

## McGuire 2

### Initiating Events

### Mitigating Systems

G

**Significance:** Dec 16, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

#### **Inadequate procedure for removal of 120VAC inverters from service**

Inadequate procedure (TS 5.4.1) for removal of Unit 2 120VAC vital inverters from service. During plant solid RCS operation in Mode 5, de-energizing the vital inverters resulted in an inoperable Low Temperature Overpressure Protection (LTOP) system required by Technical Specification 3.4.12. The finding was determined to have very low safety significance (Section 40A7).

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

G

**Significance:** Dec 15, 2000

Identified By: NRC

Item Type: FIN Finding

#### **Depth and effectiveness of the licensee's evaluation and corrective actions for failures of the standby shutdown facility (SSF) diesel generator.**

A finding was identified associated with the depth and effectiveness of the licensee's evaluation and corrective actions for failures of the standby shutdown facility (SSF) diesel generator. The licensee's corrective actions for recent SSF-related problems have not been commensurate with the risk significance of the system. A recent Problem Investigation Process report, which documented a jacket water coolant leak and subsequent emptying of the engine's radiator, was not screened to include a root cause evaluation. The licensee did not perform comprehensive corrective actions to evaluate the need for performing additional preventive maintenance on the SSF diesel generator components. The inspectors identified vendor-recommended maintenance practices that were not being implemented and service bulletins authored by the vendor that were not included in the associated controlled vendor manual located on site. This issue was determined to have very low safety significance because it was not directly linked to any specific period of unavailability for the SSF diesel generator. This instance of ineffective corrective action was an isolated example and is not considered indicative of the licensee's overall corrective action program. (Section 40A2b).

Inspection Report# : [2000010\(pdf\)](#)

G

**Significance:** Sep 15, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Compensatory Measures Result in Degradation of Flood Mitigation Function for EDG Areas**

A non-cited violation of Technical Specifications (TS) 5.4.1.a. was identified involving degradation of the flood mitigation function for the emergency diesel generator (EDG) areas. Specifically, the inspectors identified that station personnel responsible for implementing compensatory measures for flood protection on July 10, 2001, were not cognizant of their responsibilities and that the associated flood protection procedures were inadequate to ensure timely closure of a flood door protecting the Unit 1 EDGs from a design basis turbine building flood. This condition was assessed over a six hour time period on July 10, 2001, as well as similar periods of time over the last 18 months when the subject door in either unit was opened without any discernable compensatory action in place. This finding was determined to be of very low safety significance (Green). This was due to the relatively small period of duration per year, and the minimal effects that turbine building flooding would have on the availability of offsite power for those periods in question. (Section 1R06)

Inspection Report# : [2001003\(pdf\)](#)

G

**Significance:** Mar 17, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

#### **Failure to Follow Procedure PT/2/A/4350/026C, Auxiliary Shutdown Panel Verification**

Failure to follow procedure (Technical Specification 5.4.1) for PT/2/A/4350/026C, Auxiliary Shutdown Panel Verification. The procedure indicates

that all manipulations of controls at the panel shall be performed by a licensed reactor operator. A non-licensed operator performed the auxiliary shutdown manipulations during the performance of the test, contrary to the requirements of the procedure. This is captured in the licensee's corrective action program under PIP M-00-4140. This finding was determined to have very low safety significance and is being treated as a Non Cited Violation (Section 40A7).

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

---

## Barrier Integrity

---

## Emergency Preparedness

---

## Occupational Radiation Safety

---

## Public Radiation Safety

---

## Physical Protection



**Significance:** Sep 16, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure of the Electronic Switching to Provide the Central Alarm Station Operator with the Capability to Properly Assess Potential Penetrations at the Perimeter Prior to Individuals Gaining Access**

A non-cited violation of the Physical Security Plan was identified for the failure of the licensee's electronic switching on September 12, 2000, to provide the central alarm station operator with the capability to properly assess potential penetrations at the perimeter prior to individuals gaining access to the protected area (Section 3PP3.2)

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



**Significance:** Jun 16, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Perform Proper Search of Individuals Entering Protected Area**

A non-cited violation was identified when a security officer failed to properly search two individuals prior to allowing them unescorted access to the protected area. Requirements violated were established in the McGuire Physical Security Plan and implementing procedures. While the risk was low in this case, this issue was identified as more than a minor finding because granting site access to individuals who have not been properly searched can have a credible impact on safety. Additionally, the granting of access to improperly searched individuals can be viewed as a precursor to a significant event. Using the Physical Protection Significance Determination Process and identifying this finding as a vulnerability in Access Control, without a malevolent act, and with fewer than two similar findings in four quarters, the issue was determined to be within the licensee's response band and a Green finding. (Section 3PP2)

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

---

## Miscellaneous

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

Identified By: NRC

Item Type: FIN Finding

**Identification and Resolution of Problems**

Overall, the licensee's corrective action program was effective at identifying, evaluating, and correcting problems. The threshold for entering problems into the corrective action program was sufficiently low. Reviews of operating experience information were comprehensive. In general, the licensee properly prioritized items (by Action Category) in its corrective action program database, which ensured that timely resolution and appropriate causal factor analyses were employed commensurate with safety significance. One exception involved a recent condition adverse to quality in which the standby shutdown facility's (SSF) diesel generator was unavailable following the complete draining of radiator coolant because of heater shell pin-hole leaks. The licensee did not perform an in-depth root cause analysis and thorough corrective actions following its discovery of the degraded condition. Also, for potential safety equipment operability issues, the licensee did not always conduct or document thorough evaluations of present or past inoperability. Previous non-compliance issues documented as non-cited violations were properly tracked and resolved via the corrective action program. The results of the last comprehensive corrective action program audit conducted by the licensee (September 1999) were properly entered and dispositioned in the corrective action program. Based on discussions with plant personnel and the apparently low threshold for items entered in the corrective action program database, the inspectors concluded that workers at the site generally felt free to raise safety concerns to their management.

Inspection Report# : [2000010\(pdf\)](#)

Last modified : March 28, 2002