

## Beaver Valley 2

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### Initiating Events



**Significance:** Dec 29, 2001

Identified By: NRC

Item Type: FIN Finding

#### **INEFFECTIVE CORRECTIVE ACTIONS FOR UNIT 2 LOSS OF INSTRUMENT AIR (LOIA) FAIL TO PRECLUDE TWO UNIT 2 LOIA EVENTS**

The inspectors determined that corrective actions to a June 22, 2001, Unit 1 loss of instrument air (LOIA) reactor trip were not effectively implemented. Consequently, failure to identify and perform manufacturer recommended preventive maintenance tasks for the 'B' station air compressor (2SAS-C21B) loading/throttle mechanism was the direct cause of two subsequent Unit 2 LOIA events (November and December 2001). The safety significance of this finding was very low (Green) because the performance deficiency did not cause any accident mitigation equipment or functions to be unavailable.

Inspection Report# : [2001010\(pdf\)](#)

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### Mitigating Systems



**Significance:** Sep 15, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

#### **FAILURE TO IMPLEMENT TIMELY AND EFFECTIVE CORRECTIVE ACTIONS FOR DEGRADED COMPONENTS (RWST LEVEL TRANSMITTERS) WHICH HAD SAFETY SIGNIFICANCE.**

A Non-cited Violation of 10 CFR 50, Appendix B, Criterion XVI, was identified associated with the failure to implement timely and effective corrective actions for degraded components which had safety significance. Specifically, FENOC had not determined the cause of three Unit 1 level transmitter failures that occurred after the transmitters were replaced in 1998. A Part 21 notification associated with the same model series transmitters had not been recognized or evaluated prior to the actual installation of the components, and an evaluation of extent of condition and potential generic failure modes had not been performed. The team determined that this represented inadequate corrective actions. The risk associated with the failure of the refueling water storage tank (RWST) level transmitters had been determined to be very low safety significance, based on the results of the phase 3 analyses.

Inspection Report# : [2000009\(pdf\)](#)

**Significance:** N/A Sep 15, 2000

Identified By: NRC

Item Type: FIN Finding

#### **NRC SUPPLEMENTAL INSPECTION TO ASSESS LICENSEE EVALUATION AND CORRECTIVE ACTIONS TO UNIT 2 SERVICE WATER BIOFOULING EVENT**

This supplemental inspection was performed by the NRC to assess the licensee's evaluation and corrective actions associated with the macro biological fouling (biofouling). Biofouling problems affected the service water system (SWS) supply to the heat exchangers for both emergency diesel generators (EDG) in July 1999. On July 16, 1999, the licensee identified that biofouling of the safety-related SWS had occurred in the heat exchanger for the EDG 2-2, which had the potential for a common mode failure of both EDGs if the chemical treatment procedure had been followed, as planned. Although the biofouling problems occurred before implementation of the NRC's new reactor oversight process, the NRC followed up this issue with a supplemental inspection because the issue was considered to have been of low to moderate risk. This supplemental inspection was in lieu of a regional initiative inspection that would have been conducted under the previous inspection oversight process. The supplemental inspection was performed in accordance with Inspection Procedure 95001. The licensee's evaluations and corrective actions associated with the biofouling problems were adequate to identify the causes and to determine the extent of the problem. The licensee's evaluations identified the primary root causes to be: 1) Ineffective programs to address biofouling due to Zebra mussels, 2) Inadequate procedures for the removal of clams and mussels, 3) Inadequate inspections and monitoring of the SWS, including the intake bays, and 4) Inadequate procedures regarding biocide injection methods, injection frequencies, and monitoring of the SWS before and after the injection of biocides. The licensee identified a contributing root causes to be less than adequate design analysis regarding expected and acceptable SWS flow rates and actual heat rejection from the EDGs to detect biofouling. The licensee adequately identified corrective actions to address each root and contributing cause. The licensee's root cause analysis did not address the human performance issues, which were one of the root or contributing causes of the biofouling event. However, the licensee is taking appropriate corrective actions in the human performance area which envelope the human performance issues associated with the biofouling event. These actions include a Case Study done in July 2000, which described several significant events (including the biofouling event) and their fundamental causes, that was placed on the licensee's local area network (LAN) and also presented to licensee personnel from a lessons learned perspective. Also, a Human Performance Coordinator position was established earlier

this year to better focus on human performance issues. The licensee has evaluations in progress to measure the effectiveness of their corrective actions to prevent recurrence. The licensee has made appropriate procedure and program changes, including enforcing proper implementation, to measure the effectiveness of their corrective actions to prevent recurrence.

Inspection Report# : [2000013\(pdf\)](#)



**Significance:** Aug 12, 2000

Identified By: NRC

Item Type: FIN Finding

**SAFETY RELATED EQUIPMENT WAS TAKEN OUT OF SERVICE FOR MAINTENANCE THAT DID NOT NEED TO BE PERFORMED, WHICH UNNECESSARILY INCREASED SAFETY SYSTEM UNAVAILABILITY.**

Safety related equipment was taken out of service for maintenance that did not need to be performed, which unnecessarily increased safety system unavailability. Preventive maintenance was incorrectly scheduled for an emergency diesel generator (EDG) 2 years ahead of its periodic due date. Poor work coordination further extended the duration of the outage. On two occasions poor communications between operating crews resulted in safety related heat exchangers being unnecessarily disassembled to investigate increased differential pressure. No fouling was found. In both cases, the change in differential pressure was the direct result of configuration changes made by the operating crews. The finding was determined to have very low safety significance, because redundant mitigating equipment was available during the periods these components were out of service for maintenance. No violations of NRC requirements were identified.

Inspection Report# : [2000006\(pdf\)](#)

**Significance:** N/A Jun 30, 2000

Identified By: NRC

Item Type: FIN Finding

**NRC SUPPLEMENTAL INSPECTION TO ASSESS LICENSEE EVALUATION AND CORRECTIVE ACTIONS TO UNIT 1 SERVICE WATER WATER HAMMER EVENT**

This supplemental inspection was performed by the NRC to assess the licensee's evaluation of the Service Water System (SWS) vacuum break check valve 2SWS-488 failure to open and subsequent water hammer condition that occurred on November 9, 1999. On November 21, 1999 the licensee identified the water hammer had occurred after investigating the discovery of a deformed SWS metal expansion joint. In NRC inspection Nos. 50-334 & 50-412/1999-010 and 2000-001, the NRC identified an apparent violation involving the licensee's failure to promptly identify and correct conditions adverse to quality that resulted in the vacuum break check valve failure to open and a water hammer condition. On April 13, 2000, the NRC held a pre-decisional enforcement conference in the Region 1 office with the licensee to discuss the apparent violation. The NRC subsequently issued a Severity Level III Notice of Violation (NOV) in letter dated May 3, 2000. The NRC received FirstEnergy Nuclear Operating Company's (FENOC's) reply to the NOV in letter dated June 2, 2000, in which FENOC identified the causes and corrective actions taken in response to prevent recurrence. Although the failed vacuum break check valve and subsequent water hammer condition occurred before implementation of the NRC's new reactor oversight process (ROP), the NRC followed up this issue with a supplemental inspection under the new ROP. This supplemental inspection was in lieu of a regional initiative inspection that would have been conducted under the previous inspection oversight process. The supplemental inspection was performed in accordance with Inspection Procedure 95001. Cornerstone: Mitigating Systems - The licensee's evaluations of the failed vacuum break check valve (VBCV) were adequate to identify the causes and appropriately broad in scope to determine the extent of the problems. The licensee's evaluations identified the primary root cause to be less than adequate implementation of the preventive maintenance program. The licensee identified contributing root causes to be previous inadequate corrective actions to address VBCV deficiencies and personnel failure to understand the significance of previously identified VBCV deficiencies. The licensee adequately identified corrective actions to address each root cause. - The licensee has evaluations planned or in progress to measure the effectiveness of their corrective actions to prevent recurrence. The results of the licensee's periodic monitoring of a corrective action regarding preventive maintenance (PM) task deferrals beyond their limit date indicates that licensee corrective actions have been effective in ensuring preventive maintenance tasks are completed or evaluated before their limit date is reached. However, the results of the licensee's periodic monitoring of a corrective action regarding management approval of PM task deferrals entering their grace period (25% of interval) identified that approximately thirty-four of forty-four PM tasks in the grace period in June 2000 had not received the level of management approval required by the program.

Inspection Report# : [2000008\(pdf\)](#)



**Significance:** May 13, 2000

Identified By: NRC

Item Type: FIN Finding

**POOR COMMUNICATION AND UNDERSTANDING OF OPERATIONAL LIMITS RESULTED IN DEGRADED SERVICE WATER FLOW TO THE UNIT 2 "A" HIGH HEAD SAFETY INJECTION PUMP**

Poor communication and understanding of operational limits resulted in degraded service water flow to the Unit 2 "A" high head safety injection pump lube oil cooler not being evaluated nor entered into the corrective action program in a timely manner. This finding was determined to have very low risk significance because a subsequent evaluation demonstrated that the pump remained operable.

Inspection Report# : [2000004\(pdf\)](#)



**Significance:** Sep 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### INADEQUATE CORRECTIVE ACTION FOR MISPERFORMANCE OF SAFETY-RELATED PROCEDURES

The inspectors identified a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion XVI "Corrective Action," for failure to implement effective corrective measures to preclude repeated misperformance of safety-related procedures including Unit 1 Operating Surveillance Test (OST)-36.2, "Diesel Generator No. 2 Monthly Test," Rev. 32. This problem reflected ineffective problem resolution and human performance deficiencies. Operator fatigue was a contributing factor to the degraded human performance. The finding was of very low safety significance because the emergency diesel generator procedure performance errors did not represent an actual loss of safety function.

Inspection Report# : [2001008\(pdf\)](#)



**Significance:** Aug 11, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### FAILURE TO PROPERLY IMPLEMENT A MAINTENANCE PROCEDURE RESULTED IN ADDITIONAL UNAVAILABILITY OF THE UNIT 2 'C' HHSI PUMP

The inspectors identified a Non-Cited Violation for failure to properly implement a maintenance procedure which resulted in additional unavailability of the Unit 2 'C' High Head Safety Injection pump. Poor communications during the maintenance crew turnover and insufficient attention to detail when annotating the procedure resulted in the outboard seal leaking when the pump was returned to service on June 30. On July 4, the pump was subsequently removed from service for repair which resulted in an additional 54 hours of pump unavailability. The finding was of very low safety significance because both trains of High Head Safety Injection remained operable.

Inspection Report# : [2001007\(pdf\)](#)



**Significance:** Jul 27, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### FAILURE TO EVALUATE TEST FAILURES ASSOCIATED WITH TWO MOLDED CASE CIRCUIT BREAKERS TO PREVENT RECURRENCE

A Non-Cited Violation of 10 CFR 50 Appendix B, Criterion XVI was identified for failure to assure the cause of safety related molded-case circuit breaker (MCCB) test failures was identified and corrective actions taken to preclude recurrence. Two safety-related MCCBs, which had been removed from service several years ago, failed during recent testing. However, the licensee did not initiate a condition report to assure the cause would be identified and appropriate corrective actions would be taken. The MCCB test failures are significant because many MCCBs in safety-related applications were installed during initial plant construction and have not been subject to a periodic testing program. The issue affects the mitigating systems cornerstone because the problem could affect the operability and availability of mitigating systems. However, because the two breakers that failed the test acceptance criteria had already been removed from safety-related applications and were currently spares, there was no actual loss of safety function. For the MCCBs that were in service, the licensee's evaluation determined them to be operable. Consequently the finding is considered to be of very low safety significance (Green). Because the finding is of very low safety significance and is being addressed with the licensee's corrective action process, this finding is being treated as a Non-Cited Violation, consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001011\(pdf\)](#)



**Significance:** Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### ON-LINE MAINTENANCE RISK IMPACT NOT EVALUATED PRIOR TO SPENT FUEL POOL PURIFICATION SYSTEM MAINTENANCE

The inspectors identified a Non-Cited Violation of 10 CFR 50.65(a)(4), for failure to properly assess the associated change in plant risk, prior to removing the Spent Fuel Pool Cooling and Purification system from service. The resulting system configuration isolated the boric acid blender makeup capability to the refueling water storage tank. This finding was of very low safety significance because the additional time the system was out of service was small (8 hours).

Inspection Report# : [2001006\(pdf\)](#)



**Significance:** Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### INCOMPLETE EVALUATION AND RESOLUTION OF DEGRADED MAIN STEAM ISOLATION VALVE CLOSURE STROKE TIME

The inspectors identified a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion XVI, for failure to implement appropriate corrective actions to address a degraded Unit 2 main steam isolation valve closure stroke time. This finding represented incomplete problem identification and resolution. Corrective action measures did not determine the cause of degraded main steam isolation valve (MSIV) closure stroke time sufficiently to preclude repetition and verify continued operability. Controls were not established to verify air actuator pressure would be maintained at a value necessary to support continued 2MSS-AOV-101C operability. Additionally, the root cause evaluation did not fully evaluate whether the longstanding failure to

perform vendor recommended preventive maintenance would require reducing the air actuator pressure band, required to support MSIV operability. The finding was of very low safety significance because the degraded valve did not represent an actual loss of safety function at time of identification. Additionally, all other systems relied upon to mitigate a main steam line break remained operable.

Inspection Report# : [2001006\(pdf\)](#)

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**Significance:** Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO ESTABLISH THE COMPENSATORY MEASURES FOR AN INOPERABLE FIRE DOOR IN THE UNIT 2 EMERGENCY SWITCH GEAR**

The inspectors identified a Non-Cited Violation for failure to establish compensatory measures for an inoperable fire door barrier between the Unit 2 emergency switchgear rooms. This finding was of very low safety significance because the likelihood of a fire progressing through the door was considered very low. Therefore, one complete train of safety equipment was likely to remain available to mitigate the accident. Failure to establish measures for an inoperable fire barrier door was a Non-Cited Violation of Technical Specification 6.8.1, consistent with Section VI.A of the Enforcement Policy, issued on May 1, 2000.

Inspection Report# : [2001002\(pdf\)](#)

**Significance:** N/A Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

**FAILURE TO FOLLOW PLANT SHUTDOWN PROCEDURE CAUSES AUTOMATIC FEEDWATER ISOLATION**

Technical Specification 6.8.1 requires written procedures covering the activities recommended in Appendix 'A' of Regulatory Guide 1.33, Revision 2, February 1978. Station Operating Procedure 2OM-51.4.L, "Station Shutdown from 40 percent Power to Mode 5," Rev. 0, specified steam generator (SG) level be maintained within the alarm setpoint control bands. Contrary to the above, operators maintained SG levels approximately 10 percent above the alarm setpoint control bands during plant shutdown on September 23, 2000. A subsequent inappropriate rate of increase of steam dump pressure resulted in a steam generator swell and automatic feedwater isolation due to high SG level. Reference Condition Report 00-3203. Failure to properly implement the plant shutdown procedure was a Non-Cited Violation of Technical Specification 6.8.1, consistent with Section VI.A of the Enforcement Policy, issued on May 1, 2000.

Inspection Report# : [2001002\(pdf\)](#)

## Barrier Integrity

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**Significance:** Dec 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

**INADEQUATE CORRECTIVE ACTIONS FOLLOWING UNIT 2 UNUSUAL EVENT DUE TO EXCESSIVE UNIDENTIFIED REACTOR COOLANT SYSTEM LEAKAGE**

The inspectors identified a Non-Cited Violation for inadequate corrective actions during packing gland eyebolt replacement for four valves (including 2RCS-557B, the valve that was the cause of the Unit 2 Unusual Event for excessive reactor coolant system (RCS) leakage on December 11, 2000. Mechanics failed to properly consolidate valve packing following corrective maintenance and unknowingly damaged valve packing on all four valves. Station personnel did not fully understand the effects of their corrective maintenance, the design of the valve packing configuration, or properly address the cause for post-maintenance packing leakage prior to restarting the unit on December 15. Consequently, 2RCS-557B valve packing failed and initiated a 5 gallons per minute identified RCS coolant leak. The event revealed knowledge, work instruction, and work practice deficiencies associated with the station's valve packing program implementation. The finding was of very low significance because the event did not create an open pathway in the physical integrity of the reactor containment barrier or adversely affect the ability to control containment pressure. Failure to adequately perform corrective maintenance to resolve excessive packing leakage from 2RCS-557B following the December 11, 2000, Unusual Event was a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, Correction Actions, consistent with Section VI.A of the Enforcement Policy, issued May 1, 2000 (65 FR 25368).

Inspection Report# : [2000012\(pdf\)](#)

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**Significance:** Aug 12, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

**ORIGINAL DESIGN REQUIREMENTS OF THE SUPPLEMENTAL LEAK COLLECTION AND RELEASE SYSTEM AUXILIARY BUILDING VENTILATION WERE NOT INCORPORATED INTO PLANT DESIGN.**

Original design requirements of the supplemental leak collection and release system (primary auxiliary building ventilation) were not incorporated

into plant procedures. Specifically, the system is a manual system and emergency operating procedures did not have requirements to verify the ventilation fan was operating. The system provides two safety functions: 1) filter leakage from engineered safety feature equipment, and 2) provide cooling to safety related motors. The finding was determined to have very low safety significance. Engineers determined the loss of cooling to safety related motors would not affect the ability of these motors to function during the initial accident mitigation stages and operators would have sufficient time to correct the problem prior to equipment failure. Failure to incorporate design requirements into procedures was a non-cited violation of 10 CFR 50 Appendix B Criterion III, consistent with Section VI.A of the Enforcement Policy, issued on May 1, 2000.

Inspection Report# : [2000006\(pdf\)](#)

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## Emergency Preparedness



**Significance:** Jun 29, 2000

Identified By: Licensee

Item Type: FIN Finding

### **EMERGENCY RESPONSE ORGANIZATION DID NOT SUCCESSFULLY IMPLEMENT RISK SIGNIFICANT PLANNING STANDARD 10 CFR 50/47(b)(9) FOR RADIOLOGICAL ASSESSMENT**

During the June 27, 2000, exercise, the emergency response organization did not successfully implement risk significant planning standard 10 CFR 50.47(b)(9) for radiological assessment. That resulted in delaying the protective action recommendation upgrade when the simulated radiological release began. Specifically, dose assessment personnel were using data from an incorrect radiation monitor channel and incorrect units of measurement. A controller had to provide the dose assessment staff with the correct data. Dose assessment staff incorrectly used that data also, and controllers had to provide correct dose projections in order to preserve the scenario timeline. With the correct projections, the correct PAR upgrade was made. The licensee identified and addressed this issue during the June 29, 2000, critique and entered it into their corrective action program. This failure to implement a planning standard was during an exercise, not an actual event, and, therefore, it is not a violation of NRC requirements. Also, this issue was evaluated by the NRC using the Emergency SPD. It was determined to be a safety issue of very low significance because the licensee identified the failure during an exercise.

Inspection Report# : [2000007\(pdf\)](#)

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## Occupational Radiation Safety

**Significance:** N/A Dec 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

### **FAILURE TO CONTROL LOCKED HIGH RADIATION AREA DOOR**

Technical Specification 6.11 requires that procedures shall be prepared consistently with 10 CFR Part 20 and shall be adhered to for all operations involving personnel radiation exposure. Radiological Procedure 8.3, Radiation Barrier Key Control, Rev. 3 requires that doors, posted as Locked High Radiation Areas (LHRAs), be closed and locked. Contrary to the above, on December 13, 2000, a radiation technician, while performing the required high radiation area barrier checks, found a Unit 2 LHRA door at the base of the stairwell behind containment elevator (R-92-2) closed, but not locked. The area was surveyed, and no accessible areas had dose rates which exceeded 1,000 millirem per hour at 30 centimeters. The highest dose rate in the area was 900 millirem per hour on contact. This event was entered in to the licensee's corrective action system as CR 00-43267. The finding identified by the licensee was of very low significance and a violation of NRC requirements which met the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as a Non-Cited Violation.

Inspection Report# : [2000012\(pdf\)](#)

**Significance:** N/A Nov 11, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

### **FAILURE TO ADHERE TO RADIATION WORK PERMIT PROCEDURES FOR HIGH RADIATION AREA; VIOLATION OF TECHNICAL SPECIFICATION 6.11**

Technical Specification 6.12.1 requires that an entrance to a high radiation area (HRA) shall be controlled by requiring issuance of a Radiological Work Permit (RWP). Technical Specification 6.11 requires that procedures, including RWPs, shall be adhered to for all operations involving personnel radiation exposure. RWP 200-8033, "Transfer Canal Inspection," addressed work in a HRA and required that health physics (HP) technicians survey any object found in the transfer canal prior to handling by a worker. Contrary to the above, on September 27, 2000, a refueling worker picked up and handled a foreign object found on the floor of the transfer canal prior to being surveyed by HP. Reference Condition Report 00-3302.

Inspection Report# : [2000011\(pdf\)](#)

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## Public Radiation Safety

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## Physical Protection

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## Miscellaneous

**Significance:** N/A Sep 15, 2000

Identified By: NRC

Item Type: FIN Finding

**IMPLEMENTATION OF THE CORRECTIVE ACTION PROGRAM WAS ACCEPTABLE AT THE BEAVER VALLEY POWER STATION.**

The team concluded that implementation of the corrective action program was acceptable at the Beaver Valley Station. In general, problems are identified and corrective actions implemented adequately for risk significant problems. The team identified a number of instances of ineffective and untimely implementation of corrective actions to properly resolve identified deficiencies. In addition, some root cause analyses were found to be narrowly focused. The team determined that FENOC's recently completed assessment of the corrective action program by the Quality Services section was thorough and critical. Based on interviews and review of issues contained in the Ombudsman program, individuals working at the Beaver Valley Station felt free to identify safety issues without fear of retaliation.

Inspection Report# : [2000009\(pdf\)](#)

**Significance:** N/A Aug 12, 2000

Identified By: NRC

Item Type: FIN Finding

**CONDITION REPORTS WERE NOT INITIATED, CAUSES WERE INCORRECTLY OR INCOMPLETELY EVALUATED, OR INCORRECT PRIORITIES ASSIGNED TO RESOLVE PROBLEMS.**

Cross-cutting Issues: Problem Identification and Resolution. On several occasions station personnel either did not initiate condition reports for conditions adverse to quality, incorrectly or incompletely evaluated the causes, or assigned incorrect priorities to resolve problems. Condition reports were not written for electro hydraulic control system post-maintenance testing deficiencies and unnecessary emergency diesel generator unavailability until after being identified by the inspectors. Evaluation of nuclear instrument N42 miscalibration did not address double verification errors or questioning of unexpected equipment response. Evaluation of nuclear instrument N44 miscalibration mischaracterized the cause as drift and assigned no further action when further investigation was warranted. Additionally, a recent Independent Safety Evaluation Group assessment of NRC Performance Indicator Process implementation did not identify several readily apparent process or reporting errors, which were later identified by the NRC inspectors.

Inspection Report# : [2000006\(pdf\)](#)

**Significance:** N/A Jul 01, 2000

Identified By: NRC

Item Type: FIN Finding

**PROBLEM ASSESSMENT DID NOT PROPERLY EVALUATE POTENTIAL RISK SIGNIFICANCE AND IMPLEMENT TIMELY EFFECTIVE CORRECTIVE ACTIONS**

Cross-cutting Issues: Problem Identification and Resolution On two occasions, problem assessments did not properly evaluate potential risk significance and implement timely effective corrective actions. Although these deficiencies were not the root or contributing causes to the actual events, they represent adverse performance which limited the licensee's ability to identify and correct adverse safety conditions. Specifically, 1) station personnel did not recognize the potential risk significance of the degraded "A" auxiliary river water pump seal and did not correct the condition in a timely manner; and 2) the safety significance assessment for a reactor protection system (RPS) miscalibration event was also deficient, in that engineers incorrectly concluded that protective functions of the instrument channel were not affected. Additionally, corrective actions for the RPS miscalibration event did not preclude two repeat miscalibration occurrences.

Inspection Report# : [2000005\(pdf\)](#)

**Significance:** N/A Jul 27, 2001

Identified By: NRC

Item Type: FIN Finding

**IDENTIFICATION AND RESOLUTION OF PROBLEMS (PROGRAM ASSESSMENT)**

The licensee's performance in the area of problem identification and resolution was acceptable. The licensee was appropriately identifying problems and entering them into their corrective action process. Condition reports (CRs) received an adequate level of review, and when a root cause analysis was performed, the evaluations were generally thorough and adequate. Notwithstanding, the team identified that the licensee did not evaluate molded case circuit breaker test failures in sufficient detail to identify the causes of the problem and, therefore, did not provide for corrective actions to prevent recurrence. The team also identified an instance where an evaluation of a recirculation spray system flow sensing line refill interval was not technically well supported. The licensee's corrective actions were adequate to correct the identified problem and prevent recurrence. Current trends indicate a large increase in the backlog of open condition reports and corresponding corrective actions. This increase is primarily the result of the licensee's lowering of the threshold for initiating CRs.

Inspection Report# : [2001011](#)(pdf)

Last modified : March 28, 2002