

Comanche Peak 1

1Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems



Significance: Aug 20, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadvertent TS 3.0.3 Entry Due to Inoperable CRACS Trains

A self-revealing non-cited violation of Technical Specification 3.0.3 was identified when both trains of the Units 1 and 2 control room air conditioning system (CRACS) were inoperable for longer than the 7 hours specified without placing both units in Mode 3. Specifically, on August 20, 2003, the licensee discovered that Unit 1 and Unit 2 CRACS units had been inoperable according to TS 3.7.11 for several hours prior to discovery, because support systems required for operability had been removed from service for routine maintenance and surveillance. The appropriate systems were restored to make one train of CRACS operable prior to an actual power reduction, but the total duration with less than one operable train exceeded the time to enter Mode 3, as required by Technical Specification 3.0.3. Corrective actions included issuing a Shift Order; issuing lessons learned to operators and schedulers; and reviewing operations and work control procedures for improvement. This event was entered into the licensee's corrective action program as SMF-2003-2463.

This violation is greater than minor because it involves a failure to perform required actions of a Technical Specification and affects an attribute and objective of the mitigating systems cornerstone in that the lack of proper configuration control affected the capability of the CRACS to respond to initiating events. The violation is considered to have a very low safety significance (Green) because it affected only the mitigating system cornerstone and did not represent an actual loss of safety function.

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

Barrier Integrity



Significance: Dec 10, 2002

Identified By: NRC

Item Type: VIO Violation

Failure to identify a steam generator tube flaw and correct it by removing it from service in refueling outage 1RF08

As documented in NRC Special Inspection Report 05000445/2002-09, the inspectors identified a violation of 10 CFR Part 50, Appendix B, Criterion XVI for failure to promptly identify a flaw in Comanche Peak, Unit 1, Steam Generator No. 2 Tube R41C71 and correct it by removing it from service. As a result, in September 2002, the flaw developed into a leak that caused operators to shut the plant down. The tube subsequently failed in situ testing.

The final significance determination was completed and documented in "Final Significance Determination for a White Finding and Notice of Violation," (EA-04-009) dated February 13, 2004. The finding was determined to be of low to moderate safety significance (White) because the tube failed in-situ testing. This failure indicated a higher probability of inservice failure for the tube during postulated initiating events and core damage sequences.

The U.S. Nuclear Regulatory Commission (NRC) performed a supplemental inspection to assess the licensee's evaluations associated with the failure to identify and correct the steam generator tube flaw during Refueling Outage 1RF08. During this supplemental inspection, performed in accordance with Inspection Procedure 95001, the inspectors determined that the licensee performed a comprehensive evaluation of the causes and extent of the performance deficiency that resulted in failure to identify the flaw. The licensee's evaluation resulted in changes in processes and practices for eddy current analysis, improved peer review, and more supervisory oversight. The root-cause evaluation also resulted in additional reviews of the eddy current data obtained in Refueling Outage 1RF09, insuring that analysts identified similar defects. In addition, the licensee applied the lessons learned during the subsequent refueling outage for Unit 2.

Inspection Report# : [2004006\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety



Significance: May 11, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Follow Radiological Postings

A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified because two operators failed to follow radiological postings as required by procedure. Specifically, on May 11, 2003, two operators entered Unit 1 Room 1-092 which was posted "Not Routinely Surveyed, Contact RP Prior To Entry" to hang clearance tags for valve work. However, the two operators entered to complete their task and received electronic dosimeter accumulated dose alarms. During an investigation of the dosimeter alarms, it was identified that the operators entered the room without contacting radiation protection for current radiological conditions. This event was entered into the licensee's corrective action program as SMF 2003-1313.

The finding is greater than minor because it affected the Occupational Radiation Safety cornerstone objective to ensure adequate protection of worker health and safety from exposure to radiation and is associated with a cornerstone attribute (Program & Process). The finding involved individuals' potential for unplanned or unintended dose. When processed through the Occupational Radiation Safety Significance Determination Process the finding was determined to be of very low safety significance because the finding was not associated with ALARA planning or work controls, there was no overexposure or a substantial potential for an overexposure, and the ability to assess dose was not compromised.

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

Public Radiation Safety

Physical Protection

Significance: N/A Jun 05, 2003

Identified By: NRC

Item Type: FIN Finding

Verification of Compliance With Interim Compensatory Measures Order

On February 25, 2002, the NRC imposed by Order, Interim Compensatory Measures to enhance physical security. The inspectors determined that, overall, the licensee appropriately incorporated the Interim Compensatory Measures into the site protective strategy and access authorization program; developed and implemented relevant procedures; ensured that the emergency plan could be implemented; and established and effectively coordinated interface agreements with offsite organizations.

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

Miscellaneous

Significance: N/A Jun 19, 2003

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The team identified that the licensee was effective at identifying problems and putting them into the corrective action program. The licensee's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. The licensee effectively used risk in prioritizing the extent that individual problems would be evaluated and in establishing schedules for implementing corrective actions. Corrective actions, when specified, were implemented in a timely manner, with few exceptions. Licensee audits and assessments were found to be effective. On the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the corrective action program.

Inspection Report# : [2003006\(pdf\)](#)

Last modified : May 05, 2004