

Columbia Generating Station 3Q/2004 Plant Inspection Findings

Initiating Events

Significance:  Aug 17, 2004

Identified By: Self Disclosing

Item Type: FIN Finding

Inadequate Monitoring of Hotwell Level Contributes to Loss of Reactor Feedwater

A self-revealing finding associated with control room operators failure to adequately monitor condenser hotwell level occurred when hotwell level was established high in the indicating range and above the hotwell level high level alarm. This condition resulted in the associated hotwell level high level annunciator being locked in and was effectively out of service. A manual reactor trip was initiated when the hotwell level excursion resulted in the loss of the only operating reactor feedwater pump.

This finding is greater than minor because it was a human performance issue which impacted the initiating events cornerstone objective. Specifically, adequate compensatory actions were not put in place to address the hotwell level high level annunciator. This finding had crosscutting aspects in the area of human performance in that adequate monitoring of hotwell level was not implemented which contributed to the reactor scram.

Inspection Report# : [2004004\(pdf\)](#)

Significance:  Jul 30, 2004

Identified By: Self Disclosing

Item Type: FIN Finding

Failure to Follow Clearance Order Instruction Results in Loss of Reactor Feedwater

A self-revealing finding occurred when an equipment operator failed to follow a clearance order instruction when filling and venting a condensate heat exchanger. This action resulted in a low suction trip of a reactor feedwater pump, the loss of reactor feedwater and a subsequent manual reactor scram.

This finding is greater than minor because it was a human performance issue which impacted the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions. This finding had crosscutting aspects in the area of human performance in that adequate pretask briefings were not performed for the the operator placing the feedheater back into service. A Phase 2 evaluation was performed in briefings were not performed for the the operator placing the feedheater back into service. A Phase 2 evaluation was performed in accordance with Manual Chapter 0609, "Significance Determination Process," based on the finding contributing to both the likelihood of a reactor trip and that mitigation functions would not be available. The Phase 2 review was performed using the Columbia Generating Station site specific worksheets. A senior reactor analyst reviewed the Phase 2 results and performed a limited Phase 3 review. The senior reactor analyst considered the limited time the plant was at a low power level and adjusted the time in power operations to 3 hours. The finding was determined to be of low safety significance. Corrective actions included temporary senior reactor operator oversight of all pretask briefings and remedial training for the individuals involved.

Inspection Report# : [2004004\(pdf\)](#)

Significance:  Jun 10, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Follow Clearance Order Results in Mispositioned Control Rod

A self revealing noncited violation of Technical Specification 5.4.1.a (failure to follow procedure) was identified when the licensee failed to hang a clearance tag in accordance with the prescribed clearance order. This resulted in an inadvertent rod misposition event and subsequent action by control room operators to lower reactor core flow and power. Energy Northwest appropriately recovered the mispositioned control rod and hung the clearance tag in accordance with the prescribed clearance order. The primary cause of this finding was related to the crosscutting area of Human Performance.

This finding was greater than minor because the failure to hang clearance tags in accordance with the Plant Clearance Order procedure was determined to be a performance deficiency which could be reasonable viewed as a precursor to a significant event. The issue was of very low risk significance because although the finding was associated with an increase in the likelihood of an initiating event (i.e. the inadvertent rod insertion resulted in the licensee reducing core flow and reactor power) the finding; 1) did not contribute to the likelihood of primary loss of coolant accident initiator; 2) did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available; and 3) did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2004003\(pdf\)](#)

Mitigating Systems

Significance:  Aug 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Return to Service APRM B in a Timely Manner

A self-revealing noncited violation of Technical Specification 5.4.1.a occurred when operators failed to return a nuclear power range instrument to service after bypassing the instrument for a gain adjustment in accordance with a surveillance procedure. This resulted in the instrument being left out of service for an additional seven hours after it was available for use. There were indications readily available to the control room staff to identify the out of service component earlier than when it was finally identified. This finding had cross cutting aspects in the area of human performance in that the nuclear power range instrument was not appropriately returned to service and several opportunities were available, including a shift turnover to identify the condition. Corrective actions included returning the instrument to service and revising the frequency of panel walkdowns in the control room to ensure a more thorough examination of plant indications.

This finding is greater than minor because it involved a configuration control issue which impacted the mitigating systems cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. The issue was of very low safety significance (Green) because the finding did not result in the loss of function of a safety system or represent an actual loss of a safety function of a single train for greater than its Technical Specification allowed outage time.

Inspection Report# : [2004004\(pdf\)](#)

Significance:  Jun 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Address Extent of Condition and Seismic Qualification of Safety Related Disconnects

An NRC identified noncited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," was identified for the licensee's failure to promptly address the extent of condition of numerous electrical disconnects which the licensee had noted to not fully latch closed due to overdue preventative maintenance. The licensee also failed to address the impact of overdue preventative maintenance on seismic qualification of safety related electrical disconnects. Immediate corrective actions included reviewing the maintenance history of all safety-related electrical disconnects to determine if any disconnects had not received the required preventive maintenance within the specified periodicity. Energy Northwest conducted inspections and utilized engineering judgement to verify that the affected disconnects were fully latched closed.

The failures to address extent of condition in a prompt manner and to address seismic qualification was considered a performance deficiency. This finding was determined to affect the reliability and capability of mitigating systems that respond to initiating events and therefore was of greater than minor risk significance. However, the finding was of very low safety significance because the issue was determined to be a qualification deficiency confirmed not to result in a loss of function per GL 91-18.

Inspection Report# : [2004003\(pdf\)](#)

Significance:  Apr 28, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate Work Order Results in Premature Overcurrent Trip of Breaker

A self revealing noncited violation of TS 5.4.1.a was identified for an inadequate work order which resulted in a safety related breaker prematurely tripping on overcurrent. Energy Northwest appropriately adjusted the overcurrent relay and verified that the similar safety-related breaker overcurrent setpoints were appropriately set.

The licensee's failure to correctly translate design information into a work order to correctly adjust and test the overcurrent trip setpoint for a safety related breaker was determined to be a performance deficiency. This finding was determined to affect the mitigating systems cornerstone objective to ensure the reliability and capability of systems that respond to an initiating event and therefore was of greater than minor risk significance. The finding was of very low safety significance because the finding: (1) was not a design or qualification deficiency; (2) did not result in the loss of function of a safety system; (3) did not represent an actual loss of a safety function of a single train for greater than its technical specification allowed outage time; (4) did not represent an actual loss of safety function of one or more non-technical specification trains of equipment designated as risk significant per 10 CFR 50.65 for greater than 24 hours; and (5) was not potentially risk significant due to a seismic, fire, flooding, or severe weather initiating event.

Inspection Report# : [2004003\(pdf\)](#)

Significance:  Apr 06, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to have adequate procedures in effect for alternative shutdown

The inspectors identified a noncited violation of Technical Specification 5.4.1.d (inadequate procedure) because Procedure ABN-CR-EVAC, "Control Room Evacuation and Remote Cooldown," failed to provide adequate post-fire direction to: (1) assure suppression pool temperatures did not increase above residual heat removal pump temperature limits following depressurization; and (2) assure adequate core cooling with one safety relief valve stuck open.

This finding is greater than minor because it impacted the mitigating systems cornerstone and affected the ability of the low pressure coolant injection system to provide adequate core cooling to prevent core damage. This finding is of very low safety significance due to: (1) general operator knowledge that suppression pool temperatures must be monitored and shutdown cooling must be used as a means to ensure the pool retains the ability to feed the low pressure injection system; and (2) the need to initiate shutdown cooling after depressurization is probably not an immediate pressing issue. This finding was documented in the licensee's corrective action program as Problem Evaluation Request 203-0956.

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

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Significance: Apr 06, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action for a condition affecting safe shutdown

The inspectors identified a violation of License Condition 2.C(14) for the failure to take appropriate corrective measures to address a condition adverse to quality affecting the low pressure coolant injection system. During a control room fire, the system has been vulnerable to a water hammer since at least 1997 due to a leaking check valve in Train B of the residual heat removal system. The licensee took more than five years to identify the condition and failed to specify appropriate corrective measures to promptly fix the condition.

This finding is greater than minor because it impacted the mitigating systems and barrier integrity cornerstones, and affected the ability of the low pressure coolant injection system to provide adequate core cooling to prevent core damage. This finding is of very low safety significance due to the low probability that a water hammer event results in a pipe failure or loss of system function. This finding was documented in the licensee's corrective action program as Problem Evaluation Request 203-0997.

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

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Significance: Apr 06, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Preconditioning of Standby Liquid Control Valve SLC-V-1B Prior to Inservice Testing

The inspectors identified a noncited violation of Technical Specification 5.4.1.a (inadequate procedure) for inappropriate preconditioning of a standby liquid control system valve. Procedure OSP-SLC/IST-Q701, "Standby Liquid Control Pumps Operability Test," failed to prescribe testing Valve SLC-V-1B in the as-found condition.

This issue affects the mitigating systems cornerstone objective to ensure the reliability of the standby liquid control system to mitigate an initiating event to prevent undesirable consequences. This issue is more than minor because it could have an actual impact on identifying degraded valve performance and therefore impact the ability of the standby liquid control system to mitigate an anticipated transient without scram. Using the Phase 1 significance determination process the inspectors determined that the issue was of very low safety-significance because the issue: (1) was not a design or qualification deficiency; (2) did not result in the loss of a safety system; (3) did not represent an actual loss of a safety function of a single train for greater than its technical specification allowed outage time; (4) did not represent an actual loss of safety function of one or more non-technical specification trains of equipment designated as risk significant per 10 CFR 50.65 for greater than 24 hours; and (5) was not potentially risk significant due to a seismic, fire, flooding, or severe weather initiating event .

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

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Significance: Mar 10, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate maintenance procedure renders safety-related 125 VDC battery inoperable

The inspectors identified a noncited violation of Technical Specification 5.4.1.a (inadequate procedure) for testing of the safety-related inverters. Specifically, Procedure 10.25.1, "Inspection and Cleaning Division 1, E-IN-3A and E-IN-3B, and Division 2, E-IN-2A and E-IN-2B, Inverters," prescribed placing a spare inverter in-service for load tested with a second inverter that was already in-service. This condition was not analyzed and was found to render the associated 125 VDC safety related battery inoperable. The inspectors also identified a problem identification issue related to this finding.

This issue affects the mitigating systems cornerstone objective to ensure the availability of onsite emergency DC power. This issue is more than minor because it could have an actual impact on the ability of one train of emergency batteries to mitigate a loss of AC power to the safety-related inverters. Using the Phase 1 significance determination process the inspectors determined that the issue was of very low safety-significance because the issue: (1) was not a design or qualification deficiency; (2) did not result in the loss of a safety system; (3) did not represent an actual loss of a safety function of a single train for greater than its technical specification allowed outage time; (4) did not

represent an actual loss of safety function of one or more non-technical specification trains of equipment designated as risk significant per 10 CFR 50.65 for greater than 24 hours; and (5) was not potentially risk significant due to a seismic, fire, flooding, or severe weather initiating event .

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

Significance:  Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to verify the adequacy of the safety/relief valve design

A noncited violation of Criterion III of Appendix B to 10 CFR Part 50 was identified for the failure to verify the adequacy of the design of the steam safety/relief lines by performing visual inspections to verify adequate clearances and documenting the results. Calculation ME-02-92-33 required these clearances for main steam safety/relief valve piping so it could sustain the additional loading caused by a main steam line flooding event.

Inspection Report# : [2003010\(pdf\)](#)

Significance:  Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to promptly correct a condition adverse to quality associated with the 4160 VAC breaker truck-operated cell position switches

The team identified a violation of 10 CFR Part 50 Appendix B, Criterion XVI, for the failure to promptly correct a condition adverse to quality associated with all safety-related 4160 VAC breakers. The team noted eight instances where truck-operated cell position switches had displayed indication problems, and the licensee had failed to promptly identify and correct a problem associated with seismic qualification.

The associated 4160 VAC breakers were used in power circuits for emergency diesel generators, standby service water pumps, and all emergency core cooling system pumps.

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

Barrier Integrity

Significance:  Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate MSIV leak rate testing

The inspectors identified a violation of Technical Specifications Surveillance Requirement 3.6.1.3.11, in that the licensee had performed inadequate main steam isolation valve local leak rate testing since initial plant startup. The testing was inadequate because the licensee utilized non-safety related instrument air to help close and seat the valves during testing. The instrument air system provided substantially more seating pressure than the safety-related air accumulators. While the licensee had originally questioned the practice, they had inappropriately concluded that it was acceptable. Failure to properly evaluate a condition adverse to quality is a performance deficiency.

The issue had more than minor safety significance because it impacted the barriers cornerstone and the inadequate testing potentially masked problems that affected the ability of the main steam isolation valves to perform their accident mitigating function. The issue was of very low safety significance because the finding did not represent an actual open pathway in the physical integrity of the reactor containment

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

Significance:  Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate procedure

A noncited violation of Technical Specification 5.4.1a. and Criterion V of Appendix B to 10 CFR Part 50 was identified for failure to translate design basis into a procedure. Specifically, there was no procedural direction to place a second train of standby gas treatment into service if the charcoal filters of the first train were to become depleted.

Inspection Report# : [2003010\(pdf\)](#)

Significance:  Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to implement adequate corrective actions to address increased Control Room In-Leakage

The team identified a violation for an inadequate corrective action in accordance 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action" for the licensee's failure to adequately implement a procedure revision intended to ensure that control room dose limitation requirements in accordance with 10 CFR Part 50, Appendix A, General Design Criterion 19, "Control Room," were met.

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

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Significance: Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to use appropriate stroke times into the inservice testing program

A noncited violation of Criterion III of Appendix B to 10 CFR Part 50 was identified for failure to establish correct acceptance limits for the inservice testing of standby gas treatment isolation valves. Specifically, the limits established would allow the valves to operate outside of the design requirements for stroke time.

Inspection Report# : [2003010\(pdf\)](#)

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Significance: Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate emergency operating procedures

A noncited violation of Technical Specification 5.4.1b., and Criterion III of Appendix B to 10 CFR Part 50 was identified for failure to develop emergency operating procedures that would accomplish their intended functions. Specifically, the procedures for venting the drywell and wetwell to atmosphere would not vent the gasses through a de-energized standby gas treatment train as required.

Inspection Report# : [2003010\(pdf\)](#)

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Significance: Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to correctly translate design requirements into calculations

A noncited violation of Criterion III of Appendix B to 10 CFR Part 50 was identified for failure to accurately translate design requirements, along with supported assumptions into the determination of the minimum flow for the hydrogen recombiners under all accident conditions.

Inspection Report# : [2003010\(pdf\)](#)

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Significance: Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to establish acceptance criteria for surveillance test

A noncited violation of Technical Specification 5.4.1a., and Criterion XI of Appendix B to 10 CFR Part 50, was identified for failure to establish acceptance criteria for satisfying Surveillance Requirement 3.6.3.1.1. Specifically, Procedure OSP-CAC-B701, "CAC-HR-1A Preheater Operability Test," Revision 6, did not identify an acceptance criterion for the minimum air flow through the hydrogen recombiner, as required.

Inspection Report# : [2003010\(pdf\)](#)

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Significance: Oct 10, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate calculation

A noncited violation of Criterion III of Appendix B to 10 CFR Part 50 was identified for failure to prevent Calculation NE-02-85-12, "Secondary Containment Bypass Leakage Limit," Revision 1, from becoming effective prior to receiving license amendment approval. This could have permitted the operation of the plant outside of its license basis.

Inspection Report# : [2003010\(pdf\)](#)

Emergency Preparedness

Significance:  Jul 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Activate the Emergency Response Data System Within One Hour

The inspectors identified a noncited violation for Energy Northwest's failure to activate the Emergency Response Data System within 60 minutes in accordance with 10 CFR 50.72(a)(4) after declaring an Alert on July 30, 2004. This finding had cross cutting aspects in the area of human performance in that Emergency Response Data System was not initiated as required within 1 hour.

The finding is greater than minor because it was associated with an actual event response performance deficiency that affected the emergency preparedness cornerstone objective to ensure that Energy Northwest is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. By not activating Emergency Response Data System within the required time, Energy Northwest hindered the NRC's ability to verify plant conditions to ensure the appropriateness of any licensee recommended emergency response actions. The finding was of very low safety significance because although the finding was associated with an implementation problem during an actual Alert declaration, the failure to comply with the requirements of 10 CFR 50.72(a)(4) did not constitute a failure to implement a risk significant planning standard. Corrective actions included assigning additional on-shift personnel the responsibility of activating Emergency Response Data System to ensure that time requirements are met.

Inspection Report# : [2004004\(pdf\)](#)

Occupational Radiation Safety

Significance:  Apr 26, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to control a high radiation area with dose rates greater than 1.0 rem per hour

A self-revealing noncited violation of Technical Specification 5.7.2 was reviewed because the licensee failed to control a high radiation area with dose rates greater than 1.0 rem per hour. Specifically, the radiation work permit associated with waste resin processing did not specify that the dose rates in the immediate work area were as high as 8.0 rem per hour, which resulted in the loss of radiological control over work activities within the area.

The failure to control activities in a high radiation area with dose rates greater than 1.0 rem per hour is a performance deficiency. The finding was greater than minor because it was associated with the Occupational Radiation Safety Cornerstone attribute of program and process and affected the cornerstone objective to ensure the adequate protection of a worker's health and safety from exposure to radiation. The finding involved the potential for a worker's unplanned or unintended dose resulting from actions contrary to Technical Specifications. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was determined to be of very low safety significance because the finding did not involve as low as is reasonably achievable issues, no individual received an overexposure or a substantial potential for overexposure, and the ability to assess dose was not compromised. The finding was entered into the licensee's corrective action program as Problem Evaluation Request 203-2767.

Inspection Report# : [2004003\(pdf\)](#)

Significance:  Dec 19, 2003

Identified By: NRC

Item Type: FIN Finding

Failure to maintain collective doses associated with RWP 3001080 ALARA

The inspectors identified an as-low-as-reasonably-achievable finding because a performance deficiency resulted in the collective dose of a work activity that exceeded 5 person-rem and also exceeded the original dose estimation by more than 50 percent. Specifically, the licensee had to re-work the original repairs on reactor water cleanup (RWCU) Valve RWCU-MO-4. This resulted in Radiation Work Permit 30001080, "R16 RX 522' RWCU Pump Room and Mezzanine Work, High-High Rad," accruing 5.2 rem and exceeding the original dose estimate by 52 percent.

The failure to repair the reactor water cleanup Valve RWCU-MO-4 so it would pass testing requirements the first time is a performance deficiency. This finding was more than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute (as-low-as-reasonably-achievable planning/projected dose) and affected the associated cornerstone objective (to ensure adequate protection of worker health and safety from exposure to radiation). This finding involved performance deficiencies which caused the re-work of the original repair on Valve RWCU-MO-4 and resulted in unnecessary occupational collective dose for the work activity. When processed through the Occupational Radiation Safety Significance Determination Process, this finding was found to have no more than very low safety significance because the finding was an as-low-as-reasonably-achievable planning issue, but the licensee's three-year rolling average collective dose was less than 240 person-rem.

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

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Significance: Oct 04, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to use proper radiation work permit

The inspectors identified additional issues associated with a licensee identified violation of Technical Specification 5.4.1.a for workers failing to read, understand, and follow special instructions on the appropriate radiation work permit when installing insulation on the reactor core isolation cooling system. The workers received additional dose as a result of temporary shielding being prematurely removed in the work area prior to performing the work activity. Problem Evaluation Request 203-2346 documented these issues and was closed prior to the inspection. Although the violation was identified by the licensee, the inspectors identified that the licensee had not developed a corrective action plan to address recurrence of two issues: (1) use of the wrong radiation work permit to perform work on the reactor core isolation cooling system and (2) performance of a work task in an area where radiological conditions resulted in additional dose due to removal of installed temporary shielding prior to work completion on the reactor core isolation cooling system.

Energy Northwest performed work without using the appropriate radiation work permit, which would have required shielding in the work area. The workers receipt of additional dose is a performance deficiency. This finding was greater than minor because it is associated with one of the Occupational Radiation Safety Cornerstone attributes (exposure control and monitoring) and affected the associated radiation safety cornerstone objective (to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material). The finding involved workers failure to adhere to appropriate radiation work permit requirements resulting in additional dose that was contrary to Technical Specification 5.4.1.a. When processed through the Occupational Radiation Safety Significance Determination Process, this finding was found to have no more than very low safety significance because it was not an as-low-as-reasonably-achievable finding, there was no overexposure or substantial potential for anoverexposure, and the ability to assess dose was not compromised.

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

Public Radiation Safety

Physical Protection

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

Miscellaneous

Significance: N/A Oct 10, 2003

Identified By: NRC

Item Type: FIN Finding

Crosscutting Issues

The team found that the licensee, in general, identified problems, entered and prioritized problems into their corrective action program. Nevertheless, weaknesses were identified in extent of condition reviews and in the development of corrective actions. The team found the corrective actions to address the substantive finding in the crosscutting area of human performance had resulted in overall improved performance during the 2003 refueling outage.

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

Last modified : December 29, 2004