

Comanche Peak 2

2Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Oct 07, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate Procedure to Test Lockout Relay in 345 kV Switchyard Resulted in Loss of Shutdown Cooling

An inadequate maintenance procedure for testing the lockout relays on the East bus in the 345 kV switchyard resulted in the loss of residual heat removal shutdown cooling. The procedure failed to state that actuation of a relay would cause loss of power to both Unit 1 safety related 6.9 kV buses. A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified. The finding is greater than minor in that it was associated with the procedure quality attribute of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during a shutdown. The finding is of very low safety significance because reactor cavity level was greater than 23 feet above the reactor vessel flange and residual heat removal cooling was recovered within 8 minutes.

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

Mitigating Systems

Significance:  Dec 06, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to test interlock circuits for residual heat removal system cross-tie valves

The inspectors identified one finding, which was a violation of NRC regulatory requirements. The inspectors found that the licensee had failed to fully and routinely test the control circuits for the residual heat removal system crosstie valves (two per unit), which are opened from the control room to provide suction to the charging and safety injection pumps during intermediate pressure cold leg recirculation following a loss-of-coolant accident. During the inspection, to address the inspectors' concerns, the licensee performed special tests, which revealed that a limit switch for one interlock for a Unit 1 valve failed to close as required, and wiring connections for another interlock on a Unit 2 valve were loose. The licensee determined that the remaining parts of the degraded interlock circuits were intact, and concluded that these as-found conditions would not have prevented the operator from opening the valves for the recirculation mode. Despite the problems encountered, the system and its trains would have performed their safety function with the proper valve line up. The inspectors concluded that failure to routinely test these circuits and detect these failures was a noncited violation of 10 CFR Part 50, Appendix B, Criterion XI, Test Control. Criterion XI requires a licensee establish a test program to assure identification and performance of all testing required to demonstrate that systems and components will perform satisfactorily in service. The inspectors considered the finding greater than minor because the lack of testing affected the reliability of a mitigating system. The inspectors considered the risk significance to be green because there was not an actual loss of a train of risk significant equipment. This violation is being treated as a noncited violation consistent with Section VI.A.1 of the NRC Enforcement Policy (50-445;446/0208-01). This violation is in the licensee's corrective action program as SmartForms 2002-004158, 2002-

004227, and 2002-004228.

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

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Dec 13, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to properly classify a radioactive material shipment package as Surface Contaminated Object-II.

A self-revealing non-cited violation of 49 CFR 173.421 was identified because the licensee failed to properly classify a shipment package as Surface Contaminated Object (SCO)-II, Schedule 8. On May 1, 2002, box number 300125 included in Radioactive Material Shipment 2002-0039 was classified by the licensee as limited quantity based on a maximum exterior surface dose rate of 0.4 millirem per hour measured prior to shipment. However, on May 9, 2002, receipt surveys performed by Westinghouse personnel showed that the maximum dose rate on the exterior surface of the box was 2.4 millirem per hour, which exceeded the 0.5 millirem per hour limit for a limited quantity package. The team determined that this issue was self-revealing rather than licensee identified because the issue was identified during receipt surveys by the recipient of the radioactive materials shipment. The failure to properly classify box number 300125 as SCO-II was a performance deficiency. The finding was determined to be more than minor because it was associated with one of the Public Radiation Safety cornerstone attributes (Transportation Program) and affected the associated cornerstone objective. Using the Public Radiation Safety Significance Determination Process, the team determined the finding had very low safety significance because radiation limits for SCO-II were not exceeded, the package was not breached during transit, no certificate-of-compliance problem was involved, there was no low level burial ground nonconformance, and the licensee did not fail to make notifications. This violation is being treated as a non-cited violation consistent with Section VI.A.1 of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Smart Form SMF-2002-001873.

Inspection Report# : [2002010\(pdf\)](#)

Significance:  Dec 13, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to control detectable licensed radioactive material.

A self-revealing non-cited violation of Technical Specification 5.4.1a was identified because the licensee did not

prevent the release of detectable licensed radioactive material from the radiologically controlled area. Specifically, Procedure RPI-213, "Survey and Release of Material and Personnel," Revision 8, Section 4.2.1, states, in part, that the criteria for unconditional release from an Radiologically Controlled Area is no detectable activity. However, on November 12, 2002, a contract worker was discovered with radioactive material on his lanyard during an in-processing whole body count at another licensee's facility. The individual last worked at Comanche Peak Steam Electric Station. The team determined that this example was self-revealing rather than licensee identified because the example was found by another licensee. The failure to properly control detectable licensed radioactive material is a performance deficiency. The finding was more than minor because it was associated with one of the Public Radiation Safety cornerstone attributes (Material Release Program) and affected the associated cornerstone objective. Using the Public Radiation Safety Significance Determination Process, the team determined the finding had very low safety significance because there were not more than 5 occurrences and the exposure associated with each item was less than 5 millirem. This violation is being treated as a non-cited violation consistent with Section VI.A.1 of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as Smart Form SMF-2002-3975.

Inspection Report# : [2002010\(pdf\)](#)

Physical Protection

Significance: N/A Jun 05, 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# : [2003005\(pdf\)](#)

Miscellaneous

Significance: N/A Jun 19, 2003

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The team identified that the licensee was effective at identifying problems and putting them into the corrective action program. The licensee's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. The licensee effectively used risk in prioritizing the extent that individual problems would be evaluated and in establishing schedules for implementing corrective actions. Corrective actions, when specified, were implemented in a timely manner, with few exceptions. Licensee audits and assessments were found to be effective. On the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the corrective action program.

Inspection Report# : [2003006\(pdf\)](#)

Last modified : September 04, 2003