

# Columbia Generating Station

## 1Q/2003 Plant Inspection Findings

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### Initiating Events

**Significance:**  Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Man-lift inappropriately stored in control room**

The inspectors identified that the licensee failed to properly store a man-lift, located in the control room, in accordance with plant procedures. The man-lift could have tipped against control room panels containing sensitive plant system control circuits during a seismic event (or other disturbance) resulting in a reactor scram. A violation of Technical Specification 5.4.1.a was identified that is being treated as a noncited violation in accordance with Section VI.A.1 of the NRC Enforcement Policy. The inspectors determined that the issue was greater than minor in significance because it affected the reactor safety, initiating events cornerstone objective. The inspectors utilized the NRC's significance determination process Manual Chapter 0609, Appendix A worksheet and determined that the issue was of very low safety significance (Green). The issue screened out as Green because the problem did not: 1) contribute to the likelihood of a primary or secondary system loss of coolant accident initiator; 2) contribute to both the likelihood of a reactor trip and the failure of mitigation equipment; or 3) increase the likelihood of a fire or internal/external flood.

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

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### Mitigating Systems

**Significance:**  Sep 21, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

#### **Failure to Properly Design a Fire Protection Flood Barrier**

The licensee did not properly design fire protection systems, including flood barriers, to ensure that water from the systems did not affect safety-related equipment (a self disclosing issue). A spill of 15 to 20 gallons of water on the cable spreading room floor leaked through the floor to safety-related components below. The inspectors also identified that the licensee had missed multiple opportunities to identify and correct the deficiencies earlier. A violation of 10 CFR 50.48a was identified that is being treated as a noncited violation in accordance with Section VI.A.1 of the NRC Enforcement Policy. The inspectors determined that the significance was more than minor because the problem affected the reactor safety cornerstone, mitigating systems objective. Specifically, leakage through the cable spreading room floor following the actuation, rupture or inadvertent operation of the fire protection sprinkler system could adversely impact safety-related switchgear associated with Division I and II systems. The inspectors utilized the NRC's significance determination process (Manual Chapter 0609, SDP Phase 1 Worksheet for IE [initiating event], MS [mitigating system], and B [barrier] Cornerstone, dated March 3, 2002) and determined that the issue was of very low safety significance. The finding was determined to involve a design deficiency confirmed not to result in loss of function per Generic Letter 91-18, Revision 1 (Section 40A5).

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

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## Barrier Integrity

**Significance:**  Dec 10, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

### **Recurrence of containment isolation valve failures due to inadequate corrective actions**

The inspection team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the failure to take effective corrective actions to preclude containment isolation valve failures caused by system debris, a known and preventable problem. The original problem surfaced in 1996, but the licensee failed to follow through on planned corrective measures and two additional valve failures were experienced in the past 18 months. In addition, the licensee did not identify a current operability concern until prompted by the NRC and the licensee's first two attempts at addressing operability were inadequate, in part, because they were based on inaccurate information. In the past 18 months, the licensee experienced two containment isolation valve failures due to system debris - a known and preventable problem. Valves FDR-V-3 and FDR-V-4 are both 3-inch ball valves located in the drywell unidentified leakage rate instrument line. Based on the above, the team determined that the issue was more than minor in significance because the problem affected the reactor safety, barrier integrity cornerstone objective. The team utilized the NRC's significance determination process Manual Chapter 0609, Appendix A worksheet and determined that the issue was of very low safety significance (Green). The issue screened out as Green because the problem did not result in an actual open pathway in the physical integrity of the reactor containment or an actual reduction of the atmospheric pressure control function of the reactor containment.

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

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

**Significance:** N/A Mar 07, 2003

Identified By: NRC

Item Type: FIN Finding

### **Verification of Compliance With Interim Compensatory Measures Order**

On February 25, 2002, the NRC imposed by Order, Interim Compensatory Measures to enhance physical security. The inspectors determined that, overall, the licensee appropriately incorporated the Interim Compensatory Measures into the site protective strategy and access authorization program; developed and implemented relevant procedures; ensured

that the emergency plan could be implemented; and established and effectively coordinated interface agreements with offsite organizations.

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

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## Miscellaneous

**Significance:** N/A Dec 10, 2002

Identified By: NRC

Item Type: FIN Finding

### **PI&R Inspection**

NRC had documented a substantive human performance issue in NRC Inspection Report 50-397/01-04. The issue involved several plant events that were caused by poor human performance. The team reviewed corrective actions associated with that finding, which included: 1) increased contractor training and oversight during outages; 2) increased support to operators during outages; 3) increased resources towards job planning prior to outages; 4) staff coaching sessions; and 5) the use of a human performance simulator. The team also reviewed human performance data and statistics for the past two years, which showed marked improvement for the non-outage period since April 2002. Based on a review of the licensee's records and interviews with plant personnel and managers, the licensee has taken reasonable actions to preclude significant problematic human performance trends. No findings of significance were identified.

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

Last modified : May 30, 2003