Summer
4Q/2004 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Procedure for Resetting ESF Load Sequencer Results in Inadvertent Safety-Related Bus Deenergization
A self-revealing non-cited violation of Technical Specification (TS) 6.8.1.a was identified for an operator's failure to follow procedures while resetting the "A" train engineered safety features (ESF) loading sequencer self-test circuitry. This resulted in a loss of power to a safety-related emergency bus and the automatic starting of ESF equipment, including an emergency diesel generator to repower the bus.

This finding is more than minor because it affected the initiating events cornerstone attribute of configuration control and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions by deenergizing a safety-related electrical switchgear bus. The finding is of very low safety significance because the affected mitigating systems were able to perform their safety functions since the redundant train of ESF components was available and the affected ESF equipment responded by aligning to their accident state as expected for the initiating condition. The direct cause of this finding involved the cross-cutting area of Human Performance.
Inspection Report# : 2004005*(pdf)*

Significance: G Jun 26, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadequate Corrective Action Associated with Weld Repairs on C RCP Seal Injection Line
A self-revealing non-cited violation (NCV) regarding inadequate corrective action associated with weld repairs on the C reactor coolant pump seal injection line was identified.

This finding was a violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action. This finding is more than minor because it affected the initiating event cornerstone objective and the respective attribute of equipment performance. The finding is of very low safety significance because the axial orientation of the crack in the seal injection line did not contribute significantly to the likelihood of a primary loss of coolant accident and the likelihood of both a reactor trip and the loss of mitigating functions.
Inspection Report# : 2004003*(pdf)*

Significance: G May 14, 2004
Identified By: NRC
Item Type: FIN Finding
Ineffective Incorporation of Operating Experience into the Corrective Action Program
A self-revealing finding was identified for ineffective incorporation of operating experience (OE) into the corrective action program. A November 2003 operating experience report had identified an issue regarding the feedwater regulating valve positioners. However, because the licensee reviewer inappropriately assumed that the positioners were being replaced every outage and that this action was sufficient, no additional actions were taken or planned. As a result of a reactor trip on March 30, 2004, the licensee performed a root cause evaluation. The licensee identified that the positioners were the root cause and that the OE information, if incorporated properly into the corrective action program, could have precluded this reactor trip.

The team determined this finding was more than minor because failing to properly screen this OE and implement corrective actions would eventually have resulted in a feedwater transient and a potential for causing a reactor trip. The finding was of very low safety significance because, although it would cause a feedwater transient/reactor trip, it did not increase the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to a combination of a reactor trip and loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flood. The finding was not a violation of regulatory requirements because it involved non-safety related secondary plant equipment and procedures.
Inspection Report# : 2004006*(pdf)*

Mitigating Systems

Significance: G Nov 19, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedures to Test Non-Emergency Diesel Generator Trip Bypass Relays
The team identified a non-cited violation (NCV) of TS 6.8.1.c, Procedures and Programs, for failure to include the proper testing methodology in procedures to meet Technical Specification Surveillance Requirement 4.8.1.1.2.g.6.c. Technical Specification 4.8.1.1.2.g.6.c required testing to demonstrate that all emergency diesel generator trips other than overspeed, generator differential, and low lube oil pressure were automatically bypassed upon loss of voltage on the associated emergency bus concurrent with a safety injection signal. Procedures STP-0125-010 and STP-0125-011 did not provide for adequate testing of the bypass function as intended, and no other procedures were identified that satisfied the requirement. This resulted in the failure to test the bypass function since November 1996, when a similar test deficiency was discovered by the licensee and addressed by a temporary procedure change. The licensee performed testing, subsequent to the inspection, which demonstrated this feature operated properly and entered it into the corrective action program.

This finding is greater than minor because it is associated with the procedure quality attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring reliable, available, and capable systems that respond to initiating events. This finding is of very low safety significance because no loss of safety function occurred and it is not related to an event external to the plant. This finding has been entered into the licensee's corrective action program as CER 0-C-04-3626. This finding has cross-cutting aspects related to problem identification and resolution.
Inspection Report# : 2004009*(pdf)*

Significance: G Nov 19, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Take Timely Corrective Action to Address Operator Timeline Response Deficiencies
The team identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action. The licensee failed to take timely action to correct the inability of plant operators to terminate safety injection after an inadvertent emergency core cooling system (ECCS) actuation at power within the time assumed in the plant design and licensing basis. This issue was initially identified in 1993 and had not been corrected as of the date of this inspection.

This finding is greater than minor because the inability to meet the design basis timeline is associated with the procedure quality and design control attributes of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the capability that operators would be able to properly respond to an initiating event to prevent undesirable consequences. This finding was determined to be of very low safety significance because the design or qualification deficiency did not result in a loss of function per Generic Letter 91-18, Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions, Revision 1. This finding has been entered into the licensee's corrective action program as CER 0-C-04-3250. This finding has cross-cutting aspects related to problem identification and resolution.
Inspection Report# : 2004009*(pdf)*

Significance: G Jun 26, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadequate Control of Quality Related Drawings Results in Loss of RCS Pressurizer Heater Control
A self-revealing non-cited violation (NCV) regarding inadequate control of quality related drawings resulting in the loss of reactor coolant system pressurizer heater control was identified.

This finding was a violation 10 CFR Part 50, Appendix B, Criterion VI, Document Control. This finding is more than minor because if left uncorrected it would become a more significant safety concern due to the extensive use of quality related controlled drawings in the process of maintenance involving safety-related structures, systems and components. The finding is of very low safety significance due to the brief period pressurizer heater control was lost, the availability of an alternate pressurizer heater control circuit, and no actual loss of safety function occurred.
Inspection Report# : 2004003*(pdf)*

Significance: G Jun 25, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Portable Smoke Ejectors Capable of Operation During a Loss of Offsite Electrical Power
A non-cited violation of V.C. Summer Facility Operating License NFP-12, Condition 2.C.(18), was identified for failure to provide the fire brigade with portable smoke ejectors capable of operation during a loss of offsite electrical power. The licensee acquired portable, gasoline-powered electrical generators to resolve the problem.

The finding adversely affected the defense-in-depth element for fire brigade manual fire suppression capability. The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems

cornerstone objective. Because this finding only impacted the effectiveness of the fire brigade while other fire protection features, such as passive fire barriers, physical separation, and safe shutdown capability remained available to mitigate a fire, the finding was determined to have very low safety significance
Inspection Report# : 2004007*(pdf)*

Barrier Integrity

Significance: G Dec 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Procedure for Adjusting Close Latch Release Rod of "A" Train RHR Pump Motor Breaker Resulting in Breaker Failure to Close
A self-revealing non-cited violation of TS 6.8.1.a was identified for maintenance personnel's failure to properly adjust the close latch release rod associated with the "A" residual heat removal (RHR) pump motor breaker. As a consequence, the pump failed to start on October 13, 2004, during routine plant operations.

This finding is more than minor because it affected the mitigating systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences by rendering inoperable safety-related equipment for removing reactor core heat. A Significance Determination Process Phase 2 analysis determined that the finding is of very low significance because the "A" RHR pump could have been placed in service to perform its safety functions by operator actions. The pump breaker could be manually closed prior to exceeding the time of bulk boiling in the reactor vessel during accident conditions. The direct cause of this finding involved the cross-cutting area of Human Performance
Inspection Report# : 2004005*(pdf)*

Significance: G Dec 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Take Adequate Corrective Actions to Preclude Repetitive Inoperability of Containment Pressure Transmitter IPT00950
A self-revealing non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the failure to take timely and adequate corrective actions to preclude repetition of a significant condition adverse to quality concerning the inoperability of reactor containment pressure transmitter IPT00950.

This finding is more than minor because it affected the barrier integrity cornerstone attribute of containment pressure control equipment performance (i.e., reactor building spray system) and adversely affected the cornerstone objective to provide reasonable assurance that the containment barrier protect the public from radionuclide releases caused by accidents or events. The finding is of very low safety significance because the event did not involve an actual reduction in the defense-in-depth for atmospheric pressure control of the reactor containment since the three redundant containment pressure instruments remained available to initiate the reactor building spray safety functions. The direct cause of this finding involved the cross-cutting area of Problem Identification and Resolution.
Inspection Report# : 2004005*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: G Dec 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Perform Adequate Surveys and Properly Control Licensed Material

A self-revealing non-cited violation of 10 CFR 20.1501 and 20.1802 was identified concerning the licensee's failure to adequately survey the content of a metal box prior to its release from the restricted area and the resulting loss of control of licensed material. The box was sold to a licensee employee and was taken to the employee's residence. When the box was later opened, an assortment of tools and material were found to be contaminated with low-level byproduct material.

This finding was more than minor because it was associated with the cornerstone attribute of material release and it affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain. The finding involving radioactive material control was determined to be of very low safety significance because it did not result in a dose to the public greater than 0.005 rem.
Inspection Report# : 2004005*(pdf)*

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Nov 19, 2004
Identified By: NRC
Item Type: FIN Finding
Integrated Assessment for Temporary Instruction 2515/158, Functional Review of Low Margin/Risk/Significant Components and Operator Actions, Inspection
The components and systems reviewed were found to be capable of performing their intended safety functions. Generally, design controls were sufficient in areas examined by the team. The licensee's historical response to some conditions adverse to quality was not adequate. Specifically, the engineering solutions to potential emergency feedwater control valve plugging (Section 4OA5.2.1.1), inadequate emergency diesel generator testing (Section 4OA5.2.1.19), and potential inadequacies in the operator response timeline to an inadvertent ECCS actuation (Section 4OA5.3.1) were not comprehensive or timely.
Inspection Report# : 2004009*(pdf)*

Significance: N/A May 14, 2004
Identified By: NRC
Item Type: FIN Finding
Biennial Problem Identification and Resolution Inspection Results
Overall, the licensee maintained an effective program for the identification and correction of conditions adverse to quality. However, during the inspection, several minor problems were identified. The licensee was generally effective at identifying problems at a low threshold and entering them into the Corrective Action Program (CAP). However, a few instances of failing to enter or delaying entry of issues into the CAP were identified. The licensee consistently prioritized issues in accordance with their CAP and routinely performed adequate evaluations that were technically accurate and of sufficient depth. Improvements were noted in the corrective action process since the previous problem identification and resolution inspection including increased management involvement and improved management review through the use of Management Review Team meetings. Root cause analyses were performed when appropriate and problem evaluations considered extent of condition and generic implications appropriately. Corrective actions were effective in correcting problems. However, in a few cases the licensee continued to experience problems with corrective actions for issues such as ensuring closure of the steam propagation and fire doors. Management fostered a safety-conscious work environment by emphasizing safe operations and encouraging problem reporting. However, during the inspection, the NRC identified that the licensee had narrowly focused corrective actions associated with a safety-conscious work environment issue.
Inspection Report# : 2004006*(pdf)*

Last modified : March 09, 2005