# Summer
# 4Q/2003 Plant Inspection Findings

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## Initiating Events

**Significance:** G May 12, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
**Inadequate Preventive Maintenenace Results in a Reactor Trip**
A self-revealing non-cited violation was identified for inadequate preventative maintenance (PM) resulting in a reactor trip. 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," requires, in part, that procedures shall include appropriate qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished." The licensee failed to establish an adequate Electrical Maintenance Procedure (EMP)-245.005, "Main Generator and Alterrex Refueling Preventative Maintenance," to preclude a condition that resulted in a reactor trip.

The finding is more than minor because it resulted in a reactor trip. The self-revealing finding is of very low safety significance since the event did not contribute to the likelihood of a primary or a secondary system loss of coolant accident (LOCA) initiator, did not contribute to a loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal / external flood.
Inspection Report# : 2003004*(pdf)*

**Significance:** G 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:** G 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:** G 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:** G 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:** G 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:** G Apr 05, 2003

Identified By: NRC

Item Type: FIN Finding

**Aministrative 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)*

**Significance:** G 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)*

**Significance:** G 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)*

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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:** G 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:** G 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

Last modified : March 02, 2004