

Oconee 2

3Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Detect Non-Conforming Parts during Receipt Inspections

A NCV of 10CFR50.55a(g)(4) and 10CFR50, Appendix B, Criterion VII was identified by the inspectors, in that measures taken to preclude the installation of non-conforming replacement parts and the ability to evaluate the suitability of replacement during the Quality Assurance (QA) receipt inspection process were not adequate. Specifically, this was identified for inadequate QA review during receipt inspections that resulted in the licensee installing one non-conforming Control Rod Drive Mechanisms (CRDM) (Split Nut) Flange Ring on Unit 2, and discovering, prior to the installation in Unit 3, 68 CRDMs and 552 CRDM Hold Down Bolts that did not meet the design and procurement specifications. This finding was more than minor because non-conforming material was actually installed in Unit 2. However, it was determined to be of very low safety significance because there was not a loss of system function. (Section 40A5.1C)

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

Mitigating Systems

Significance:  Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to follow a procedure required by TS 5.4.1, resulting in multiple reactor operators/senior reactor operators failing to properly reactivate their licenses

The inspectors identified a non-cited violation of Technical Specification 5.4.1(a) for failure to follow Operation Management Procedure 1-12, "Maintenance of Licensed Operator, Shift Technical Advisor, and Non-licensed Operator Qualifications," resulting in multiple reactor operators/ senior reactor operators failing to properly reactivate their licenses. This finding is greater than minor because it affected the Mitigating System Cornerstone human performance attribute to ensure that licensed operators are available, reliable, and capable to respond to initiating events to prevent undesirable consequences. The finding was evaluated using the Operator Requalification Human Performance SDP and was determined to be of very low safety significance. Based on more than 20 percent of the reactivated operators failed to meet the requirements as defined in procedure OMP 1-12, the issue was a Green finding. (Section 40A5.6)

Inspection Report# : [2003004\(pdf\)](#)

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify the SSF Degraded Grommets as a Deficient Condition in the PIP Corrective Action Program

A non-cited violation (NCV) of 10CFR50, Appendix B, Criterion XVI, Corrective Action, was identified by the inspectors for failure to promptly identify the degraded standby shutdown facility (SSF) diesel cooling water seals in the problem investigation process (PIP) program. This finding was considered to be more than minor based on the fact that subsequent analysis of the grommets noted significant degradation and this analysis would likely not have been performed without initiation of the PIP. Therefore, if the cause of the degradation was left uncorrected, the mitigation systems cornerstone objective of ensuring the continued reliability of equipment needed to respond to initiating events would be affected. In addition, continued degradation of the grommets would become a more significant safety concern. This issue was considered to be of low safety significance (Green) because the grommets were replaced during the SSF diesel overhaul before they failed in service. (Section 1R12.2)

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

G

Significance: Apr 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate Combustible Material in the KHU Complex

A non-cited violation of Paragraph 3.D of the Oconee Operating License was identified for failure to implement and maintain all provisions of the approved fire protection plan which includes Nuclear System Directive (NSD) 313, Control of Flammable and Combustible Material. The temporary storage of wooden crates at the KHU complex was not evaluated and approved by the fire protection engineer as required by NSD 313. Subsequent evaluation determined increase in fire loading necessitated a fire watch tour be performed every six hours. This issue was determined to be of very low safety significance (Green) as it did not result in the impairment or degradation of fire protection features or defense in depth for safe shutdown. (Section 1R05)

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

G

Significance: Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Correct the Turbine Driven Emergency Feedwater Lube Oil Sump Water Intrusion adverse Condition

The licensee failed to correct a water intrusion problem following identification in 1998, 1999, and 2000 that water was entering the Units 1 and 2 turbine driven emergency feedwater (EFW) pump lube oil sumps. A non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, requirements was identified for failure to identify the source of the water intrusion, failure to identify the rate of water intrusion, and failure to correct the condition adverse to quality. Water in the turbine driven EFW pump lube oil sumps had a credible affect on the operability, availability, reliability and function of the TDEFW mitigation system and was therefore, more than minor. This finding was determined to be of very low safety significance due to the multiple trains of equipment capable of performing secondary side heat removal not affected by the performance deficiency. This included two trains of motor driven EFW pumps per unit, potential cross connect of EFW between units, and the standby shutdown facility. (Section 1R12.2)

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

G

Significance: Dec 31, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Perform Surveillance within the Required Periodicity

An inadequacy in the licensee's work planning program resulted in a missed Technical Specification (TS) required surveillance test involving the Keowee Hydro Station overhead power path. A non-cited violation of TS surveillance

requirements (SR) 3.3.19.1, Channel Functional Test for Degraded Grid Voltage Protection Actuation Logic Channels, SR 3.8.1.15, 230kV Circuit Breaker Actuation on Switchyard Isolation, and TS 5.5.18, Keowee Hydro Unit Commercial Power Generation Testing Program, was identified when it was discovered that PT/0/A/610/022, Keowee Over Frequency Protection Functional Test, was not performed within the required TS SR frequency. This violation is more than minor because it affected the mitigating system cornerstone objective of equipment reliability, in that, a complex series of tests for the emergency power supply were not performed within the specified frequency. This self-revealing finding was determined to be of very low safety significance based on the fact that there was no unavailability of the Keowee units resulting from the missed surveillances. (Section 1R22.2)

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

Barrier Integrity

Significance:  Dec 31, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

Failure to Identify SG Tube Defect

A self-revealing finding was identified for the failure of a steam generator tube to successfully meet the "3 times normal operating delta-p pressure" (3 DP) test criterion (4250 psid) during the in-situ pressure testing process. A performance deficiency was identified, in that the in-service inspection procedures did not have enough guidance to be able to identify a defect in this tube the previous outage; thereby, allowing the unit to operate last cycle with one tube that may not have met the 3 DP limit the entire cycle. The finding was of very low safety significance because, the tube did not fail the performance criterion of meeting the "accident leakage limit." Specifically, having ruptured at a test pressure of 3987, the tube exceeded the normal operating delta pressure (1490 psid), main steam line break/faulted condition (2898 psid), and the main feedwater anticipated transient without scram analysis pressure (~1500 psid). In addition, the unit exhibited no signs of leakage during the last operating cycle from this tube. (Section 1R08.1)

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

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Jul 11, 2003

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution Inspection

The team identified that the licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution. The licensee maintained a low threshold for identifying problems as evidenced by the continued large number of Problem Investigation Process reports (PIPs) entered annually into the CAP. The inspector's independent review did not identify significant adverse conditions which were not in the CAP for resolution.

Evaluation and prioritization of problems was generally effective; although, one example was noted where an evaluation did not thoroughly examine the potential for generic implications. Corrective actions specified for problems were generally adequate; although, several examples were noted where corrective actions were not complete or not comprehensive. Audits and self-assessments continued to identify issues; however, some examples were noted where the issues were not correctly classified for resolution. Previous non-compliance issues documented as non-cited violations were properly tracked and resolved via the CAP. Personnel at the site felt free to raise safety concerns to management and to resolve issues via the CAP.

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

Last modified : December 01, 2003