

## South Texas 1

### 1Q/2004 Plant Inspection Findings

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## Initiating Events



**Significance:** Dec 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Inappropriate operator response to an event resulted in multiple pressurizer PORV lifts during operations in a water solid condition.**

The inspectors identified a noncited violation of Technical Specification 6.8.1.a regarding Regulatory Guide 1.33 required procedure. Licensee procedure "Conduct of Operations," Revision 21, requires, in part, that if the plant does not perform or respond as expected, operations personnel will take conservative action to return the plant to a known condition. On March 26, 2003, operators inappropriately responded to plant conditions making an event more significant because operators did not understand and control the impact of the restoration of power to an instrumentation panel. They also did not understand the interactions between the normal pressurizer controller and the cold overpressure mitigation system. This issue was greater than minor because it affected the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations, in that operators contributed to initiating this event and making it more significant. The performance deficiency was determined to represent a finding of very low safety significance. This was based on a Phase 1 screening in accordance with Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process." The major factors in this determination were the continued availability of methods to control reactor coolant system pressure and the short period of time that the cold overpressure mitigation system was nonfunctional.

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



**Significance:** Apr 01, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to follow procedure results in failure to manage the assessed risk consequences of a heavy load lift over operating residual heat removal trains as prescribed in 10 CFR 50.65(a)(4), maintenance**

A noncited violation was identified for the failure to manage the assessed risk consequences of a heavy load lift over operating residual heat removal trains as prescribed in 10 CFR 50.65(a)(4), maintenance rule. During the recent Unit 1 outage at Mode 5, the licensee removed the reactor coolant Pump 1B motor from containment without following the requirements of station procedures developed to mitigate the risk associated with heavy load lifts. The licensee lost focus of this risk mitigating procedure and lifted the motor over residual heat removal Trains A and B without isolating them from the reactor coolant system as required by the procedure. This finding is in the licensee's corrective action program as Condition Report 03-5296. This finding is greater than minor because it affects the initiating events cornerstone by increasing the likelihood of an initiating event. If a load drop would have occurred, it could have caused a shutdown loss of coolant accident. The finding is of very low safety significance because the licensee maintained mitigating equipment available.

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

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## Mitigating Systems



**Significance:** Sep 20, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Ineffective maintenance practices for motor operated valve actuators resulted in failure of a residual heat removal valve actuator.**

A non-cited violation of 10 CFR 50, Appendix B, Criterion V, was identified related to ineffective maintenance practices for motor operated valve actuators. Ineffective maintenance practices resulted in the failure of a residual heat removal valve actuator and for numerous similar problems in other valve actuators. Specifically, the licensee failed to implement procedural requirements to develop, perform, track, and close out corrective actions for vendor technical bulletins and advisories. Guidance from a 1989 vendor advisory alerting the licensee to failures of motor operated valve actuators and recommending corrective measures was incorporated into station maintenance procedures without taking action to assure that actuators in the plant were actually corrected.

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

## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

G**Significance:** Apr 04, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**Failure to follow radiation work permit requirements.**

A self-revealing noncited violation was identified because the licensee failed to follow the requirements of a Technical Specification 6.8.1a required procedure. Specifically, on March 31, 2003, two workers failed to have health physics personnel coverage prior to breaching a contaminated system associated with Reactor Coolant Pump 1B, as required by their Radiation Work Permit 2003-1-0098. The failure to follow the requirements of a Technical Specification required procedure is a performance deficiency. The issue was more than minor because it is associated with a cornerstone attribute (program and process) and affected the Occupational Radiation Safety cornerstone objective (to ensure the adequate protection of the worker's health and safety from exposure to radiation from radioactive material). The finding involved the failure to control radiological work that was contrary to Technical Specification requirements. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was found to have very low safety significance because it was not an ALARA issue, there was no overexposure or substantial potential for an overexposure, and the ability to assess dose was not compromised. Inspection Report# : [2003002\(pdf\)](#)

G**Significance:** Apr 04, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to perform an adequate airborne survey.**

An NRC identified noncited violation of 10 CFR 20.1501a was identified because the licensee failed to perform an adequate airborne survey during decontamination activities. Specifically, during a review of surveys, the inspectors identified two examples in which air samplers were not properly positioned to ensure work area airborne radiological conditions were monitored. The failure to appropriately position air samplers to perform a representative airborne survey of a work area is a performance deficiency. The issue was more than minor because it was associated with a cornerstone attribute (program and process) and affected the occupational radiation safety cornerstone objective (to ensure the adequate protection of the worker's health and safety from radiation and radioactive material). The finding involved the failure to control radiological work that was contrary to regulatory requirements. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was found to have very low safety significance because it was not an ALARA issue, there was no overexposure or substantial potential for an overexposure, and the ability to assess dose was not compromised. Inspection Report# : [2003002\(pdf\)](#)

G**Significance:** Apr 04, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**Failure to inform a worker of the radiological conditions in the work area.**

A self-revealing noncited violation of 10 CFR 19.12 was identified because the licensee failed to inform a radiation worker of the radiological conditions in the work area. Specifically, a worker failed to get briefed on the work area radiological conditions at the Unit 1 health physics access point. Additionally, a health physics technician providing job coverage did not inform the worker of the conditions. The failure to inform a worker of the radiological conditions in a work area is a performance deficiency. The issue was more than minor because it was associated with a cornerstone attribute (program and process) and affected the occupational radiation safety cornerstone objective (to ensure the adequate protection of the worker's health and safety from radiation and radioactive material). The finding involved the failure to control radiological work that was contrary to regulatory requirements. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was found to have very low safety significance because it was not an ALARA issue, there was no overexposure or substantial potential for an overexposure, and the ability to assess dose was not compromised. Inspection Report# : [2003002\(pdf\)](#)

## Public Radiation Safety

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### Physical Protection

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### Miscellaneous

**Significance:** N/A Jun 12, 2003

Identified By: NRC

Item Type: FIN Finding

#### Identification and Resolution of Problems

The licensee's actions to enhance employee protection and reporting of safety concerns were determined to be in compliance with the terms and conditions of the Order. Licensee audits, surveys, and assessments were found to be adequate. A safety conscious work environment at STP was found to be in place, maintained, and accepted by licensee personnel. The inspectors found workers at the site felt free to identify concerns to their supervision and to input safety findings into their corrective action program or Employee Concerns Program without fear of retaliation. The licensee's compliance with the terms and conditions of the Order were verified through direct inspection and documentation reviews.

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

Last modified : May 05, 2004