

Millstone 3

Initiating Events

Mitigating Systems

G**Significance:** Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

DESIGN CONTROL - FAILURE TO IDENTIFY AND EVALUATE A DESIGN DEFICIENCY REGARDING THE RECIRCULATION SPRAY SYSTEM (RSS) AND SUSCEPTIBILITY TO WATER HAMMER

The inspectors identified a failure to evaluate the ability of the service water piping to withstand a column separation water hammer. Specifically, the licensee failed to evaluate whether certain portions of the service water return piping from the recirculation spray system were susceptible to transient loads in excess of those described in design basis structural integrity limits. The finding impacted the Mitigating Systems Cornerstone and had the potential to reduce the reliability of service water cooling to the recirculation spray system. However, this finding was determined to be of very low safety significance (Green) because a subsequent operability determination concluded that the affected piping system would remain functional under postulated accidents conditions. The issue was determined to be a violation of 10 CFR 50, Appendix B, Criterion III, Design Control. Because the finding is of very low safety significance and was captured in the licensee's corrective action program, this finding is being treated as a non-cited violation, consistent with Section VI.A of the NRC Enforcement Policy. Inspection Report# : [2002005\(pdf\)](#)

G**Significance:** Feb 09, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

AN INADEQUATE PROCEDURE CAUSED A DELAY IN THE DISCOVERY OF DISCHARGED BREAKER CLOSING SPRINGS FOR THE "B" EMERGENCY DIESEL GENERATOR (EDG) RESULTING IN AN EXTENDED PERIOD OF EDG INOPERABILITY

The inspectors determined that following the conduct of testing activities that discharged the "B" EDG breaker closing springs, no documented requirement existed to verify that the springs were recharged. This resulted in a delay in the discovery of "B" EDG system inoperability and therefore, also in an extended period of time for the subject EDG unavailability. While the total unavailability time period (approximately 37 hours) was within the TS allowed outage time for one inoperable EDG, the inspector identified that TS 3.8.1.1, action b. requires certain verification activities of redundant electrical power supply availability within 1 hour, 8 hour, and 24 hour time periods. These actions were not performed, as required in the times allotted, because of the noted delays associated with the discovery of the inoperable "B" EDG condition. The inspector evaluated this condition using the NRC Significance Determination Process and concluded that the condition was of very low significance (Green) because the plant TS provided for an AOT of 72 hours, because the AC electrical offsite sources and redundant onsite sources remained operable during the period of "B" EDG unavailability, and because no plant work was done to compromise the Unit 3 risk configuration during the time that the EDG inoperability was not recognized. The issue was determined to be a violation of technical specification 3.8.1.1, AC Sources. Because the finding is of very low safety significance and was captured in the licensee's corrective action program, this finding is being treated as a non-cited violation, consistent with Section VI.A of the NRC Enforcement Policy. Inspection Report# : [2001014\(pdf\)](#)

G**Significance:** Feb 01, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY AND CORRECT A CONDITION ADVERSE TO QUALITY REGARDING A DEGRADED SAFETY-RELATED CHECK VALVE IN THE UNIT 3 EDG AIR START SYSTEM

The Problem Identification and Resolution team inspectors identified a failure to promptly identify and correct a condition adverse to quality regarding two instances where a safety related check valve in the Unit 3 emergency diesel "A" air start system failed to prevent a pressure decrease in the associated air receiver tank. However, the failure to identify and evaluate this problem is considered to have a very low safety significance because of the redundant air receivers and compressors, and remote monitoring of air receiver pressure. This issue was determined to be a violation of 10 CFR 50 Appendix B, Criterion XVI, Corrective Action. Because the finding is of very low safety significance and was captured in the licensee's corrective action program, the finding is being treated as a non-cited violation, consistent with section VI.A of the NRC Enforcement Policy.

Inspection Report# : [2001015\(pdf\)](#)

Significance: TBD Jun 30, 2001

Identified By: Licensee

Item Type: URI Unresolved item

QUENCH SPRAY SYSTEM MANUAL VALVE MISALIGNMENT

An apparent violation of Technical Specification 3.6.2.1, Containment Quench Spray System, involving the failure to adequately verify the position of quench spray system discharge valves, was identified in LER 50-423/2001-001. The safety significance of the finding is under review, and the apparent violation is being treated as an unresolved item.

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

Barrier Integrity



Significance: G Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE PROCEDURE TO DRAIN AN ISOLATED REACTOR COOLANT SYSTEM LOOP

The inspectors identified an inadequate operating procedure, which resulted in a failure to maintain an isolated reactor coolant system (RCS) loop pressure below its TS required pressure limit. The finding impacted the Barrier Integrity Cornerstone and had an actual impact of exposing an isolated RCS loop to a pressure that exceeded a pressure-temperature limit delineated in the TS. The finding was of very low safety significance (Green) because there was no adverse impact on the structural integrity of any RCS components and the requirements of TS were met. This issue was determined to be a violation of Technical Specification 6.8.1, Procedures and Programs. Because the finding is of very low safety significance and was captured in the licensee's corrective action program, this finding is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2002005\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Feb 01, 2002

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION AND RESOLUTION TEAM INSPECTION RESULTS

Overall the licensee identified problems at an appropriate threshold and entered them into the CAP for resolution. The identification of repetitive trends appeared proper. However, the use of trend cause codes to identify possible precursor trends was limited. No deficiencies were identified in completed operability determinations. The significance level 1 root cause evaluations reviewed during the inspection sufficiently identified likely causal factors and corrective actions. The significance level 2 apparent cause evaluations generally appeared appropriate. The

selected effectiveness reviews were of good quality. Several instances were identified where the evaluation of problems documented in significance level 2 and level "N" condition reports were either not adequately evaluated or prioritized for completion, or were not completed in sufficient detail to provide for timely and effective corrective actions. Corrective actions appeared appropriate. The effectiveness reviews selected were of good quality, including several where the reviewer appropriately identified inadequate corrective actions. Some safety-related pump bearing oil problem concerns continue to occur, but previous corrective actions may not have had time to correct existing issues.

Inspection Report# : [2001015\(pdf\)](#)

Last modified : March 25, 2003