

McGuire 1

Initiating Events



Significance: Mar 23, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Follow Power Ranger Test Procedure

Licensee Identified Violation of Technical Specification 5.4.1.a, which requires that written procedures shall be implemented covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Regulatory Guide 1.33 requires procedures for surveillance tests. On January 14, 2002, maintenance technicians failed to follow surveillance procedure PT/1/A/4600/014D, NIS Power Range N-41 Analog Channel Operational Test, by bypassing the incorrect power mismatch channel. As a result of this error and the performance of the procedure, Unit 2 control rods inserted until plant operators terminated the rod movement. This finding had a credible impact on safety because the maintenance technicians' error caused a reactivity change which resulted in a challenge to plant operators. This issue was determined to be of low safety significance because of prompt operator action and because it did not result in a significant plant transient. This issue was entered into the licensee's corrective action program as PIP M-02-0140 (Section 4OA7)

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

Mitigating Systems



Significance: Dec 21, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Performance of Unit 1 ECCS Recirculation Sump Inspection

An NCV of Technical Specification (TS) 5.4.1.a. was identified for the inadequate performance of a Unit 1 containment cleanliness inspection which partially implements TS 3.5.2.8 to ensure debris is not present in the area of the ECCS sump. Prior to this identification, the licensee had previously completed inspections for debris in accordance with Nuclear Site Directive (NSD) 104, Material Condition/Housekeeping, Cleanliness/Foreign Material; however, the licensee's containment inspections failed to identify the adverse condition. The finding was more than minor because it could have had a credible impact on safety by reducing the reliability of the ECCS pumps during accident scenarios due to potential blocking of the ECCS sump. The finding was of very low safety significance based on corrective actions taken to contain the fibrous insulation prior to entering a Mode of operation where the ECCS sump was required to be operable. (Section 1R20)

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



Significance: Sep 14, 2002

Identified By: NRC

Item Type: FIN Finding

Not Considering the TS Bases Required Operating Time in an Operability Determination

A finding was identified for not considering the Technical Specification (TS) bases required operating time in an operability determination for equipment in a degraded condition. Following the discovery of a refrigerant leak on the A control room area chiller, the licensee concluded that the condition did not affect operability. However, in making the determination, the licensee did not consider the design bases of the control room area chilled water system to maintain the control room temperature for 30 days of continuous occupancy. Upon considering the TS bases operating time without establishing compensatory measures, the licensee declared the train inoperable. Not considering the TS bases operating requirements in operability determinations with equipment in degraded conditions could become a more significant safety concern because it may result in TS LCOs not being met. This finding was determined to be of very low safety significance (Green) because the A train control room area chiller was not inoperable for greater than its TS allowed outage time. (Section 1R15).

Inspection Report# : [2002003\(pdf\)](#)



Significance: Sep 14, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate Corrective Actions to Prevent Recurrence of ND Pump Discharge Check Valve Sticking Open

A self-revealing non-cited violation of 10 CFR 50, Criterion XVI, was identified for a failure of licensee corrective actions to effectively modify the Unit 2A residual heat removal (ND) pump discharge check valve (2ND-23) to preclude it from sticking open following a similar event on the opposite Train valve in April 1999. This resulted in valve 2ND-23 sticking open during system flushing in April 2002, rendering both trains of ND inoperable. If left uncorrected, this issue could have become a more significant safety concern, because it could have affected the functional capability of the ND system. This finding, which was evaluated using Phase II of the SDP and reviewed by a regional Senior Reactor Analyst, was determined to be of very low safety significance. This determination reflects the fact that this issue only becomes a potential problem during the injection phase of a large break loss of coolant accident when the Train of ND with the stuck open check valve fails to start and/or run following the associated safety injection signal. (Section 40A3.2)
Inspection Report# : [2002003\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety



Significance: Mar 23, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure to Control Two Areas as Locked High Radiation Areas

Contrary to TS 5.7.2, during fuel movement on March 2, 2002, two areas were identified by the licensee with general area dose rates exceeding 1000 mrem/hr which were not controlled as locked high radiation areas and were accessed by individuals. This issue was determined to be of very low safety significance based on the location of the elevated dose rates relative to the individuals' work areas, appropriate worker actions including exiting the area when elevated dose rates were initially detected, and monitoring results which indicated no significant unexpected exposures were received by the workers. This issue is documented in the licensee's corrective action program as PIPs M-02-01017 and M-02-01018 (Section 40A7).

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



Significance: Mar 23, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure of an Individual to Respond Appropriately to an Alarming ED

Contrary to TS 5.7.1, on February 27, 2002, an individual worker in the Unit 2 Reactor Building, posted as a high radiation area, failed to respond appropriately to his Electronic Dosimeter (ED) integrated dose alarm. This issue was determined to be of very low safety significance based on monitoring results which indicated the worker was in low dose rate areas within the posted high radiation area when the alarm sounded and no over-exposures occurred. This issue is documented in the licensee's corrective action program as PIP M-02-00907 (Section 40A7).

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

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Aug 29, 2002

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION & RESOLUTION

The inspectors concluded that, in general, problems were properly identified, evaluated, and corrected. The licensee was effective at identifying problems and entering them in the corrective action process. Generally, issues were prioritized and evaluated appropriately, and in a timely fashion. The evaluations of significant problems were of sufficient depth to determine the likely root or apparent causes, as well as address the potential extent of the circumstances contributing to the problem and provide a clear basis to establish corrective actions. Corrective actions that addressed the causes of problems were generally identified and implemented. Reviews of sampled operating experience information were comprehensive. Licensee audits and assessments were found to be adequately broad based and effective in providing management a tool for identifying adverse trends. 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 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. The inspectors identified that an element of the corrective action program had not been fully developed, in that limited quarterly trending of issues was performed.

Inspection Report# : [2002007\(pdf\)](#)

Last modified : March 25, 2003