

Hatch 1

Initiating Events



Significance: Mar 31, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

MULTIPLE FAILURES OF MAIN CONTROL ROOM AIR CONDITIONERS

A non-cited violation (NCV) was identified for the licensee's failure to place the main control room air conditioning system in Maintenance Rule (MR) (a)(1) status as required by licensee procedure 40AC-ENG-020-0S and 10 CFR 50.65. The licensee had identified one maintenance preventable functional failure (MPFF) in October 2000 and three MPFFs between December 22, 2000, and January 14, 2001. The performance criteria established for this system was 1 (MPFF) per 36 months. The licensee was aware of the repetitive MPFFs, but had not assessed the system for potential escalation to MR (a)(1) status until identified by the inspectors in March 2001. Following an assessment in March 2001, the licensee concluded that the system should have been placed in MR (a)(1) status on January 1, 2001.

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

Mitigating Systems



Significance: Dec 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

PERSONNEL ERROR RESULTS IN A CONDITION PROHIBITED BY THE PLANT'S TECHNICAL SPECIFICATIONS

A non-cited violation was identified for failure to follow procedures in removing the 1B Core Spray minimum flow valve from service concurrent with an inoperable 1A Low Pressure Coolant Injection train, resulting in two low pressure Emergency Core Cooling System (ECCS) subsystems being rendered inoperable. Unit 1 Technical Specification 5.4.1.a requires that written procedures shall be implemented covering the activities listed in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Maintenance personnel failed to follow procedures and maintenance work order (MWO) work process sheets and removed the 1B Core Spray minimum flow valve from service while the 1A Low Pressure Coolant Injection train was inoperable. This violation was entered in the licensee's corrective action program as Condition Report (CR) CO 0008198. The safety significance of this finding was very low because other mitigating systems remained operable and the degraded configuration existed for a short duration.

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



Significance: Oct 17, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Prevent Recurrence of Emergency Bus Undervoltage Relay Setpoint Drift.

A non-cited violation (NCV) of 10 CFR 50, Appendix B, criterion XVI [Corrective Actions] was identified by the inspectors for the licensee's failure to identify repetitive calibration problems and prevent recurrence of a setpoint drift problem associated with 4 kv emergency bus undervoltage relays. The finding was of very low safety significance because the setpoint drift would not result in the failure of the Emergency Diesel Generator (EDG) to provide emergency power to the bus, but would only result in a delay of the automatic start feature of the EDG. Additionally, this problem would have to occur in multiple relays simultaneously before the auto start feature of the EDG would be affected. The inspectors reviewed the past 11 years and did not identify any examples where the problem occurred in multiple relays simultaneously.

Inspection Report# : [2001005\(pdf\)](#)



Significance: Oct 17, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

The Increase in Risk Associated with Maintenance on the Upstream Traveling Water Screen was not Assessed.

10 CFR 50.65(a)(4) requires, in part, that before maintenance is performed on systems shown to be risk significant, the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activity. On September 13, 2001, the increase in risk associated with

maintenance on the upstream traveling water screen was not assessed, as described in the licensee corrective action program Reference CR 2001007635.

Inspection Report# : [2001005\(pdf\)](#)



Significance: G Sep 29, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure to Record the as-found Main Steam Isolation Valve Limit Switch Settings as Required by Technical Specification and Sureveillance Procedures.

Technical Specification Surveillance SR 3.3.1.1.13 requires that a channel calibration of Main Steam Isolation Valve (MSIV) limit switches be conducted every 18 months. Procedure 52SV-B21-001-0S, MSIV Limit Switch Inspection, Rev. 4, Ed. 3, implements this requirement, in part, by recording the as found MSIV limit switch settings. It was determined on August 31, 2001, that the as found MSIV limit switch settings were not being recorded as described in the licensee corrective action program Reference CR 2001006969.

Inspection Report# : [2001005\(pdf\)](#)

Significance: N/A Jun 15, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Adequate 50.59 Evaluation for Modification to Intake Structure.

A non-cited violation of 10 CFR 50.59 was identified for an inadequate evaluation associated with the licensee's change to the river intake structure. Specifically, the 10 CFR 50.59 safety analyses associated with lifting and bolting maintenance plugs in the roof of the intake structure, by temporary modification and then by procedure, did not provide an adequate technical basis to support the determination that an unreviewed safety question did not exist. The evaluation failed to address the consequences of a postulated loss of one or two pumps of the residual heat removal service water due to tornado-generated missiles passing through the gap caused by raising the maintenance plug. This condition existed periodically since 1993.

Inspection Report# : [2001004\(pdf\)](#)



Significance: G Jun 15, 2001

Identified By: NRC

Item Type: FIN Finding

A change to the intake structure was completed by lifting and bolting maintenance plugs in each side of the common roof structure to provide additional cooling.

A change to the intake structure was completed by lifting and bolting maintenance plugs in each side of the common roof structure to provide additional cooling. This modification performed periodically since 1993, by temporary modification and then by procedure, left the residual heat removal service water pumps susceptible to a tornado-generated missile. Because of the relatively low probability of a tornado-generated missile traversing the gap between the intake structure roof and maintenance plug, this finding was considered of very low safety significance.

Inspection Report# : [2001004\(pdf\)](#)

Barrier Integrity



Significance: G May 10, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

CLEARANCE RESTORATION RESULTS IN REACTOR COOLANT LEAK

The inspectors identified a non-cited violation of a clearance procedure required by Technical Specification 5.4.1, which requires that procedures be established, implemented and maintained. Operators incorrectly modified and verified a clearance restoration order, causing approximately 50 gallons of reactor coolant to be vented to atmosphere in the reactor building. An individual and an elevation of the reactor building was contaminated. However, operators expeditiously recognized and isolated the leak, minimizing the radiological and plant consequences. The vent line was also small bore piping, limiting the size of the leak. Consequently, the issue was determined to be of very low safety significance.

Inspection Report# : [2000003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety



Significance: Oct 17, 2001

Identified By: NRC

Item Type: FIN Finding

Failure to Perform Corrective Maintenance or Implement Compensatory Measures for Degraded Primary Meteorological Tower Atmospheric Temperature Instruments.

The inspectors identified a finding of very low safety significance for the licensee's failure to perform corrective maintenance or implement compensatory measures for degraded primary meteorological tower atmospheric temperature instruments that impaired the ability to assess offsite dose during a plant emergency. The finding has very low safety significance because the secondary meteorological tower instruments were available for use and no release of radioactivity that required a prompt offsite dose assessment occurred. There was no actual public safety consequence.

Inspection Report# : [2001005\(pdf\)](#)

Physical Protection



Significance: Dec 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

UNAUTHORIZED ACCESS TO PROTECTED AND VITAL AREAS

The licensee identified that an unauthorized individual gained access to protected and vital areas contrary to Physical Security Plan requirements. The site Physical Security Plan requires that all individuals requiring unescorted access to the protected and vital areas are screened according to established guidance. In Licensee Event Report S01 - 2000, the licensee identified that an unauthorized individual gained access to protected and vital plant areas contrary to Physical Security Plan requirements. This issue was entered in the licensee's corrective action program as Condition Report (CR) CO 0008108.. The inspectors reviewed this issue and determined that the violation was of very low significance. This violation was dispositioned as a licensee identified Non-Cited Violation.

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



Significance: Mar 17, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Apparent security violation - intrusion detection

The licensee failed to detect an unauthorized penetration into the protected area during testing.

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

Miscellaneous

Significance: N/A Feb 16, 2001

Identified By: NRC

Item Type: FIN Finding

RESULTS OF PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION

The inspectors determined that, in general, problems were properly identified, evaluated, and corrected. A very low threshold for self-identification was demonstrated. Significant problems were adequately addressed. Minor problems were noted involving corrective actions not being documented within the corrective action program, timeliness of evaluations and documentation of repetitive problems, timeliness of corrective actions, corrective actions which were unclear or incomplete, and severity level classification of condition reports.

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

Significance: N/A Feb 16, 2001

Identified By: NRC

Item Type: VIO Violation

FAILURE TO DOCUMENT ISSUES REQUIRED BY 10 CFR 50.73

The inspectors identified one no-color finding during the Problem Identification and Resolution inspection associated with the failure to document issues required by 10 CFR 50.73 . A Licensee Event Report did not identify that the operating procedure for the Reactor Core Isolation Cooling system turbine allowed the operator to attempt to restart the Reactor Core Isolation Cooling system by opening the Trip and Throttle valve with the steam supply valve full open and the turbine control system demanding maximum speed. This method of restarting the tripped Reactor Core Isolation Cooling system contributed to repetitive overspeed trips during a January 26, 2000, event. This violation was originally documented as a non-cited violation on May 1, 2000. However, at the time of this inspection the licensee had not taken action to restore compliance or develop corrective actions to prevent recurrence. This violation is now being cited based on the NRC's determination that the licensee failed to restore compliance within a reasonable time after the original violation was identified.

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

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

Significance: N/A Nov 30, 2001

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution (PI&R) Inspection Results

The inspectors determined that the licensee's threshold for identifying problems remained sufficiently low and that the licensee was effective at evaluating problems and developing corrective action. No findings of significance were identified. General improvement was noted since the last NRC Problem Identification and Resolution (PI&R) inspection, which was documented in IR 50-321/01-02 and 50-366/01-02, dated March 16, 2001. Since then, the licensee had implemented a new corrective action program (CAP) which strengthened the implementing procedures, increased department management involvement, and established a separate group to manage the CAP as a full-time function. Particularly noteworthy was establishment of a dedicated Trend Coordinator position and a Corrective Action Program Coordinator (CAPCO) position for each department. The Trend Coordinator was responsible for monitoring the CAP and identifying adverse trends. The CAPCO's were responsible for coordinating the resolution of condition reports assigned to their department. Although the new CAP had only been in place since August, 2001, the inspectors also noted improvement with the consistency of the problem evaluation and resolution. However, the inspectors did find that previous issues with identification of repetitive problems and departmental self-assessments continued, and that there were minor deficiencies with the implementing procedures.

Inspection Report# : [2001009\(pdf\)](#)



Significance: Jul 23, 2001

Identified By: NRC

Item Type: FIN Finding

Failure to Perform Preventative Maintenance on Traveling Water Screen System Instruments that Affected the Performance of Plant Service Water.

The inspectors identified a finding of very low safety significance for the licensee's failure to perform preventative maintenance on traveling water screen (TWS) system instruments that affected the performance of the Plant Service Water (PSW) system. As a result, the screens became clogged with debris and the intake structure water level decreased causing fluctuations in PSW flow and pressure. Operators reduced power to 85% on Unit 1 and 90% on Unit 2 in response to the problem and dispatched operators to start the TWS locally. Quick response of the operators prevented further degradation of PSW as well as any adverse impact on mitigating systems. The finding has very low safety significance because prompt operator response and performance demonstrated that the procedures in place were satisfactory and the operators were properly trained to perform the evolution.

Inspection Report# : [2001005\(pdf\)](#)

Last modified : March 28, 2002