

## South Texas 2

### Initiating Events

**Significance:**  Jul 07, 2002

Identified By: NRC

Item Type: FIN Finding

#### **Licensee Did Not Align Safety-related Instrumentation to Diverse Power Sources, Contributing to a Reactor Trip When an Inverter Fuse Blew**

On July 7, 2002, power was lost to the Train D instrumentation channel when the associated inverter blew a fuse. Because it was the licensee's practice to operate with all four controlling steam generator water level channels powered from that channel, the level instruments all failed low, causing the control system to increase feedwater flow to maximum. Operators were unable to gain manual control of four channels fast enough to control level and the unit tripped on high steam generator water level. The inspectors concluded that the licensee had not maintained an operating equipment lineup that would minimize events that upset plant stability and challenged safety functions. This performance deficiency was considered to be of more than minor significance because it affected the performance objective of the initiating events cornerstone by increasing the likelihood of a plant trip or transient. The issue was screened as Green using Phase 1 of the Significance Determination Process.

Inspection Report# : [2002004\(pdf\)](#)

**Significance:**  Feb 07, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

#### **Inadequate Procedure for Switching Offsite Power Transformers Leads to Manual Trip**

On February 7, 2001, Unit 2 operators improperly executed an attempt to transfer a pair of 13.8KV buses from one offsite power transformer to another, de-energizing the buses. One train of engineered safety feature (ESF) equipment lost power and was reenergized from its standby diesel generator. Operators manually tripped the reactor in response to loss of power to Reactor Coolant Pump 2A. The event was caused by operator error, lack of procedure guidance, time pressure to satisfy breaker interlocks, improper communications, and lack of supervision. Failure to provide adequate procedural steps to transfer offsite power sources was a violation of Technical Specification 6.8.1 and Regulatory Guide 1.33. This violation is being treated as a noncited violation consistent with Section VI.A.1 of the NRC Enforcement Policy and is in the licensee's corrective action program as Condition Report 01-2270. This issue had a credible impact on safety and could be viewed as a precursor to a more significant event. The errors removed the preferred offsite power from Train A safety equipment, challenging the ESF diesel and reducing the reliability of accident mitigation equipment in that train. The safety significance of this human performance related event was determined to be very low because all mitigation equipment remained available.

Inspection Report# : [2000014\(pdf\)](#)

**Significance:**  May 07, 2000

Identified By: Self Disclosing

Item Type: FIN Finding

#### **Power transient during maintenance activity due to inadequate balance of plant calibration procedure.**

An uncontrolled power increase from full power occurred in Unit 2 while calibrating a deaerator level instrument in the steam plant. The procedure, which was normally performed when the plant was shutdown, did not alert the technicians to the effects of performing the procedure while at power. Operator action terminated the power increase at a peak of 103.7 percent and restored power below 100 percent within 3 minutes. This issue was characterized as a "green" finding using the significance determination process. It was of very low risk significance due to the brief duration of the transient and no thermohydraulic limits were exceeded.

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

---

## Mitigating Systems

**Significance:**  Dec 21, 2001

Identified By: NRC

Item Type: FIN Finding

### **Following An Event In Which Minnows Clogged ECW Train 1C, The Licensee Was Slow to Identify and Implement Effective Actions From A Safety Perspective**

Following an event in which Train C of the Unit 1 essential cooling water system was rendered inoperable because the discharge strainer in Train 1C clogged with small fish, the licensee was slow to identify and implement actions which would have effectively prevented recurrence. Specifically, no effective barriers were identified which would have prevented a buildup of fish in an idle train suction bay during a rapid drop in temperature in the essential cooling pond similar to that which occurred during the event. The initial corrective actions did not assure that the licensee would have effectively monitored for an increase in the fish population and did not include any specific steps to prevent a train from being rendered inoperable if an increase was detected. The licensee added actions to chlorinate idle intake bays at least daily, improve monitoring, and identify a response plan if a buildup of fish was detected. The inspectors concluded that this provided a reasonable barrier to fish population increases in the bays, even during a period of cold weather. This issue was considered to be more than minor because it represented a potential for a repeat failure, which had a credible impact on safety, and could affect the operability, availability, reliability, and function of a train of accident mitigation equipment. This finding was determined to be of very low safety significance because two trains would remain available.

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

**Significance:**  Dec 06, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### **Lack of Corrective Action**

The team determined that the licensee failed to identify the need for and implement corrective action to address the degraded condition of Steam Generator Power-Operated Relief Valves, 2MSPV7411, 2MSPV7431, and 2MSPV7441 for a period of four weeks, until prompted by the inspection team. The licensee's corrective action program did not promptly evaluate the out-of-specification condition of the electrohydraulic fluid for the steam generator power operated relief valves. Analysis results received in early November for oil samples drawn in late October 2001 were not reviewed and assessed by the licensee's engineering staff until December 6, 2001, when questioned by the inspection team. Three sample results exceeded the licensee's criteria. This was a violation of Criterion XVI of Appendix B to 10CFR50, Corrective Action, which requires that conditions adverse to quality be promptly identified and corrected. The safety significance of this condition is very low as the licensee performed an evaluation to determine that the valves were operable, and the evaluation was accepted by the team. Since the licensee entered this finding into their corrective action program in Condition Reports 2001-19637, -19641, and -19642, this violation is being treated as a noncited violation in accordance with Section VI.A.1 of the Enforcement Policy.

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

**Significance:**  Dec 06, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Assure Adequate Design**

The measures established by the licensee to assure that the current design would support the safety analysis were not adequate. The team identified a failure to verify the adequacy of the plant design in both units to support the current

safety analysis for a loss of normal feedwater event. The failure of the A Train Emergency Diesel Generator with a loss of offsite power could result in the loss of two of the four auxiliary feedwater pumps. The safety analysis for loss of normal feedwater assumes that three pumps will be available. The Train D (Turbine-Driven) Pump cannot be assumed to be available as the essential power for the Train D pump room cooling is supplied from Train A essential power which also supplies the Train A (Electric-Driven) pump. This was identified as a violation of Criterion III of Appendix B to 10 CFR Part 50. The licensee performed an evaluation which concluded that the Train D Pump would perform its safety function at the predicted elevated room temperature for the required mission time. The licensee had previously installed administrative requirements to assure that three pumps would be operable when required. Because of the very low safety significance, and because the licensee has included the item in their corrective action program as Condition Reports 2001-19586 and 2000-19700, this design control violation is a noncited violation (NCV 50-498/01-04-02; 50-499/01-04-02). in accordance with Section VI.A of the Enforcement Policy.

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

**Significance:** N/A Nov 20, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to satisfy procedure prerequisite leads to inadvertent filling of ESF diesel fuel oil storage tank without verifying satisfactory chemistry**

Operators failed to recognize that two routine evolutions using the fuel oil storage and transfer system conflicted because they did not properly verify that the prerequisites were satisfied. When an attempt was made to add fuel oil to the technical support center diesel day tank, the fuel oil storage tank (FOST) for standby diesel generator (SDG) 12 was filled instead. Failure to satisfy prerequisites for OPOP02-FO-0001 was a violation of Technical Specification 6.8.1 and Regulatory Guide 1.33. This violation constitutes an additional example of a previously identified violation (NCV 499/2001005-02) and is not being cited individually. This event had no direct safety significance. The licensee would normally have sampled oil being used to fill a SDG FOST to verify that Technical Specification purity requirements were satisfied prior to filling. However, samples of SDG 12 FOST obtained after filling demonstrated that Technical Specification requirements were not violated. However, as with the earlier event, this issue was determined to be more than minor because the violation suggested a programmatic problem in procedure adherence that could have a realistic potential safety or regulatory impact. If left uncorrected, this violation would become a more significant safety and regulatory concern. Understanding and properly adhering to approved procedures is a key element of human performance necessary to support reactor safety.

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

**Significance:**  Sep 18, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

**Load Sequencer Maintenance Resulted in De-energized ESF Bus and Inoperable Auxiliary Feedwater Train**

The licensee did not recognize that performing maintenance on the Train 1C engineered safety features (ESF) load sequencer rendered Auxiliary Feedwater (AFW) Pump 1C inoperable. A defective new part was not bench-tested, and caused a load shed and deenergized an ESF bus when the load sequencer was energized for testing. The bus had to be manually reenergized because the associated standby diesel generator was out of service. A noncited violation was identified for Work Order 212619, a procedure required by Technical Specification 6.8.1 and Regulatory Guide 1.33, which was inappropriate to the circumstances. This issue was in the licensee's corrective action program under Condition Report 01-14840. This issue had an actual impact on safety because auxiliary feedwater was unintentionally made inoperable and nonfunctional. The violation for the procedure inappropriate to the circumstances was more than minor because of this actual impact on safety. The finding was of very low safety significance (Green) because only one of four trains of AFW was affected, impacting only the mitigation system cornerstone.

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

**Significance:** N/A Sep 18, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to have a required procedure for restoring emergency AC bus power from the normal source.**

Failure to have a procedure to energize an emergency AC bus from its normal source of power, a procedure required by

Technical Specification 6.8.1 and Regulatory Guide 1.33 (Reference Condition Report 01-14699).

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

**Significance:**  May 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to follow procedures resulted in replacing hydraulic oil in steam generator power operated relief valve with out-of-specification oil**

Inspectors identified a noncited violation for failure to follow a procedure. Maintenance personnel replaced hydraulic fluid in Steam Generator Power Operated Relief Valve 1C without first having chemistry personnel sample the new fluid as specified in the maintenance procedure. The oil was later determined to be out-of-specification due to excessive water content. The safety significance of this issue was determined to be very low (Green) because the oil was determined to be within limits that support operability of the steam generator power operated relief valve. However, if left uncorrected this issue could become a more significant safety concern and could credibly affect the reliability of safety equipment supplied with oil from this tank. Failure to follow 0PMP04-SG-0007, Revision 10, "Steam Generator PORV Hydraulic Actuator Maintenance," was a violation of Technical Specification 6.8.1, for a Regulatory Guide 1.33 referenced procedure. This violation is being treated as a noncited violation consistent with Section VI.A.1 of the NRC Enforcement Policy and is in the licensee's corrective action program as Condition Report 01-9476.

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

**Significance:** N/A May 29, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to maintain adequate design control for the packing system of a primary isolation valve.**

Report The licensee identified a violation for configuration control due to the first isolation valve from the reactor coolant system, in the letdown line, having an inappropriate packing configuration. This manual valve had been changed from a dual packing arrangement with a leakoff line between packing sets to a single packing configuration. However, the single set of packing was above the leakoff line such that the valve had to be backseated to keep reactor coolant from leaking to the reactor coolant drain tank. This issue was an example of inadequate design control, contrary to 10 CFR 50, Appendix B, Criterion III. This violation is being treated as a noncited violation. Reference Condition 01-5556.

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

**Significance:**  May 10, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate tagging control results in partially draining a safety injection accumulator**

The inspectors identified a noncited violation for failure to ensure adequate system alignment was maintained. Following modifications to the safety injection test header, freeze seals were melted without first establishing the correct system alignment. Operators repeatedly vented the system without recognizing that this drained water from the 2C safety injection accumulator until after it was drained below the Technical Specification minimum level. This issue was considered to be a cross-cutting issue for both human performance and problem identification and resolution. Human performance problems, in the form of inadequate communications about and review of isolation boundaries, and limited understanding of the impact of the multiple operations of the same system, were the cause of draining water from the safety injection accumulator. Operators were slow to respond to indications of lowering accumulator level and identify the cause. Further, this issue was under-classified by the licensee for significance, such that no probable cause determination or corrective actions beyond restoring operability were initiated until the inspectors brought the significance of the event to licensee management's attention. As a result, this was also considered to be a finding against the licensee's problem identification and resolution process. The licensee calculated that, if left uncorrected, power could have increased to just over 100.3 percent, which would not have challenged any safety limits. An inadvertent dilution is an initiating event analyzed in the Updated Final Safety Analysis Report, Chapter 15, and this event was bounded by that analysis. However, this issue was determined to be more than minor because the violation

suggested a programmatic problem in procedure adherence that could have a realistic potential safety or regulatory impact. If left uncorrected, this violation would become a more significant safety and regulatory concern, because understanding and properly adhering to approved procedures is a key element of human performance necessary to support reactor safety. This finding was determined to have very low safety significance (Green) because the operators were able to negate the effect of the error.

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

G

**Significance:** Sep 29, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

**Workers Left a Tool In Containment Recirculation Sump Following Work. Maintenance Procedure Had Inadequate Foreign Material Controls**

The licensee found a tool in the Train B containment recirculation sump inside both debris screens in Unit 2. The tool was left behind during preventive maintenance inside the sump almost eight months earlier. The licensee determined that the maintenance instructions did not provide adequate foreign material control instructions, which was a violation of 10 CFR 50, Appendix B, Criterion V. This violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy. The safety significance of this issue was very low due to this tool being considered too heavy to be ingested during containment recirculation conditions, however, the potential for other more bouyant objects being left inside the sump was credible due to poor administrative controls and worker practices. A subsequent review determined that proper foreign material exclusion controls were only used in about half the maintenance jobs performed in similar sumps during the previous two years. An object ingested from this sump could affect the containment spray pump or either safety injection pump of the associated train.

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

G

**Significance:** Aug 29, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**Criterion III violation for failure to maintain Breaker E2C1 configuration in accordance with its design basis.**

When a 480V safety bus feeder breaker unexpectedly tripped, the licensee determined that the breaker had been installed for 10 months with the overcurrent trip setpoint too low to fulfill the breaker's function of supplying safety related loads on Bus E2C1. This was determined to be a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," because the station's procedures did not control the configuration of replacement breakers to ensure that the design basis of the breaker was satisfied. This violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy. The issue was placed into the licensee's problem identification and resolution program as Condition Report 00-13689. The safety significance of this finding was very low because the licensee had the ability to restore power to all critical loads in a prompt manner using existing procedures and training.

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

G

**Significance:** Apr 18, 2000

Identified By: Licensee

Item Type: FIN Finding

**Incomplete impact review of outage work tagout resulted in declaring a train of equipment inoperable in the operating unit.**

Unit 1 operators did not thoroughly determine the impact of a tagout to deenergize an electrical panel before authorizing the tags. This caused an unexpected loss of a portion of the instrument air system that impacted safety cooling water systems for both units. Operators in Unit 2, which was operating at full power, responded to the resulting low intake bay level in the Train C essential cooling water system by declaring the train, and thus all supported equipment, inoperable. This issue was characterized as a "green" finding using the significance determination process. It was determined to have very low risk significance because the remaining two trains of ESF equipment were sufficient to maintain mitigating system capability.

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



## Barrier Integrity

**Significance:**  Aug 29, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Follow a Procedure to Update AFD Computer Constants as Required by TS 6.8.1 and Reg. Guide 1.33**

Instrumentation and controls technicians did not ensure that computer constants needed to calculate axial flux difference were updated during calibrations of the nuclear instruments as required by the calibration procedures. The plant computer was the only method used to calculate core axial flux difference, and to alarm if limits were approached. This failure to follow procedures was a non-cited violation of Technical Specification 6.8.1 and Regulatory Guide 1.33. The axial flux difference function was still operable with the old constants not properly updated for two channels, since the computer constants had changed by a small amount. However, this issue was considered to be more than minor because, if left uncorrected, it would be of greater safety concern because instrument inaccuracies could increase over time as the core burned up and detectors aged. The error affected operators' ability to maintain reactor power distribution within limits in order to protect the fuel clad barrier. This issue screened as a Green issue using Phase 1 of the Significance Determination Process because only the fuel clad barrier was potentially affected. Inspection Report# : [2002004\(pdf\)](#)

**Significance:** N/A Apr 19, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

### **A steam generator tube was not inspected under the 100 percent expanded eddy current examination requirement invoked by TS 4.4.5.2.**

A violation of Technical Specification 4.4.5.2 was identified for the failure to perform an expanded eddy current examination of all inservice steam generator tubes when the defect threshold was been exceeded. In February 1997, during Refueling Outage 2RE05, the defect threshold was exceeded and the Technical Specification requirement was invoked. On October 16, 1998, during Refueling Outage 2RE06, it was discovered that Tube R02C59 in Unit 2 Steam Generator 2B was inadvertently not examined as required during the previous refueling outage. Thus, the steam generator was operated in this condition for a full cycle in violation of the Technical Specification. During subsequent examination of Tube R02C59, it was determined that no indications or defects existed. This issue was characterized as a No Color finding in accordance with Manual Chapter 0610, in that no Group 2 questions were affirmative and Group 3 questions indicated the issue was greater than minor and was being documented to close a licensee event report. This condition was identified by the licensee and corrective actions were specified in Nonconformance Report NR-THX-98-002, and reported in Licensee Event Report 50-499/1998-003. Inspection Report# : [2001002\(pdf\)](#)

**Significance:**  May 06, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

### **Condition outside licensing basis identified and corrected.**

During a design review for the replacement steam generators, the licensee identified that both units were outside their licensing basis because both charging pumps restarted automatically upon a loss of offsite power. The safety analysis for loss of offsite power assumed that the charging pumps would not restart upon a loss of power because this condition may result in overfilling the pressurizer. The licensee promptly modified both units to restore the facility to within the license basis. The failure to properly incorporate the licensing basis into the plant as-built design was a violation of 10 CFR Part 50, Appendix B, Criterion III. This violation is being treated as a noncited violation in accordance with Section VI.A of the NRC Enforcement Policy and is in the licensee's corrective action program as Condition Report 00-3229. This violation was characterized as a "green" issue using the significance determination process. It was determined to have very low risk significance because the existing plant configuration (power-operated relief valve

capacity) was sufficient to prevent challenging the pressurizer safety valves. To create a loss of reactor coolant system integrity via the power-operated relief valves would require a loss of offsite power, a power-operated relief valve failure, and a power-operated relief valve block valve failure, which is a low probability scenario.

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

---

## Emergency Preparedness

---

## Occupational Radiation Safety

**Significance:**  Oct 13, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

### **Technical Specification 6.8.1 requires procedures for the radiation work permit system.**

Technical Specification 6.8.1 requires procedures for the radiation work permit system. Section 4.4 of Procedure OPGP03-ZR-0051, "Radiological Access and Work Controls," Revision 14, requires radiation workers to review and comply with applicable radiation work permit [requirements]. On February 20 and October 13, 2001, four workers using two different radiation work permits did not comply with the applicable requirements of their permits, as described in the licensee's corrective action program, reference Condition Reports 01-2916 and 01-16500. This violation is being treated as a noncited violation. The safety significance of this finding was determined to be very low by the Occupational Radiation Safety Significance Determination Process because there was no actual over-exposure or substantial potential for an over-exposure, and the ability to assess dose was not compromised.

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

**Significance:**  Mar 16, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to inform workers of the storage of radioactive materials**

On March 13-14, 2001, the inspector identified two occasions when radiation protection personnel failed to keep radiation workers informed of the storage of radioactive materials on the 19 foot elevation inside the biological shield-wall of the Unit 2 reactor containment building. 10 CFR Part 19, Section 19.12(a) states, in part, that all individuals who in the course of employment are likely to receive in a year an occupational dose in excess of 100 millirem shall be kept informed of the storage, transfer, or use of radiation and/or radioactive material. The failure to keep radiation workers informed of the storage of radioactive materials is a violation of 10 CFR 19.12(a). These two examples of a violation are being treated as a noncited violation and are in the licensee's corrective action program as Condition Reports 01-4268 and 01-4307. This noncited violation was characterized as a Green finding using the Occupational Radiation Safety Significance Determination Process. This issue was determined to be of very low safety significance because these incidents did not result in an overexposure, or have a substantial potential for an overexposure, and the ability to assess dose was not compromised.

Inspection Report# : [2000014\(pdf\)](#)

**Significance:**  Mar 16, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

### **Failure to follow radiation work permit requirements**

Technical Specification 6.8.1 requires procedures for the radiation work permit system. Section 4.4 of Plant General Procedure OPGP03-ZR-0051, "Radiological Access and Work Controls," Revision 13, states, in part, radiation workers

will review and comply with applicable radiation work permit [requirements]. On March 8, 2001, six workers entered a high radiation area using a radiation work permit that did not allow entry into high radiation areas. On March 9, 2001, two workers entered an overhead area in the reactor containment building without contacting health physics personnel as required by their radiation work permit. On March 12, 2001, four workers entered an overhead area in the reactor containment building without contacting health physics personnel as required by their radiation work permit. These events are described in the licensee's corrective action program, reference Condition Reports CR01-3767, CR01-3951, and CR01-4135 (respectively).

Inspection Report# : [2000014\(pdf\)](#)

**Significance:**  Nov 16, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to wear required dosimetry when entering a high radiation area**

Technical Specification 6.12.1 requires, in part, any individual entering a high radiation area be provided a radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received. On October 24, 1999, an individual entered a high radiation area without an alarming dosimeter as described in the licensee's corrective action program, reference CR 99-14992.

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

**Significance:**  Nov 16, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to follow radiation work permit requirements**

Technical Specification 6.8.1 requires procedures for the radiation work permit system. Form 1 of Procedure OPRP0-ZR-001, "Radiation Work Permits," Revision 8, states, in part, that an individual shall read, understand, and comply with the requirements of the radiation work permit. On November 4, 1999, an individual entered a high radiation area while logged in on a radiation work permit which did not allow entrance into a high radiation area as described in the licensee's corrective action program, reference CR 99-15678.

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

---

## Public Radiation Safety

**Significance:**  Jan 11, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to list all required radionuclides on shipping papers**

49 CFR 173.433 requires that shipping papers list 95 percent of the most abundant radionuclides based on their A2 values (used to determine proper waste classification). On October 21, 1998, Radwaste Shipment 2-98-0035 consisting of 13 containers of surface contaminated objects did not list 95 percent of the most abundant radionuclides contained in the shipment, as described in the licensee's corrective action program, reference Condition Report 99-1913.

Inspection Report# : [2000014\(pdf\)](#)

---

## Physical Protection



**Significance:**  Apr 05, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to revoke an individual's unescorted access when an individual was terminated.**

The failure to revoke an individual's unescorted access when an individual was terminated and no longer required unescorted access, was a violation of Section 4.1 of the physical security plan and paragraph 8.5 of procedure OPGP09-ZA-0001, Revision 11. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Condition Record 00-6209. This closed LER 498;499/2000-S01.00. This noncited violation was characterized as a "green" finding using the physical protection significant determination process. The violation had very low risk significance (green) because there were no more than two similar findings in the last four quarters.

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

---

## Miscellaneous

**Significance:** N/A Sep 23, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

**Reactor Operator assumed duties with inactive license.**

Reactor operator assumes control room watch with an inactive license contrary to 10 CFR 55.53 (Reference Condition Report 00-11749).

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

**Significance:**  Sep 10, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Satisfy Procedure Prerequisite Leads to Inadvertent Dilution; The cause was not determined because the event was underclassified.**

Operators failed to recognize that two routine evolutions using the chemical and volume control system conflicted. When they attempted to add borated water to the system, only pure water was added, challenging operators to take action to avoid an unintended power increase above 100 percent. The inspectors concluded that the root cause of this event was a failure to recognize that the plant was not in the configuration required by the procedure in use, in part because of a culture that permitted a loose interpretation of what constituted the required system alignment. The licensee's corrective action program underclassified the significance of this event, and as a result did not adequately identify the cause. It was initially treated as minor because operators were able to negate the effect of the error. The inspectors concluded that this should have been treated as a reactivity management event as defined in the licensee's procedures. Failure to follow 0POP02-CV-0001, "Makeup to the Reactor Coolant System," Revision 17, was a violation of Technical Specification 6.8.1 and Regulatory Guide 1.33. This violation is being treated as a noncited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (Reference Condition Reports 01-14307 and 01-14309). The licensee calculated that, if left uncorrected, power could have increased to just over 100.3 percent, which would not have challenged any safety limits. An inadvertent dilution is an initiating event analyzed in the Updated Final Safety Analysis Report, Chapter 15, and this event was bounded by that analysis. However, this issue was determined to be more than minor because the violation suggested a programmatic problem in procedure adherence that could have a realistic potential safety or regulatory impact. If left uncorrected, this violation would become a more significant safety and regulatory concern, because understanding and properly adhering to approved procedures is a key element of human performance necessary to support reactor safety. This finding was determined to have very low safety significance (Green) because the operators were able to negate the effect of the error.

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

**Significance:** N/A Jun 14, 2001

Identified By: NRC

Item Type: FIN Finding

**Licensee's problem identification and resolution program was effective.**

The licensee adequately identified problems and placed them in the corrective action program. Safety significance was appropriately considered in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementation of corrective actions. However, the team identified examples where the evaluations were not clearly documented. With minor exceptions, corrective actions were implemented in a timely manner. Corrective actions to prevent recurrence of conditions adverse to quality were effective. Licensee audits and assessments were effective in identifying problems. Based on the interviews conducted during this inspection, workers at the site felt free to input safety issues into the problem identification and resolution program.

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

**Significance:** N/A Jul 06, 2000

Identified By: NRC

Item Type: FIN Finding

**The facility's corrective action program was effective.**

The team identified that the licensee was effective at identifying problems and putting them into the corrective action program. The licensee self-identified the significant deficiencies identified during the review period. The licensee effectively prioritized the extent to which individual problems would be evaluated consistent with their safety and risk significance and established schedules for implementation of corrective actions. In most instances, the licensee implemented corrective actions that were timely and effective. However the team observed two isolated cases in which corrective actions were ineffective. The cases involved security access authorization and access control.

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

**Significance:** N/A Jun 24, 2000

Identified By: NRC

Item Type: FIN Finding

**Programmatic controls did not ensure corrective actions were timely.**

Inspectors identified that the licensee did not have specific programmatic controls to ensure that corrective actions for degraded or non-conforming conditions were completed within an appropriate time frame. In one example, the licensee delayed correcting a material-related nonconforming condition in a cooling water line to Standby Diesel Generator 21 five times, including the next refueling outage, without formally evaluating the acceptability of the schedule delays. In this case, the licensee was able to adequately justify delaying the work and no specific safety concerns were identified. Because of the programmatic implications, this was determined to be a finding of no color as a cross-cutting issue dealing with problem identification and resolution

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

Last modified : December 02, 2002