

# Harris 1

## 2Q/2003 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to establish adequate general operating procedures for reactor trip recovery and hot standby to minimum load (nuclear startup)**

Green. A non-cited violation of Technical Specification 6.8.1 was identified for a failure to establish adequate general operating procedures for reactor trip recovery and hot standby to minimum load (nuclear startup). The general operating procedures did not ensure that the main feedwater regulating valves were shut or isolated prior to operators shutting the reactor trip breakers. Not isolating the main feedwater regulating valves during recovery from a reactor trip resulted in two main feedwater regulating valves opening when the reactor trip breakers were shut. Being in this condition caused a high level in two steam generators and protective signals to trip the main feedwater pumps, isolate the feedwater lines, and start the motor-driven auxiliary feedwater pumps. The self-revealing issue was greater than minor because it involved a procedural inadequacy that resulted in automatic actuations of equipment related to the mitigating system cornerstone. The issue had very low safety significance because the unit was shutdown and no safety limits were affected.

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

**Significance:** N/A Nov 15, 2002

Identified By: NRC

Item Type: FIN Finding

#### **95001 SUPPLEMENTAL INSPECTION FOR WHITE PERFORMANCE INDICATOR**

Supplemental inspection was conducted to assess the licensee's evaluation associated with a White performance indicator in the initiating events cornerstone. The White performance indicator involved crossing the threshold from Green to White for the Unplanned Scrams per 7,000 Critical Hours Performance Indicator for the third quarter of calendar year 2002. Specifically, the licensee experienced three reactor trips during the first three quarters of 2002. The first reactor trip, which occurred on January 2, 2002, was a manual trip from approximately 7 percent reactor power caused by an equipment failure associated with the main feedwater regulating valve bypass valve for the C steam generator. The second reactor trip, which occurred on July 13, 2002, was a manual trip from approximately 85 percent reactor power caused by an equipment failure associated with the digital electro-hydraulic control system. The third reactor trip, which occurred on August 15, 2002, was an automatic trip from approximately 100 percent reactor power caused by a momentary grid undervoltage condition. The licensee's problem identification, root cause and extent-of-condition evaluations, and corrective actions for the three reactor trips were adequate. Common cause aspects linking the three reactor trips from a risk perspective were not evident.

Inspection Report# : [2002012\(pdf\)](#)

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### Mitigating Systems

**Significance:** N/A May 09, 2003

Identified By: NRC

Item Type: FIN Finding

### **SPECIAL INSPECTION OF LOSS OF SHUTDOWN COOLING DUE TO LOSS OF CCW**

Overall, the licensee conducted a comprehensive review of the loss of shutdown cooling event of April 28, 2003. Task Analysis, Event and Causal Factor Analysis, and Fault Tree Analysis techniques were utilized to determine contributing and root causes for the event. The event review team recognized the potential common cause vulnerability of incorrect relief valve nozzle ring settings and initiated an extent of condition evaluation to address the problem. Past operability reviews adequately addressed system operability considerations. The special inspection team concluded that the root cause of the event was inadequate corrective action from previous similar events which allowed the conditions within the CCW system to repeat, causing the relief valve to lift. In addition, past corrective actions for incorrect relief valve nozzle ring setting problems were ineffective which caused the relief valve to remain open for an excessive period of time.

Inspection Report# : [2003008\(pdf\)](#)



**Significance:** Apr 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

### **INADEQUATE ROVING CONTINUOUS FIRE WATCHES**

Green. A failure to complete a written evaluation required by 10 CFR 50.59 involving two fire watch related procedures resulted in an inappropriate use of continuous fire watches to rove between fire areas. A non-cited violation of 10 CFR 50.59 (d)(1) was identified. This finding is greater than minor because there was a reasonable likelihood that the subject changes would have required Commission review and approval prior to implementation. However, the finding is of very low safety significance because the consequences of the change would not have adversely affected the licensee's ability to achieve and maintain safe shutdown of the plant.

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



**Significance:** Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO IDENTIFY THAT THE RWST LEVEL TRANSMITTERS WERE SUSCEPTIBLE TO FLOODING**

Green. A non-cited violation (NCV) of 10 CFR 50 Appendix B Criterion XVI was identified for failing to identify that the 4 refueling water storage tank level transmitters did not meet General Design Criteria 2 for protection from flooding when, on two occasions (July and August 2001), 1 of 4 transmitters was affected by rain water accumulation and declared inoperable. This issue was of very low risk significance because of the low probability of the flooding condition that would cause Refueling Water Storage Tank (RWST) transmitter failure coinciding with the need for the RWST contents, and because operator action in the mitigating system cornerstone would negate any equipment damage, and because another multi-train containment heat removal system was available in the barrier integrity cornerstone.

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

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## **Barrier Integrity**

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

**Significance:**  Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROPERLY IMPLEMENT CALIBRATION PROCEDURES USED TO ENSURE ACCURATE RADIONUCLIDE ANALYSES OF AIRBORNE EFFLUENT PARTICULATE SAMPLES IN ACCORDANCE WITH ODCM REQUIREMENTS**

Green. An NCV of Technical Specification (TS) 6.8.1 was identified for the failure to properly implement calibration procedures used to ensure accurate radionuclide analyses of airborne effluent particulate samples required by the Offsite Dose Calculation Manual (ODCM) Table 4.11-2. The finding was of very low safety significance because it involved the failure to meet a regulatory requirement but did not significantly impair the licensee's ability to assess results of gaseous effluent particulate releases to the offsite environs.

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

**Significance:**  Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROPERLY IMPLEMENT THE REMP AIR AIRBORNE MONITORING PROGRAM IN ACCORDANCE WITH THE ODCM REQUIREMENTS**

Green. An NCV of TS 6.8.1 was identified for the failure to properly implement Radiological Environmental Monitoring Program continuous airborne monitoring activities specified in the ODCM Table 3.12-1. The finding was of very low safety significance because it involved the failure to meet a regulatory requirement but did not significantly impair the licensee's ability to corroborate results of effluent releases to the offsite environs.

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

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## Physical Protection

**Significance:**  Apr 11, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to remove a worker, whose fitness may have been questionable, from activities within the scope of 10 CFR Part 26.**

Green. An inspector identified a non-cited violation of 10 CFR 26.27(4)(b)(1). The finding is greater than minor,

because if left uncorrected, the issue could have become a more significant safety concern in that the trustworthiness and reliability of employees is an critical attribute of the Physical Protection Cornerstone objective. It was determined to be of very low safety significance because it involved a failure to meet regulatory requirements involving the access control/behavioral observation program; however, there was no malevolent action and there have not been greater than two similar findings in the previous four quarters.

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

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## Miscellaneous

Last modified : September 04, 2003