

Harris 1

3Q/2003 Plant Inspection Findings

Initiating Events

Significance: N/A Sep 19, 2003

Identified By: NRC

Item Type: FIN Finding

95001 SUPPLEMENTAL INSPECTION FOR WHITE PERFORMANCE INDICATOR (UNPLANNED SCRAMS)

This 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 in the second quarter of calendar year 2003. Specifically, the licensee experienced three reactor trips during the first two quarters of 2003 and also one reactor trip in the third quarter of 2003. The first reactor trip, which occurred on May 18, 2003, was an automatic trip from approximately 27 percent reactor power most likely caused by an equipment failure associated with the main turbine generator electrical overspeed protection circuit. The second reactor trip, which occurred on May 20, 2003, was a manual trip from approximately 20 percent reactor power caused by an equipment failure associated with a condensate booster pump. The third reactor trip, which occurred on June 14, 2003, was a manual trip from approximately 100 percent reactor power caused by an equipment failure associated with a main feedwater pump. The fourth reactor trip, which occurred on August 17, 2003, was a manual reactor trip from approximately 100 percent reactor power caused by an equipment failure of a condensate pump.

The licensee's problem identification, root cause and extent-of-condition evaluations, and corrective actions for the four reactor trips were adequate. Common cause aspects linking the four reactor trips from a risk perspective were not evident.

Inspection Report# : [2003009\(pdf\)](#)



Significance: G 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\(pdf\)](#)

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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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\(pdf\)](#)

Miscellaneous

Significance: N/A Jul 25, 2003

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION & RESOLUTION

The licensee was effective at identifying problems at a low threshold and entering them into the corrective action program. The licensee properly prioritized issues and routinely performed adequate evaluations that were technically accurate and of sufficient depth. Formal root cause evaluations for significant conditions adverse to quality were especially thorough and detailed. Corrective actions developed and implemented for problems were timely and effective, commensurate with the safety-significance of the issue. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. Based on discussions conducted with plant employees from various departments the inspectors did not identify any reluctance to report safety concerns. However, several minor problems were identified related to thoroughness and effectiveness of corrective action, and equipment deficiencies not properly entered into the corrective action program.

Inspection Report# : [2003005\(pdf\)](#)

Last modified : December 01, 2003