

## Comanche Peak 2

### 2Q/2005 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Nov 03, 2004  
Identified By: Self Disclosing  
Item Type: FIN Finding

##### **Loss of Unit 2 Turbine Load Due to Missed Step in Transferring Control to Manual Hydraulic Control**

A self-revealing finding was identified for failing to follow the procedure to transfer turbine control from the electro hydraulic control to the manual hydraulic control which resulted in a Unit 2 turbine runback to 65 percent turbine load. No violation of NRC requirements occurred because the turbine control system is nonsafety-related.

The finding is more than minor because it resulted in a plant transient, similar to example 4. b. of Appendix E to Manual Chapter 0612. The finding is associated with the human performance attribute and affects the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as at power operations. The finding was processed through the significance determination process and determined to be of very low safety significance (Green) because it was a transient initiator but did not increase the likelihood that mitigation equipment would not be available.

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

**Significance:**  Oct 08, 2004  
Identified By: Self Disclosing  
Item Type: FIN Finding

##### **Unit 2 Downpower Due to Loss of Heater Drain Forward Flow During Calibration of 2-HV-2589B**


A self-revealing finding was identified for inadequate control of maintenance activities which resulted in the loss of heater drain forward flow to the Unit 2 main feedwater pumps and subsequent reactor downpower to approximately 60 percent power to avoid a plant trip on loss of feedwater flow. Troubleshooting a heater drain pump recirculation valve unexpectedly caused the opposite recirculation valve to open. No violation of NRC requirements occurred because the heater drain system is nonsafety related.

The finding is more than minor because it resulted in a plant transient, similar to example 4. b. of Appendix E to Manual Chapter 0612. The finding is associated with the human performance attribute and affects the Initiating Events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as at power operations. The finding was processed through the significance determination process and determined to be of very low safety significance (Green) because it was a transient initiator but did not increase the likelihood that mitigation equipment would not be available.

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

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#### Mitigating Systems

**Significance:**  Jun 23, 2005  
Identified By: Self Disclosing  
Item Type: NCV NonCited Violation

##### **Failure to protect the integrity of the annual reactor operator requalification examination as described in 10 CFR 55.49**

A self-revealing NCV was identified for the failure to protect the integrity of the annual reactor operator requalification examination as described in 10 CFR 55.49. The examination material was inadvertently left in the control room simulator facility following annual requalification examination administration. The material was subsequently discovered by the on-coming initial operator licensing instructors. The licensee has counseled individuals involved, reviewed and made changes to the controlling procedure, and reviewed the operator examination security processes and procedures to identify areas for improvement.

This finding was determined to be more than minor because, if left uncorrected, the finding could become a more significant safety concern. Based on the results of a Significance Determination Process using Manual Chapter 0609, Appendix I, this finding was determined to have very low safety significance, since compensatory actions were immediately taken upon discovery of the examination compromise. The cause of the finding is related to the cross cutting element of human performance (Section 1R11.3).

Inspection Report# : [2005003\(pdf\)](#)

**G****Significance:** Jun 23, 2005

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**Failure to follow procedure by de-energizing the wrong battery charger resulting in the loss of all Unit 2 control room annunciators**

A self-revealing NCV was identified for the failure of a plant operator to follow established procedures as required by Technical Specification 5.4.1 when the wrong Unit 2 battery charger was de-energized while the plant was shutdown in Mode 6. The battery charger that was inadvertently de-energized was the sole power source of the Unit 2 control room annunciators. All Unit 2 control room annunciators were lost for a period of approximately seven minutes. Refueling cavity level indication and the plant computer remained operational during the event.

This finding is greater than minor because it affected the configuration control, equipment performance, and human performance attributes of the Mitigating Systems Cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Using the Inspection Manual Chapter 0609 Appendix G shutdown operations significance determination process, the inspectors determined the finding was of very low safety significance because the finding did not (1) increase the likelihood of a loss of RCS inventory, (2) degrade the licensee's ability to terminate a leak path or add RCS inventory when needed, or (3) degrade the licensee's ability to recover decay heat removal once it is lost. The cause of the finding is related to the cross cutting element of human performance (Section 4OA3.1).

Inspection Report# : [2005003\(pdf\)](#)**G****Significance:** Dec 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to fully implement Commission granted relief and alternative requirements**

The team identified a non-cited violation of 10 CFR 50.55a(f)(6)(i), for failure to fully implement NRC granted relief and alternative inservice testing requirements. Specifically, the licensee failed to perform the alternative requirement for periodic assessments, which precluded the reassessment of components to reflect changes in plant configuration, component performance test results, industry experience, and other inputs to the risk-informed process. The finding has very low safety significance and has been entered into the corrective action program as Smart Form SMF-2004--003883-00.

The team characterized this finding as greater than minor because the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage) was affected. The finding is associated with the equipment performance attribute of the mitigating systems cornerstone. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process", this finding is determined to be of very low safety significance because there was no actual loss of a safety function.

Inspection Report# : [2004008\(pdf\)](#)**G****Significance:** Dec 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to maintain design control over a safety class boundary isolation**

A non-cited violation of 10CFR50 Appendix B Section III, Design Control, was identified for failure to maintain the design requirements for a safety class piping isolation boundary in the makeup line to the Condensate Storage Tank. The licensee performed plant modifications and operating procedure changes which involved a fundamental change in status of safety class piping boundary isolation valves from normally closed to normally open without determining that the new configuration did not meet the system design requirements. The issue was entered into the corrective action program as Smart Form SMF-2003-001773-00.

The licensee had performed an operability assessment of the Auxiliary Feedwater System and concluded that the system remains operable, even though it is degraded because of the lack of appropriate double valve isolation between the Class III and Class V piping in the Condensate Storage Tank makeup line. The licensee assessment showed operations personnel had over 30 minutes to manually isolate a leak from the non-safety class piping. The licensee is planning to modify the Condensate Storage Tank makeup lines to incorporate double check valve isolation meeting the appropriate design requirements for normally using the line for tank recirculation.

The team characterized this finding as greater than minor because the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage) was affected. The finding is associated with the design control attribute of the mitigating systems cornerstone. Using the Phase 1 worksheet in Manul Chapter 0609, "Significance Determination Process", this finding is determined to be of very low safety significance because there was no actual loss of a safety function.

Inspection Report# : [2004008\(pdf\)](#)

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

**Significance:**  Oct 22, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

### **Failure to maintain and analyze composite samples on two occasions**

The team reviewed a self-revealing non-cited violation of Technical Specification 5.5.1, which occurred when the licensee failed on two occasions to sample in accordance with Offsite Dose Calculation Manual requirements. Specifically, during the third quarter of 2002 and the fourth quarter of 2003, the licensee failed to maintain portions of composite samples from the plant effluent tanks. The samples are required to be collected monthly and analyzed quarterly. The finding was placed into the licensee's corrective action program.

The finding is greater than minor because it is associated with one of the cornerstone attributes (effluent measurement) and affects the cornerstone objective because the failure to implement offsite dose calculation requirements decreases the licensee's assurance that the public will not receive unnecessary dose. The team determined that the finding had very low safety significance because: (1) the finding was not a radioactive material control finding, (2) it was an effluent release program finding, (3) the finding impaired the licensee's ability to assess dose, (4) the licensee did not fail to assess dose because it was able to assess dose to the public using the remaining composite samples, and (5) it did not result in doses that exceeded 10 CFR Part 50, Appendix I or 10 CFR 20.1301(d). This finding had crosscutting aspects associated with human performance. When licensee personnel failed to store the samples properly, they directly contributed to the finding.

Inspection Report# : [2004009\(pdf\)](#)

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## Physical Protection

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

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## Miscellaneous

Last modified : August 24, 2005