

Vermont Yankee

4Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Work instructions Resulted in "B" Service Water Header Degradation

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for an inadequate procedure for the development and use of work instructions for work affecting quality. Consequently, no work instructions were provided to include proper verifications of safety-related piping locations in the vicinity of core boring activities. As a result, contractor personnel inadvertently perforated the "B" SW supply header while core boring.

This finding is greater than minor because it resulted in the degradation of the SW system. However, the inspectors determined that this issue is of very low safety significance (Green) because the performance deficiency did not result in an increase in the likelihood of a loss of service water initiating event and it did not result in a loss of safety function of the system.

Inspection Report# : [2003007\(pdf\)](#)

Mitigating Systems

Significance:  Dec 31, 2003

Identified By: NRC

Item Type: FIN Finding

Two of Nine Operating Crews Failing Their Facility-Administered Annual Simulator Examinations

A finding was identified associated with operating crew performance on the simulator during facility-administered requalification examinations. Of nine crews evaluated, two failed to pass their simulator examinations.

The finding is considered to be greater than minor because it reflected the potential inability of the operating crews to take appropriate safety-related actions in response to actual abnormal or emergency conditions. The finding is of very low safety significance (Green) because less than 34 percent of the operating crews failed, the failed crews were remediated prior to returning to shift, and there were no operating crew failures the previous year.

Inspection Report# : [2003007\(pdf\)](#)

Significance:  Aug 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Alternate Shutdown Capability was not Independent for a Fire in the Control Room or Cable Spreading Room

The inspectors identified a non-cited violation of 10 CFR 50, Appendix R, Section III, "Alternate and Dedicated Shutdown Capability," paragraph L.3, which requires that "the alternate shutdown capability shall be independent of the specific fire area(s) and shall accommodate post fire conditions where offsite power is available and where offsite power is not available for 72 hours." The primary, alternate shutdown power source control power fuses were found in the off position. In this condition, the alternate shutdown capability was not independent for a fire in the control room or cable spreading room.

This finding was greater than minor because fuses were improperly installed which impacted the ability to implement an alternate shutdown independent of a fire in the control room or cable spreading room. The finding was determined to be of very low significance (Green) since its safety function (i.e., restoration of power) could be accomplished before core damage would occur through the use of the "A" EDG.

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

Significance:  Aug 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Adequate Corrective Actions for Relief Valve Test Failures

The team identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to establish effective corrective actions to address quality issues identified during in-service relief valve testing.

This finding is greater than minor since the failure to develop adequate corrective actions for in-service relief valve test failures could allow similar problems to remain undetected in other potentially affected relief valves and adversely impact mitigating system reliability. This finding was determined to be of very low significance (Green) since an actual loss of the safety system function had not occurred as a result of this problem.

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

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Effective Corrective Actions Regarding Safety-Related Electrical Cable Separation

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to take effective corrective actions to address cable separation deficiencies in the cable vault.

This finding is considered to be greater than minor because it affected the Mitigating Systems Cornerstone Objective of Equipment Availability. Specifically, cable separation deficiencies continue to be identified by NRC inspectors in the safety-related cable vault despite corrective actions taken by the licensee to address previous NRC-identified cable vault cable separation issues. The finding was determined to be of very low safety significance because no actual loss of safety function was identified.

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

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Effective Corrective Actions Regarding Continued Failures Standby Liquid Control System Relief Valves

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to take effective corrective actions to address continued lift setpoint testing failures of standby liquid control

(SLC) system relief valves.

This finding is considered to be greater than minor because the on-going history of SLC system relief valve testing failures affected the Mitigating Systems Cornerstone objective of equipment reliability. The finding was determined to be of very low safety significance since relief valve failures would not have resulted in a loss of SLC system safety function.

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

Significance:  Mar 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

CST ENCLOSURE LOW TEMPERATURE EXCEEDED WITH NO CR WRITTEN

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to take timely corrective actions in regards to condensate storage tank (CST) enclosure temperatures that fell below the administrative limits listed in auxiliary operator logs.

This finding is greater than minor because it affected the Mitigating Systems Cornerstone objective of equipment reliability, in that, CST level instruments were left vulnerable to low temperatures which could impact the automatic swap-over function of the high pressure injection (HPCI) and reactor core isolation cooling (RCIC) system suction from the CST to the suppression pool. The finding was determined to be of very low safety significance because an actual loss of safety function did not occur with the level instrumentation. This finding also affected the cross-cutting area of Problem Identification and Resolution, in that, untimely corrective actions resulted in the vulnerability of the CST level instrumentation to cold temperatures.

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

Barrier Integrity

Significance:  Mar 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE DESIGN CONTROL FOR HPCI EXHAUST CHECK VALVES

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," for a failure to adequately control the design of the HPCI system discharge check valves.

This finding is greater than minor because it affected the Barrier Integrity Cornerstone, in that, the inadequate design controls applied to the replacement of HPCI turbine exhaust check valves V23-3 and V23-4 resulted in repeated failures during local leakage rate tests performed on these valves. The finding was determined to be of very low safety significance because the failure of the check valves did not result in an actual open pathway in the physical integrity of reactor containment.

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

Emergency Preparedness

Significance:  Apr 06, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Action of Past Exercise Problems Since 2001

The inspectors identified a finding of very low safety significance (Green) that is also a non-cited violation of 10 CFR 50.47(b)(14) and Appendix E.IV.F.2.g., which states in part, formal critiques shall identify weak or deficient areas that need correction and any deficiencies identified as a result of exercises or drills are (will be) corrected. Entergy failed to take adequate corrective actions for eight problems that were found to be repetitive from previous Emergency Preparedness exercises/drills conducted since 2001 and was again identified during the 2003 biennial exercise.

This finding was determined to be of very low safety significance (Green) by using Manual Chapter 0609, Appendix B, Emergency Preparedness (EP) SDP, EP Risk Determination Flow Chart, Sheet 1, because the finding was identified as a failure to comply with a non-risk significant planning standard (10 CFR 50.47(b)(14) and was not a planning standard function failure. This finding is more than minor because it is associated with the EP cornerstone attribute and effects the ERO performance cornerstone objective (Planning Standard 10 CFR 50.47(b)14). A failure to correct past problems could impede ERO performance during an actual event.

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

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance:  Mar 28, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FFD TESTING NOT IN ACCORDANCE WITH 10 CFR 26.24

A self-revealing, non-cited violation of 10 CFR 26.24(a)(2) was identified for a failure of the licensee to perform random drug and alcohol testing on an annual rate equal to at least 50 percent of the workforce for calendar year 2002. This finding is greater than minor because if affected the objectives of the Physical Protection Cornerstone, in that, it constituted a vulnerability that affected the licensee's Access Authorization System (Personnel Screening Program). The finding was determined to be of very low safety significance because the finding was not a malevolent act and the licensee had not had greater than two similar findings during the last four calendar quarters.

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

Miscellaneous

Last modified : March 02, 2004