

## Millstone 3

### 2Q/2004 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Mar 31, 2004  
Identified By: NRC

Item Type: FIN Finding  
**FAILURE TO IMPLEMENT POST MAINTENANCE TESTING TO IDENTIFY IMPROPERLY PERFORMED VALVE REPAIRS ON INSTRUMENT AIR DRYER SYSTEM**

The inspectors identified a finding for the failure to implement adequate post-maintenance testing following valve repairs on the instrument air system. The post-maintenance test (PMT), as performed by Operations, did not adequately cycle a 4-way valve to ensure maintenance had been performed correctly. As a result of the improper PMT performance, Dominion did not identify the maintenance errors following reinstallation of the 4-way valves prior to declaring the system operable. Subsequently, the instrument air system lost air pressure 4 hours after restoring the system to service. However, the transient was limited because a service air system cross-tie valve opened to restore instrument air pressure. Following the air transient, Dominion performed corrective maintenance, and then implemented a procedure to fully retest the instrument air dryer prior to declaring it operable.

The finding is more than minor because it affected the equipment performance attribute of the Initiating Events cornerstone objective of limiting the likelihood of events that upset plant stability at power. The failure to specify adequate PMT led directly to a degraded instrument air system and increased the likelihood of a Loss of Instrument Air event. The risk of this finding was determined to be of very low safety significance (Green) because, although the instrument air system vented to atmosphere, the service air system cross-tie valve to the instrument air system opened and air pressure was restored. The instrument air pressure stabilized and recovered such that there was no actual loss of equipment due to the temporary drop in pressure and an actual loss of instrument air did not occur. This finding is related to the cross-cutting issue of Human Performance.

Inspection Report# : [2004005\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Sep 27, 2003  
Identified By: NRC

Item Type: NCV NonCited Violation  
**FAILURE TO ADEQUATELY EVALUATE AND CORRECT AN IDENTIFIED DEGRADATION OF THE SERVICE WATER (SW) PUMP/MOTOR COUPLING**

The inspectors identified a non-cited violation of 10 CFR 50 Appendix B, Criterion XVI, for the failure to evaluate and correct an identified condition adverse to quality (physical degradation) associated with the "B" service water (SW) pump/motor coupling. The inspectors found that the licensee had not properly evaluated a degraded condition of the "B" SW pump/motor coupling and associated fasteners after a condition report documented the "B" SW pump packing and coupling degradation. Subsequently, the licensee declared the pump inoperable and replaced the coupling.

This finding is more than minor because the failure to evaluate the identified degradation of a mitigating system, and to take corrective actions, would have allowed further degradation and affected operability of the system. The finding is associated with the equipment performance attribute of the mitigating systems cornerstone and the objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. However, the finding was determined to be of very low safety significance based on the as-found condition and an analysis of the existing degradation that concluded the SW pump was capable of meeting its safety function.

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

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#### Barrier Integrity

**Significance:**  Jun 30, 2004  
Identified By: NRC

Item Type: NCV NonCited Violation  
**INADEQUATE CORRECTIVE ACTIONS TO PREVENT REPETITIVE FAILURES OF THE QSS AND RSS CONTAINMENT ISOLATION CHECK VALVES**

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, which requires, in part, that conditions adverse to quality, such as failures, are promptly identified and corrected. Contrary to this requirement, Dominion did not take effective corrective actions to address repetitive failures of local leak rate tests (LLRT) for the quench spray system and recirculation spray system containment isolation check valves. The

inspectors determined that over the span of 8 years, the same known failure mechanism resulted in an approximate 50% LLRT surveillance test failure rate for these check valves. This finding is more than minor because it is associated with the Barrier Integrity cornerstone attribute of structures, systems, and components (SSC)/Barrier Performance - containment isolation SSC reliability. Unacceptable leakage past these check valves resulted in a decrease in operational capability of the containment isolation system and a decrease in reliability of containment isolation SSCs. This violation has been determined to have a very low safety significance since there was not an actual open pathway in the physical integrity of reactor containment. This finding is related to the cross-cutting issue of Problem Identification and Resolution.

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

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

[Physical Protection](#) information not publicly available.

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## Miscellaneous

**Significance:** N/A Feb 27, 2004

Identified By: NRC

Item Type: FIN Finding

### **PROBLEM IDENTIFICATION AND RESOLUTION TEAM INSPECTION RESULTS**

The team determined that the licensee was generally effective at identifying discrepant conditions at an appropriate threshold and entering them into the corrective action program. Once entered into the system, issues were usually prioritized appropriately and in a timely fashion; and were properly evaluated commensurate with the safety significance. Overall, the evaluations reasonably identified the causes of the problem, the extent of the condition, and provided for corrective actions to address the causes. However, in some cases, the corrective action program was not effectively used to resolve and prevent problems. There were some instances where issue evaluations, as well as the associated corrective actions, were not effective in resolving problems. There were also some examples in which condition reports were characterized at a lower category than prescribed by the corrective action program.

Inspection Report# : [2004002\(pdf\)](#)

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