

## Comanche Peak 2

### 1Q/2004 Plant Inspection Findings

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#### Initiating Events

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#### Mitigating Systems

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**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\(pdf\)](#)

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#### Barrier Integrity

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#### Emergency Preparedness

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#### Occupational Radiation Safety

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**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\(pdf\)](#)

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## Public Radiation Safety

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### 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\(pdf\)](#)

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### 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