

## Summer 2Q/2003 Plant Inspection Findings

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### Initiating Events

**Significance:**  Apr 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Assess and Manage the Increase in Risk of High Voltage Switchyard Activity on Planned EDG Maintenance**

The licensee failed to assess and manage the increase in risk of high voltage switchyard activity on planned emergency diesel generator (EDG) maintenance. An inspector-identified non-cited violation of 10 CFR 50.65(a)(4) was identified. The finding is more than minor because the failure to properly manage the increase in risk could have had a credible impact on the initiating event cornerstone for challenges to critical safety functions. The finding was determined to be of very low safety significance because no actual loss of safety function occurred and the B train EDG was available for onsite power.

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

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### Mitigating Systems

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: FIN Finding

#### **Incomplete Inspections of Portions of the Service Water System**

One finding was identified involving inadequate maintenance or testing procedures resulting in an incomplete inspection of the Service Water piping to the Emergency Feedwater system. No violation of regulatory requirements was identified. The finding was greater than minor due the potential to have a degraded safety-related water supply to the Emergency Feedwater System. The finding is of very low safety significance because an actual loss of safety function was not identified.

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

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Take Appropriate Corrective Action for Maintenance Rule 10 CFR 50.65(a)(1) Goals Not Being Met For Chill Water System**

The licensee failed to take appropriate corrective actions when established maintenance rule 10 CFR 50.65(a)(1) goals were not met for the safety-related heating ventilation and air conditioning chill water system. An inspector-identified non-cited violation of 10 CFR 50.65(a)(1) was identified. The failure to take corrective actions when Maintenance Rule performance or condition goals were not met was considered more than minor because if the finding was left

uncorrected the unavailability or unreliability of the chiller units would result in the inability to maintain main control room temperatures within technical specifications limits. The finding was determined to be of very low safety significance since one chiller train was operable throughout the time the unavailability performance criteria and (a)(1) goals were exceeded.

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

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Take Adequate Corrective Actions to Address a Non-Conservative Technical Specification Action Statement**

The licensee failed to take adequate corrective action to inform operations staff and issue administrative guidance to limit the time of a technical specification action statement for emergency feed water instrumentation. Approximately six weeks after initial identification of the finding the licensee had not taken actions to address the deficiency and on-shift operations personnel were unaware of the need to limit the time the instrumentation was removed from service. An inspector-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI was identified. The finding is more than minor because if the issue was left uncorrected the finding would become a more significant safety concern, in that, the amount of time that the instruments were removed from service would increase the plant's susceptibility to an inadvertent actuation of the system. The finding is of very low safety significance as a result of the licensee's immediate action to issue administrative guidance to operations staff which would have the instrumentation returned to service within a six-hour action statement.

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

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Take Adequate Corrective Actions to Preclude Repetition of Blocking Open a Steam Propagation Door**

After August 23, 2002, the licensee failed to take adequate corrective actions to preclude repetition of a significant conditions adverse to quality concerning the control of steam propagation barrier (SPB) doors. As a result on April 22, 2003, the SPB door for the C train chill water unit was not properly controlled during maintenance activities and was blocked open contrary to station procedures. An inspector-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI was identified. The finding is more than minor because if the issue was left uncorrected the finding would become a more significant safety concern, in that, with the SPB door blocked open the unit was susceptible to a high energy line break (i.e., steam or feedwater) that would render both trains of chill water inoperable. The finding is of very low safety significance due to the low likelihood of a steam or feedwater line break accident and due to the time-delayed impact that a loss of all chillers units would have before control room ventilation temperature limits would be exceeded.

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

**Significance:**  Apr 05, 2003

Identified By: NRC

Item Type: FIN Finding

**Administrative Controls Associated With A Technical Specification Amendment Request Were Not Implemented**

The licensee failed to ensure that appropriate administrative controls, which were established in accordance with NRC Administrative Letter 98-10, "Dispositioning of Technical Specifications That Are Insufficient To Assure Plant Safety," were implemented. As a result, the licensee failed to recognize the need for more restrictive administrative

controls when an emergency feedwater instrument was removed from service. The appropriate administrative controls were implemented after the issue was raised by the inspectors. An inspector-identified finding was identified. The finding is more than minor because if the issue was left uncorrected the finding would become a more significant safety concern, in that, the amount of time that the instruments were removed from service would increase the plant's susceptibility to a unit trip. The finding is of very low safety significance since the licensee took conservative actions and returned the instrumentation to service within the six-hour proposed action statement.

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

G

**Significance:** Apr 05, 2003

Identified By: NRC

Item Type: FIN Finding

**An Incorrect Initial Root Cause and an Inadequate Troubleshooting Effort Resulted in Unplanned Unavailability of An Emergency Diesel Generator**

The licensee did not conduct a thorough problem identification and resolution effort in that an incorrect initial root cause and an inadequate troubleshooting effort resulted in unplanned unavailability of the B train emergency diesel generator (EDG). An inspector-identified finding was identified. The failure to properly conduct a thorough root cause effort was considered more than minor because the finding is associated with the mitigating systems cornerstone and affected the cornerstone objective to ensure availability of the B train EDG. The finding was determined to be of very low safety significance due to the availability of A train EDG for onsite power.

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

G

**Significance:** Apr 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Take Adequate Corrective Actions to Preclude Repetitive Freezing of a Safety-Related CST Level Transmitter Sensing Line**

After January 23, 2003, the licensee failed to take adequate corrective actions to preclude repetition of a significant condition adverse to quality concerning cold weather protection of the condensate storage tank (CST) level instrumentation. As a result the same sensing line froze on February 17, 2003. An inspector-identified non-cited violation of 10 CFR 50, Appendix B, Criterion XVI was identified. The finding is more than minor, in that, the safety-related level transmitter affected a mitigating system cornerstone attribute and could affect the cornerstone objective to ensure availability, reliability and capability of safety-related instrumentation for the emergency feedwater system. The finding is of very low safety significance because the actual level of the CST was properly maintained and a redundant level indicator was available.

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

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\(pdf\)](#)

**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\(pdf\)](#)

**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\(pdf\)](#)

**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\(pdf\)](#)

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## Barrier Integrity

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## Emergency Preparedness

**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 implement 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

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: FIN Finding

### **Failure to Maintain Meteorological Tower Data Recovery Greater Than the 90 Percent as Described in the Final Safety Analysis Report**

The inspectors identified a finding regarding the licensee's failure to maintain the meteorological tower data recovery greater than 90 percent as described in Section 2.3.3.2.4 of Updated Final Safety Analysis Report. This finding is greater than minor because the elevated incidence of out of service meteorological monitoring instrumentation and

reduced frequency of meteorological data recovery affected the offsite dose monitoring attribute of the public radiation safety cornerstone. The finding is of very low safety significance in that no instances were identified when planned effluent releases were made with the required meteorological sensors inoperable. Further, the impact on the licensee's ability to assess dose to a maximally exposed offsite individual using the five year average meteorological monitoring data was negligible, and plant effluent releases were within the design criteria specified in 10 CFR 50, Appendix I, for the period of interest.

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

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## Physical Protection



**Significance:** Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

### **Improperly Transmitted Safeguards Information**

On April 11, 2003, the licensee improperly transmitted Safeguard Information externally over unapproved and unprotected telecommunication circuits. An inspector-identified non-cited violation of 10 CFR 73.21(g)(3) was identified. The finding is more than minor because the finding is associated with the physical protection cornerstone and affects the cornerstone objective to ensure that the physical protection system can protect against a design basis threat. Specifically, the cornerstone attribute in the area of response to contingency events for implementation of the protective strategy, including mitigating actions, would be vulnerable as a result of improperly transmitted Safeguards Information. The finding was determined to be of very low safety significance because no similar finding had been identified during the previous four quarters.

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

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## Miscellaneous

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