

Perry 1

1Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURES WHEN BYPASSING LPRMs

Green. A self-revealing Non-Cited Violation of Technical Specification (TS) 5.4 occurred on January 31, 2003, when technicians bypassed two local power range monitoring (LPRM) detectors without using the appropriate procedure. As a result, average power range monitor (APRM) C was not bypassed prior to bypassing the LPRMs and the operating crew was not aware of the activities in progress.

Inspection Report# : [2003003\(pdf\)](#)

Significance:  Jun 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedures While Paralleling to the Grid

The inspectors identified a Non-Cited Violation of Technical Specification 5.4.1.a for failure to follow procedures while paralleling to the grid. Licensee personnel failed to verify synchronization prior to closure of a main generator output breaker. The finding was of very low safety significance because the event did not effect the likelihood of a loss of coolant accident, contribute to both a scram and loss of mitigation equipment, nor increase the likelihood of flooding or fire.

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

Mitigating Systems

Significance:  Mar 31, 2003

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROMPTLY IDENTIFY AND CORRECT DEGRADED FIRE BARRIER

Green. The inspectors identified a licensee performance deficiency in that the licensee failed to promptly identify and correct a degraded fire barrier between the Division 3 and Division 1 switchgear rooms. The condition existed since May 2001 but was not identified until May 2002. Following identification of the degradation, the licensee established an hourly fire watch, but 10 months later had yet to correct the degraded fire barrier.

Inspection Report# : [2003003\(pdf\)](#)

Significance:  Mar 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE EXTENT OF CONDITION REVIEW FOR ECCW INOPERABILITY DUE TO SAFETY/NON-SAFETY PIPING INTERFACE

Green. The inspectors identified a licensee performance deficiency involving a Non-Cited Violation for failure to promptly identify and correct a condition adverse to quality in that the licensee did not recognize that during chemical addition to the emergency closed cooling water (ECCW) system, the system is cross-connected to non-safety piping. The licensee had previously identified that ECCW was rendered inoperable during periodic testing of check valves due to cross-connection with non-safety piping, but failed to thoroughly evaluate the extent of condition and recognize a similar condition existed during routine chemical additions.

Inspection Report# : [2003003\(pdf\)](#)

Significance: SL-IV Feb 14, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Severity Level IV Non-Cited Violation associated with the licensee's failure to perform safety evaluations in accordance with 10 CFR 50.59

The team identified a Severity Level IV Non-Cited Violation associated with the licensee's failure to perform safety evaluations in accordance with 10 CFR 50.59 for changes made to the facility as described in the Updated Final Safety Analysis Report. Specifically, the licensee failed to complete a documented safety evaluation for a change to the facility as described in the Updated Final Safety Analysis Report that involved: 1) the incorporation of new electrical standards affecting battery maintenance and acceptance criteria, and 2) changes to a plant drawing and procedure which reduced electrical separation criteria.

Inspection Report# : [2003002\(pdf\)](#)

Significance:  Feb 14, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to perform adequate design reviews for installation of half-couplings on a B train emergency service water elbow.

Green. The team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's inadequate design reviews associated with the installation of half-couplings on a B train 14 inch emergency service water elbow. The licensee installed half-couplings in response to a through-wall leak and an area of wall loss identified on a 14 inch emergency service water elbow. However, the licensee's design review was inadequate in that, it failed to include the requirements of Section XI of the American Society of Mechanical Engineers Code. Specifically, the licensee failed to identify the cause of the flaw, failed to adequately characterize the dimensions of the flaw, nor was the potential growth of these flaws considered. Further, the repair design did not include flaw removal or component replacement.

Inspection Report# : [2003002\(pdf\)](#)

Significance:  Feb 14, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to perform adequate design reviews for installation of a rupture disc in the exhaust piping of the division 3 high pressure core spray diesel generator.

Green. The team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's inadequate design review associated with installation of a rupture disc in the exhaust piping of the division 3 high pressure core spray emergency diesel generator. This finding was self-revealed on October 25, 2000,

after the diesel generator was placed in service following this modification, the rupture disc failed in less than 3 minutes due to pressure induced fatigue. The licensee's design review for the rupture disc was inadequate because it did not adequately consider pressure induced fatigue loading.

Inspection Report# : [2003002\(pdf\)](#)



Significance: Dec 28, 2002

Identified By: NRC

Item Type: VIO Violation

HIGH PRESSURE CORE SPRAY PUMP FAILURE TO START

Technical Specification 5.4 requires, in part, that procedures be established, implemented, and maintained as recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Regulatory Guide 1.33, Appendix A, Section 9, "Procedures for Performing Maintenance," recommends that maintenance activities that affect the performance of safety-related equipment should be performed in accordance with written procedures appropriate to the circumstances. Procedure GEI-0135, Revision 1, March 30, 1999, "ABB Power Circuit Breakers 5 KV Types 5HK250 and 5HK350 Maintenance," Step 15.14.3.3 requires a visual check of the cell switch normally open contacts to verify they are in the flat horizontal position prior to breaker installation. The procedure allows in a note to the step, that it may be acceptable for contact bars to not be in flat horizontal alignment provided a clear make/break of the contacts is observed. Contrary to the above, the licensee failed to implement procedure GEI-0135 during the installation and inspection of the high pressure core spray pump breaker from 1994 through October 23, 2002. Specifically, the licensee did not verify that the contacts were in the flat horizontal position prior to breaker installation or that there was a clear make/break of the contacts. This failure to verify the alignment of the contacts resulted in degradation of the connection over time and failure of the pump to start during surveillance testing on October 23, 2002.

Inspection Report# : [2002008\(pdf\)](#)



Significance: Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO DEMONSTRATE EFFECTIVE MAINTENANCE FOR THE ROD CONTROL AND INFORMATION SYSTEM

Green. The inspectors identified a NCV of 10 CFR 50.65 (a)(2) for the licensee's failure to demonstrate that the performance of the rod control and information system (RCIS) was being effectively controlled through the performance of appropriate maintenance. The licensee's failure to consider the rod insertion function of the RCIS when evaluating system performance was determined to be the cause of the error. The issue was evaluated as having very low risk significance (Green) since, although the mitigation system cornerstone was affected in that reactivity control was degraded by loss of a RCIS safety, no actual loss rod insertion ability occurred due to other methods being available. (Section 1R12)

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



Significance: Sep 30, 2002


Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURES FOR IMPROPERLY FUNCTIONING CONTROL ROOM INDICATIONS

Green. The inspectors identified a NCV of Technical Specification (TS) 5.4 for the licensee's failure to follow procedures regarding tagging of improperly reading equipment. The primary cause was the crosscutting issue of human performance since the technicians and operators failed to recognize out-of-specification data in the partially completed surveillance indicated equipment degradation. The finding was more than minor because an indication used by control


room personnel for vessel level did not read correctly and under other circumstances a failure of a control function could have been overlooked. The finding was of low safety significance because no loss of automatic protective functions occurred and other indications of vessel level were available to operators. (Section 1R22)
Inspection Report# : [2002006\(pdf\)](#)

Significance:  Jun 30, 2002
Identified By: NRC
Item Type: FIN Finding

Inadequate Posting of Protected Equipment During Risk Significant Maintenance Activities

The inspectors identified a licensee performance deficiency associated with the protection of Emergency Service Water 'B' and 'C' trains during a Division 1 ('A' train) outage. Although the 'B' and 'C' pumps were posted as protected equipment, the motor control centers were not. The finding was of very low safety significance because, although the inspectors observed considerable work activities in the immediate vicinity of the motor control centers, the mitigation systems remained operable.


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

Significance:  Jun 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation

Failure to Correct Procedure Deficiency Involving Surveillance Test Equipment

A Non-Cited Violation of 10 CFR 50 Appendix B, Criterion XVI for failure to ensure conditions adverse to quality are corrected. The licensee failed to correct a previously identified procedure deficiency associated with test equipment used to test the level 3 and level 8 Reactor Protection System and Residual Heat Removal shutdown insulation functions. As a result, during the April 2002 performance of the 24-month surveillance, the licensee experienced a similar failure. The finding was of very low safety significance because, although the procedure deficiency had an actual impact causing the loss of one channel of level protective functions for several hours, no actual loss of safety function occurred.

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

Significance:  Jun 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation

Failure to Incorporate Instrument Uncertainty Into Design Basis Calculations and Procedures

(GREEN) The inspection team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." Specifically, the emergency service water system forebay temperature limit was not properly incorporated into plant procedures. Specifically, the plant procedures did not include margin to account for temperature instrument uncertainty. As a result, the emergency service water forebay temperature could have exceeded its design limit during plant operation without being detected. The finding was greater than minor because it impacted the ability of the emergency service water system to perform its design basis function and lake temperatures had previously approached the design basis limit. The finding was of low safety significance because the emergency service water system was operable. (Section 1R21.1).

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

Barrier Integrity

Significance:  Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM TECHNICAL SPECIFICATION REQUIRED TESTING

Green. The inspectors identified a violation of TS surveillance requirement (SR) 3.6.1.9.1 in that the licensee failed to perform TS required surveillance testing and appropriate post-maintenance testing (PMT) following packing adjustment of a main steam shutoff valve. SR 3.6.1.9.1 specified that the licensee verify isolation times of main steam shutoff valves at a frequency in accordance with the Inservice Testing Program. The Inservice Testing Program specifically stated that following adjustment of stem packing, stroke time testing will be performed. Contrary to this requirement, no stroke time testing was performed on the valve. The inspectors also noted that the condition was further aggravated by the licensee's use of an operability determination to declare the valve operable once the missed PMT was initially identified. The licensee failed to recognize the TS compliance aspect until prompted, repeatedly, by the inspectors. The inspectors determined that the finding was more than minor because the failure to perform PMT on a safety related component could reasonably be viewed as a precursor to a significant event. The finding was of very low risk significance because, although the barrier integrity cornerstone was affected in that containment systems capability was not demonstrated through TS required surveillance testing, subsequent testing demonstrated that the system would have performed its intended safety function. (Section 1R19)

Inspection Report# : [2002008\(pdf\)](#)

Emergency Preparedness

Significance:  Apr 12, 2002

Identified By: NRC

Item Type: FIN Finding

Inadequate critique of certain exercise controller and participant actions in the Operations Support Center

The licensee's exercise critique did not identify inappropriate exercise controller interactions with some participants who were involved in Operations Support Center (OSC) activities. Specifically, on multiple occasions various participants were given information by a licensee exercise controller during the exercise before they had opportunities to demonstrate how they would either earn such information or how they could identify and correct mis-information. Also, the licensee's critique did not identify a few instances of exercise participants' failure to implement adequate protective measures associated with OSC activities. The NRC has determined that the above finding on the inadequate critique of certain OSC controller and exercise participants' performances was of very low safety significance (Green). In accordance with NRC's Enforcement Policy, the critique issue is not a violation of NRC requirements since it was associated with an exercise, rather than with an actual emergency response.

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

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : May 30, 2003