resulted in a risk significance less than or equal to nine as indicated on the counting rule worksheet. A contributing cause of this finding is related to the cross-cutting area of Problem Identification and Resolution (PI&amp;R). Entergy did not implement and institutionalize industry operating experience through changes to PM strategies for large pump motors. [P.2(b)]</p>						
<b>NonCited Violation</b>						
<b>Initiating Events</b>	04/14/2005	DUANE ARNOLD	<b>Green</b>	*SCWE: N	*HP: Y	*PIR: N
Docket/Status: 05000331 (C)						
Open: <a href="#">2005003</a>						
(PIM) FAILURE TO PROPERLY PREPLAN MAINTENANCE INSTRUCTIONS RESULTING IN AN INADVERTENT GROUP SEVEN ISOLATION.						
<p>A finding of very low safety significance was identified through a self-revealing event regarding the failure to have adequate maintenance procedures while working on the Drywell to Reactor Building <b>Closed Cooling Water</b> Loop Return Header Isolation. The inadequate procedure resulted in an inadvertent Group Seven Isolation. The licensee restored the inadvertent Group Seven Isolation and informed all site personnel of the issue through a yellow announcement sheet. The finding was more than minor because this event had an adverse impact on the initiating events cornerstone attribute of procedural quality. The</p>						

inadequate procedure resulted in an actual Group Seven isolation. This finding was determined to be of very low safety significance since the finding did not increase the likelihood of a loss of reactor coolant system (RCS) inventory, or degrade the ability to terminate a leak path, or degrade the ability to recover decay heat removal (DHR). An NCV of Technical Specification (TS) 5.4.1, "Procedures," was identified for the failure to have adequate maintenance procedures.

<b>Initiating Events</b>	03/31/2006	THREE MILE ISLAND	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
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Docket/Status: 05000289 (C)

Open: [2006007](#)

(PIM) Deficient Abnormal Operating Procedures for Loss of Vital 120 Volt Electrical Bus, Loss of 4160 Volt Bus, and Loss of NSCCW

The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 6.8.1, for failure to adequately establish and implement procedures required by Regulatory Guide 1.33, Section 6, "Procedures for Combating Emergencies and Other Significant Events." Specifically, no procedure existed to combat an emergency caused by a loss of electrical power to a vital bus. Additionally, the procedures to combat emergencies caused by a loss of 4160V AC and a loss of Nuclear Services **Closed Cooling Water** (NSCCW) were inadequate in that pump trip criteria and detailed guidance to the control room operators were not provided. AmerGen has acknowledged that these problems exist and provided the team an abnormal operating procedure (AOP) implementation schedule showing that new AOPs will be generated to correct these deficiencies in 2006. This finding is more than minor because it is associated with the procedure quality attribute of the Initiating Events cornerstone and the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. However, this finding was determined to have very low safety significance (Green) using Phase 1 of the NRC significance determination process described in NRC Inspection Manual Chapter (IMC) 0609, Appendix A, since the finding does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. The finding has a cross-cutting aspect related to the area of Problem Identification and Resolution in that AmerGen personnel did not identify that some AOPs were inadequate.

<b>Initiating Events</b>	12/31/2006	OYSTER CREEK	<b>Green</b>	*SCWE: N	*HP: Y	*PIR: N
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Docket/Status: 05000219 (C)

Open: [2006005](#)

(PIM) Clearance Activity Performed Out of Sequence And Causes Trip of 'A' Shutdown Cooling Pump

A self-revealing finding was identified regarding inadequate procedure adherence when work

activities on the 480 V '1A2' switchgear during 1R21 refueling outage resulted in a trip of a reactor building **closed cooling water** (RBCCW) and shutdown cooling (SDC) pump on October 22, 2006. Specifically, the steps in the clearance order were performed out of sequence. This finding was determined to be a non-cited violation of technical specification 6.8.1a, "Procedures and Programs." AmerGen's corrective actions for this issue involved re-mediating the operators involved; and senior management lead training sessions with all operations personnel which reviewed management's expectations for use of error prevention tools such as procedural compliance, peer checking, and questioning attitude. The finding was more than minor because it was associated with the configuration control attribute of the initiating events cornerstone and affected the objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown operations. This finding was evaluated using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," attachment 1, checklist 7 because it occurred during a refuel outage and reactor coolant system level in the reactor vessel was greater than 23 feet. The finding was of very low safety significance because the issue did not degrade the licensee's ability to recover decay heat removal once it was lost. The performance deficiency had a cross-cutting aspect in the area of human performance because operators did not follow procedures. (Section 1R20)

<b>Mitigating Systems</b>	03/31/2004	PEACH BOTTOM	<b>Green</b>	*SCWE: N	*HP: N	*PIR: N
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Docket/Status: , 05000277 (C) , 05000278 (C)

Open: [2004002](#)

(PIM) Maintenance Rule Bases Exceeded on the 2A Reactor Building Closed-Cooling Water Heat Exchanger and E-2 Emergency Diesel Generator

The NRC identified a non-cited violation (NCV) of 10 CFR 50.65, the Maintenance Rule, having very low safety significance (Green). As of December 14, 2003, the 2A reactor building **closed cooling water** (RBCCW) heat exchanger exceeded the unavailability criteria established by Exelon in its Maintenance Rule scoping document. The RBCCW system was not monitored against Exelon established criteria of two percent unavailability per 24 month period. Additionally, as of February 13, 2004, the E2 emergency diesel generator (EDG) exceeded the reliability criteria established by Exelon in its Maintenance Rule scoping document. The E2 EDG performance was not monitored against Exelon established criteria of one maintenance preventable functional failure (MPFF) per 24 month period. The events determined to be MPFFs on the E2 EDG occurred on March 21, 2003, and September 15, 2003. The finding is more than minor because the E2 EDG was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The 2A RBCCW heat exchanger was associated with the Equipment Performance attribute of the Initiating Events cornerstone. Exelon's not analyzing the E2 EDG or the 2A RBCCW heat exchanger performance in accordance with the maintenance rule was determined to have very low safety significance (Green) using Phase 1 of the Significance Determination Process (SDP) for Reactor Inspector

Findings for At-Power reactor situations.

<b>Mitigating Systems</b>	03/31/2005	PERRY	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
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Docket/Status: 05000440 (C)

Open: [2005002](#)

(PIM) FAILURE TO TAKE PROMPT CORRECTIVE ACTION AFTER IDENTIFYING THAT ERRONEOUS OR UNEXPLAINABLE DATA WAS RECORDED DURING TS REQUIRED TESTING

Inspectors identified a finding of very low safety significance and a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions" on January 18, 2005. Specifically, the licensee failed to take prompt corrective action after identifying on January 17, 2005, that erroneous or unexplainable data was recorded during Technical Specification required emergency **closed cooling water** (ECCW) 'B' pump and valve operability testing. The primary cause of this finding was related to the cross-cutting area of Problem Identification and Resolution. After the inspectors brought the issue to the attention of control room personnel, the licensee initiated action to re-code the surveillance as "no credit" based on suspect data. Action was also initiated to reschedule the surveillance prior to its overdue date of February 4, 2005. The licensee's subsequent performance of the surveillance test was not properly performed which resulted in a missed Technical Specification 5.5.6 surveillance and an additional 10 CFR 50, Appendix B, Criterion XVI violation was identified by the inspectors. The test was performed correctly, with acceptable results, on February 5, 2005, to satisfy Technical Specification requirements. The inspectors concluded that the failure of a system engineer, an engineering supervisor, and a senior reactor operator to take action to correct an identified condition adverse to quality was more than minor in that it could reasonably be viewed as a precursor to a significant event and, with respect to the performance of Technical Specification required surveillance testing, was associated with the reactor safety cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring mitigating system availability, reliability, and capability. The inspectors determined that the finding did not involve the loss of safety function in that ECCW 'B' subsequently satisfactorily completed the required quarterly pump and valve operability test. The inspectors therefore concluded that the finding was of very low safety significance.

<b>Mitigating Systems</b>	03/31/2005	PERRY	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
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Docket/Status: 05000440 (C)

Open: [2005002](#)

(PIM) FAILURE TO IDENTIFY AND CORRECT INADEQUATE CREW PERFORMANCE DURING ECCW TESTING

Inspectors identified a finding of very low safety significance and a violation of 10 CFR 50,

Appendix B, Criterion XVI, "Corrective Actions" on February 7, 2005. Specifically, the licensee failed to identify and correct a condition adverse to quality following the inspectors' identification, on January 18, 2005, of an improperly performed Technical Specification required surveillance. As a result of the licensee's failure to properly evaluate the January 5, 2005, performance deficiency and take appropriate corrective action, the surveillance test was again performed improperly on February 1, 2005. In addition to causing unnecessary safety system unavailability during repetitive performances of the procedure, the inadequate performance of the test on February 1, 2005, resulted in a missed Technical Specification 5.5.6 surveillance. The primary cause of this finding was related to the cross-cutting area of Problem Identification and Resolution. The test was performed correctly, with acceptable results, on February 5, 2005, to satisfy Technical Specification requirements. An apparent cause investigation was initiated to review surveillance performance issues. The inspectors concluded that the failure of the licensee to adequately address performance issues with respect to a Technical Specification required surveillance procedure was more than minor in that it could reasonably be viewed as a precursor to a significant event and, in this case, resulted in a second improper performance and a missed Technical Specification surveillance. Additionally, the issue was associated with the reactor safety cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring mitigating system availability, reliability, and capability. The inspectors determined that the finding did not involve the loss of safety function in that emergency closed cooling water 'B' subsequently satisfactorily completed the required quarterly pump and valve operability test. The inspectors therefore concluded that the finding was of very low safety significance.

<b>Mitigating Systems</b>	05/26/2005	PERRY	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
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Docket/Status: 05000440 (C)

Open: [2005003](#)

**(PIM) FAILURE TO ADEQUATELY ADDRESS ECCW OILER CONCERNS**

A finding of very low safety significance and an associated NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was NRC-identified when licensee personnel failed to adequately review available industry operating experience information and failed to identify degraded oil reservoirs that could adversely impact the operability of both Emergency **Closed Cooling Water** (ECCW) pumps. The team determined that the finding was of more than minor significance since the finding was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using IMC 0609, "Significance Determination Process," the team determined that this finding 1) was not a design deficiency or qualification deficiency; 2) did not represent an actual loss of safety function of a system; 3) did not represent an actual loss of safety function of a single train for greater than its TS allowed outage time; 4) did not represent an actual loss of safety function of one or more non-TS trains of equipment designated as risk significant; and 5) did not screen as potentially risk significant due to seismic, flooding, or a severe weather initiating event. Therefore, the finding screened as Green and was considered to

be of only very low safety significance. As part of the licensee's immediate corrective actions, a walkdown of all potentially affected oil reservoirs was conducted and the reservoirs were verified to be able to properly provide makeup oil to all potentially affected pump bearings. This finding affected the cross-cutting area of Problem Identification and Resolution because licensee personnel failed to adequately resolve a known industry problem associated with improper reservoir installation.

<b>Mitigating Systems</b>	04/18/2008	THREE MILE ISLAND	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
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Docket/Status: 05000289 (C)

Open: [2008006](#)

(PIM) Failure to Stage Equipment Required by Abnormal Operating Procedures

The inspectors identified a NCV of Technical Specification (TS) 6.8.1, which requires that written procedures be implemented as recommended in Appendix A of Regulatory Guide (RG) 1.33, including abnormal operating procedures (AOPs) for loss of service water. Specifically, the AOP for loss of river water was inadequately implemented when equipment required was not staged to support the AOP implementation. The finding is more than minor because it is associated with the procedure quality attribute of the Mitigating Systems Cornerstone, and the associated cornerstone objective of ensuring the reliability of systems (and personnel) that respond to initiating events to prevent undesirable consequences. Specifically, this finding reduced the reliability of the operators to complete the AOP. This finding was of very low safety significance (Green) because the finding is not a design or qualification deficiency, does not represent a loss of safety function, and does not screen as potentially risk significant due to external hazards. Although the operators would be delayed without the staged hoses, the inspectors concluded that the alternative cooling safety function could be provided to the Nuclear Services **Closed Cooling Water** (NSCCW) system within the time limit specified by AmerGen's calculations. The finding has a cross-cutting aspect related to the area of PI&R, corrective action program component, in that, AmerGen identified that the hoses were missing in January 2008, and did not implement CAs to replace the hoses required by the AOP until identified by the inspectors. [P1.(d)] (Section 4OA2.a.3.a)

<b>Mitigating Systems</b>	06/30/2009	OYSTER CREEK	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
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Docket/Status: 05000219 (C)

Open: [2009003](#)

(PIM) Medium Voltage Cables Maintained Submerged for Extended Period of Time

The inspectors identified a NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Exelon has not implemented effective actions to minimize water accumulation and submergence of medium voltage cables contained in the turbine building **closed cooling water** (TBCCW) heat exchanger pit as recommended by their cable

conditioning monitoring program. Exelon’s corrective actions included revising equipment operator instructions to direct them to ensure that cables were not maintained submerged. This issue has been entered into Exelon’s corrective action program. The finding was more than minor in accordance with IMC 0612, Appendix B (Section 1-3), “Issue Screening,” because it was associated with the equipment performance 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. In accordance with IMC 0609.04 (Table 4a), “Phase 1 - Initial Screening and Characterization of Findings,” the finding was determined to be of very low safety significance (Green). The performance deficiency had a cross-cutting aspect in the area of problem identification and resolution, operating experience [IMC 0305, Aspect P.2(b)], because Exelon did not implement and institutionalize operating experience through changes to station processes, procedures, and equipment. Specifically, Exelon did not change operations instructions or plant equipment to better monitor and remediate the presence of water in the TBCCW heat exchanger pit to minimize the submergence of medium voltage cables as recommended by internal and external operating experience.

<b>Mitigating Systems</b>	06/11/2010	GINNA	<b>Green</b>	*SCWE: N	*HP: N	*PIR: Y
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Docket/Status: 05000244 (C)

Open: [2010006](#)

(PIM) Failure to Take Adequate Corrective Actions for Elevated Chlorides in the 'A' EDG Jacket Water Heat Exchanger

The team identified an NRC-identified finding of very low safety significance associated with a non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” in that measures were not established to assure that a condition adverse to quality was promptly identified and corrected. Specifically, after Ginna identified that monthly samples of the emergency diesel generator (EDG) jacket water system were not being taken and analyzed for chlorides and fluorides, a sample was not taken and analyzed for approximately 5 months. Additionally, after the analysis indicated that the chlorides were over twice the procedural limit, Ginna did not increase the chloride sampling frequency, did not take action to return the chlorides to within specifications, and did not complete an analysis for long term effects on the EDG as required by chemistry procedure CH-138, “**Closed Cooling Water** Systems Chemistry Optimization Plan,” Revision 1. Ginna’s corrective actions included evaluating the degradation of the 'A' EDG jacket water due to the elevated chloride level in the 'A' EDG jacket water heat exchanger exceeding 90 days and developing a plan to reduce the chloride level to within specification. This finding is more than minor because if left uncorrected, elevated chloride levels in the 'A' EDG jacket water system could lead to a more significant safety concern. Specifically, elevated chlorides in the 'A' EDG jacket water heat exchanger could lead to degradation of the jacket water heat exchanger through stress corrosion cracking and impact the reliability of the 'A' EDG. This finding is associated with the Mitigating Systems Cornerstone and affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences

(i.e., core damage). The team determined that the finding was of very low safety significance (Green), because it was not a design or qualification deficiency confirmed not to result in loss of operability; did not result in a loss of safety function; and did not screen as potentially risk significant due to a seismic, flooding, or a severe weather initiating event. This finding has a cross-cutting aspect in the area of problem identification and resolution because Ginna did not take appropriate actions to address the elevated chloride level in the 'A' EDG jacket water system.

<b>Mitigating Systems</b>	06/30/2010	MILLSTONE	<b>Green</b>	*SCWE: N	*HP: Y	*PIR: N
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Docket/Status: , 05000423 (C)

Open: [2010003](#)

(PIM) NCV 05000423/2010003-02 Charging Pump Overheating and Cavitation during RCS Loop Vacuum Fill

Green. A self-revealing NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings”, was identified for Dominion’s failure to have an adequate procedure for starting the charging pumps. Specifically, OP 3304A, “Charging and Letdown,” did not require verification of Reactor Plant **Closed Cooling Water** (RPCCW) flow to the seal water heat exchanger. On May 1, 2010, Dominion started the “B” centrifugal charging pump without cooling water supplying the seal return heat exchanger. This caused the charging pump to overheat and cavitate, and resulted in the pump being declared inoperable. Dominion entered this issue into their corrective action program. This finding was more than minor because it was associated with the configuration control 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. The inspectors determined that the finding was of very low safety significance (Green) because it did not result in a loss of safety function, a loss of safety function of a single train for greater than its technical specification allowed outage time, or a loss of risk significant non-technical specification train of equipment. Additionally, it is not 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, Work Control because Dominion relied on the work control process to assure that the RPCCW cooling water was in service to the seal water heat exchanger at the time that the RCS loop vacuum fill was scheduled. The work control process was insufficiently robust to ensure that cooling water was supplied to the seal water heat exchanger during charging pump operations. [H.3.b]. (Section 71111.20)

<b>Barrier Integrity</b>	05/15/2009	OYSTER CREEK	<b>Green</b>	*SCWE: N	*HP: Y	*PIR: N
Docket/Status: 05000219 (C)						
Open: <a href="#">2009007</a>						
(PIM) Inadequate Design Control for RBCCW Containment Isolation Valve Modification						
<p>Green. The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, “Design Control,” in that Exelon did not ensure the adequacy of a reactor building closed cooling water system containment isolation check valve design. Specifically, Exelon modified the check valve but did not ensure that the replacement valve could meet the existing design basis temperature value. In response, Exelon entered the issue in their corrective action program and evaluated the design temperature of the check valve to assure the valve would function properly during postulated events. The finding is more than minor because it is associated with the design control attribute of the Barrier Integrity Cornerstone and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The team determined the finding screened as very low safety significance (Green) because it did not represent a degradation of the radiological barrier function provided for the control room, auxiliary building, or spent fuel pool, did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere, did not represent an actual open pathway in the physical integrity of reactor containment, and did not involve an actual reduction in function of hydrogen igniters in the reactor containment. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices Component, because Exelon did not define and effectively communicate expectations regarding procedural compliance and personnel did not follow procedures. Specifically, Exelon did not comply with procedure CC-AA-102, “Design Input and Configuration Change Impact Screening,” to evaluate the design temperature of the newly installed check valve to ensure that all affected systems can perform their design basis functions. (IMC 0305, Aspect H.4(b))</p>						