

## Summer

### Initiating Events

### Mitigating Systems

G**Significance:** Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**failure to properly test the component cooling water valves resulting in preconditioning**

Performing a system re-alignment prior to stroke time testing two component cooling water valves resulted in the valves being preconditioned, i.e., not being tested under as-found conditions. An inspector-identified non-cited violation of 10 CFR 50 Appendix B, Criterion XI was identified. This finding is more than minor because preconditioning can mask the as-found condition of the valves and any potential performance issues. The finding is of very low safety significance due to the limited impact that the preconditioning had on the valve stroke times

Inspection Report# : [2002004\(pdf\)](#)G**Significance:** Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**failure to take timely corrective action on A train emergency diesel generator high lube oil strainer differential pressure condition**

After May 12, 2002, the licensee failed to take corrective actions to preclude repetition of high strainer differential pressure on the lube oil strainer for A emergency diesel generator (EDG). As a result, high strainer differential pressure re-occurred in September, October and November 2002. The EDG was declared inoperable in November due to the high strainer differential pressure. An inspector-identified non-cited violation of 10 CFR 50, Appendix B was identified. The finding is more than minor because it affected the capability of the EDG to respond to initiating events i.e., loss of offsite power. The finding is of very low safety significance because of the low likelihood that a loss of offsite power event would occur and that the B train EDG was available and operable to supply onsite electrical power.

Inspection Report# : [2002004\(pdf\)](#)G**Significance:** Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**failure to take adequate corrective actions to perform an evaluation of the impact of increased system pressure on flooding within buildings other than the emergency diesel generator building**

Corrective actions to evaluate increased service water system pressure on internal flooding calculations addressed only the emergency diesel generator buildings. Other flooding calculations were not evaluated involving other cooling water systems, affected buildings, and other areas containing safety-related equipment which could also be impacted by increased flooding levels or spray. An inspector-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI was identified. The finding is more than minor because it affected the cornerstone objective to ensure the availability, reliability and capability of safety-related equipment in areas, other than the EDG building, from the effects of internal flooding. The finding is of very low safety significance because the increase in flood levels in other areas did not adversely impact affected equipment or render them unable to perform their intended safety function.

Inspection Report# : [2002004\(pdf\)](#)G**Significance:** Sep 28, 2002

Identified By: NRC

Item Type: FIN Finding

**Engineering Information Request did not properly address American Society of Mechanical Engineers code requirements**

The inspectors identified a Green finding concerning the licensee's failure to develop an adequate Engineering Information Request which would have resulted in an inadequate post-maintenance test and a failure to meet American Society of Mechanical Engineers code requirements. The safety significance of the finding was very low based upon the low likelihood of a major component water system break on the B train and the availability of the A train service water.

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



**Significance:** Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**Improper control of steam propagation door DRIB/301**

The inspectors identified a non-cited violation of Technical Specification 6.8.1.a for a failure to maintain proper control of a steam propagation barrier as required by procedures. During post-maintenance for the A train emergency diesel generator jacket water heater replacement, a steam propagation barrier was blocked open. The safety significance of the finding was very low due to the low likelihood of a steam or feedwater line break accident and the short duration that the condition existed.

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



**Significance:** Jun 29, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate design control of the MFW pumps recirculation flow control valve logic**

The inspectors identified one non-cited violation evaluated as having very low safety significance (Green) for inadequate design control of the main feedwater pumps recirculation flow control valves logic. The licensee failed to implement proper design control through adequate testing of the digital control logic modification in order to fully understand the operation of the system. The design change to the circuit logic prevented the control room operators from having manual control of the valves which resulted in an automatic reactor trip. Post-modification testing did not identify the logic flaw in the recirculation valve controls. The safety significance of the finding was very low because the reactor trip response and emergency feedwater system availability were unaffected by the design flaw in the circuit logic.

Inspection Report# : [2002002\(pdf\)](#)



**Significance:** Mar 30, 2002

Identified By: NRC

Item Type: FIN Finding

**Alternative ways to address loss of chill water not evaluated**

The inspectors identified a green finding concerning the licensee's failure to evaluate and specify mitigating actions appropriate to the circumstances for a loss of chill water. The abnormal operating procedure allowed mitigating actions which would block open the steam propagation barrier (SPB) doors to the room containing safeguards activation circuitry, thereby increasing risk. Alternative ways to cool the room were available and had not been evaluated for implementation rather than opening the SPBs. The safety significance of this finding was very low based upon the low likelihood of a steam line break accident during the 30 hours allowed by Technical Specifications to reach cold shutdown when chill water is unavailable.

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

**Significance:** TBD Nov 28, 2001

Identified By: NRC

Item Type: URI Unresolved item

**Decision of When to Enter Fire Emergency Procedure FEP-4.0 and Evacuate the Main Control Room Due to a Fire**

A finding was identified, in that, the lack of operator training combined with licensee management's expectations regarding when to enter fire emergency procedure (FEP)-4.0, Control Room Evacuation Due to Fire, could result in the operators taking actions during a fire in the main control room (MCR) that would not be consistent with the licensee's safe shutdown analysis, fire hazards analysis, or procedure FEP-4.0. The operator training program neither addressed nor had job performance measures (JPM)/simulator scenarios for MCR operator actions and evacuation due to a fire in accordance with procedure FEP-4.0. This finding was determined to have a credible impact on safety because it affected the ability of the operators to perform actions (within the times required by the licensee's safe shutdown analysis and fire hazards analysis) necessary to achieve and maintain post-fire safe shutdown conditions. Licensee management's philosophy and expectations contributed to the operators' performance and slow response in deciding whether to enter procedure FEP-4.0 and evacuate the MCR during two simulator scenarios observed by the team.

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

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## Barrier Integrity

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## Emergency Preparedness

G**Significance:** Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**failure to take timely corrective action to address emergency preparedness procedure detection methods deficiencies**

The licensee failed to take timely corrective action to address emergency preparedness procedure deficiencies which resulted in an emergency classification mis-classification of an event during training. The licensee had identified the issue in April 2001; however, corrective actions were not implemented to preclude similar mis-classification errors during training sessions in September and October 2002. An inspector-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI was identified. The finding is more than minor because it affected the licensee's capability to properly classify an event. The finding is of very low safety significance because the mis-classification of the different events was identified during training scenarios and the performance indicator for drill / exercise performance did not change thresholds.

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

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

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## Miscellaneous

G**Significance:** Mar 30, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

**Contrary to 10 CFR 50.54(a)(4) Final Safety Analysis Report Revision Notice 01-116, which reduced commitments in the quality assurance program, was implemented without prior NRC approval**

10 CFR 50.54(a)(4) requires NRC approval prior to making changes which reduce commitments in the quality assurance program as presented in the Final Safety Analysis Report. On December 26, 2001, Revision Notice (RN) 01-116, which reduced commitments, was implemented without prior NRC approval. This issue was entered in the corrective action program under CER 0-C-02-0228.

Inspection Report# : [2001005\(pdf\)](#)**Significance:** N/A Mar 01, 2002

Identified By: NRC

Item Type: FIN Finding

**Annual Problem Identification and Resolution Inspection Results**

The inspectors concluded that, in general, problems were properly identified, evaluated, and corrected. Improvements were noted in the corrective action process since the previous problem identification and resolution inspection. The process for classifying issues and the criteria for requiring root cause assessments were now more clearly based upon safety significance. The licensee was effectively prioritizing and evaluating issues commensurate with their safety significance. Root cause analyses were generally performed when appropriate and problem evaluations considered extent of condition and generic implications appropriately. Corrective actions were generally effective in correcting problems. Management fostered a safety-conscious work environment by emphasizing safe operations and encouraging problem reporting. However, during the inspection, several minor problems were identified. These included: site personnel not always generating condition evaluation reports (CERs) at the threshold expected by plant management; the corrective action process allowed human performance issues in a CER to go unaddressed when a CER was changed to another type of corrective action document which evaluates only technical issues; relationships between the CER process and identified peripheral processes were not always clearly established; and several timeliness issues associated with due dates. In addition, there were opportunities for increased management involvement in certain activities such as increased presence and involvement with personnel at the corrective action screening committee meetings.

Inspection Report# : [2002006\(pdf\)](#)

Last modified : March 25, 2003