

## Point Beach 1

### 2Q/2005 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Jan 08, 2005

Identified By: NRC

Item Type: FIN Finding

##### **Overload and Trip of Nonsafety-Related Bus**

The inspectors determined that a finding of very low significance (Green) was self-revealed when the feed breaker for nonsafety-related motor control center (MCC) 1B41 opened due to an overloaded bus during monthly turbine lube oil system checks. The licensee subsequently determined that the cause was a failure to appropriately control loads on MCC 1B41. No violation of NRC requirements occurred.

The issue is more than minor since the finding was associated with the configuration control and procedure quality attributes of the Initiating Events cornerstone and adversely impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was considered to be of very low significance because the finding did not affect the loss of coolant accident initiators; did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation functions would not be available; and the finding did not increase the likelihood of a fire or flood. The licensee took immediate corrective actions to ensure all loads were properly controlled and had several planned corrective actions which included developing additional load management actions and developing a new procedure regarding load management for this nonsafety-related bus.

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

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#### Mitigating Systems

**Significance:**  Jun 30, 2005

Identified By: NRC

Item Type: FIN Finding

##### **Adverse Trend of Failure to Ensure Causal Evaluations for Conditions Adverse to Quality for which Operability Recommendations were Performed**

The inspectors identified a finding of very low significance (Green) for an adverse trend of failures to perform causal evaluations for conditions adverse to quality which only received operability recommendations, to ensure the cause of the conditions were identified and corrected. The licensee further evaluated the issue and corroborated the adverse trend, and in addition identified the issue potentially extended to condition reports documenting conditions adverse to quality with only maintenance rule evaluations performed. No violation of NRC requirements occurred.

The inspectors also determined that the primary cause of this finding was related to the cross-cutting area of Problem Identification and Resolution, because the licensee failed to perform causal evaluations commensurate with the significance of the condition reports to ensure the conditions adverse to quality were identified and corrected.

The issue was more than minor because the underlying issues associated with the finding were associated with the equipment performance and design control attributes of the Mitigating Systems cornerstone and adversely impacted the cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using IMC 0609, Appendix A, Phase 1 screening for the Mitigating Systems cornerstone and determined the finding was of very low significance. The licensee took action to enter the item into the corrective action process and develop interim corrective actions. At the end of the inspection period, the licensee had not completed the evaluation of the finding.

Inspection Report# : [2005004\(pdf\)](#)

**Significance:**  Mar 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Emergency Diesel Generator Fuel Oil Filters in Duplex**

A Green finding associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the failure to take corrective actions for a condition adverse to quality. The inspectors noted that in March 2003, corrective action program document CAP031641 was written to assess the licensee's operational practice of having the two fuel oil duplex strainers on each of the four emergency diesel generators set to dual filter mode instead of single mode. The assessment concluded that the optimal position

was single mode because it allowed changing the filter elements with the emergency diesel generator running. The dual filter mode required the emergency diesel generator to be stopped to change the filters. In January 2004, CAP031641 was closed with no actions taken to address this condition adverse to quality.

The inspectors also determined that the primary cause of this finding was related to the cross-cutting area of problem identification and resolution, because the licensee failed to take any corrective actions to correct this condition adverse to quality.

This issue was more than minor because if left uncorrected the finding could become a more significant safety concern. In addition, the finding affected the Mitigating Systems cornerstone attributes of configuration control and equipment performance. The inspectors evaluated the finding using NRC Inspection Manual Chapter IMC 0609, Appendix A, Phase 1 screening for the Mitigating Systems cornerstone and determined that the finding was of very low safety significance because it was not a design or qualification deficiency that was confirmed to result in a loss of function per Generic Letter 91-18.

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

**G**

**Significance:** Feb 27, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Procedure Delays Return of Battery Charger**

A finding of very low safety significance was self-revealed for a violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for an Abnormal Operating Procedure (AOP) that was not adequate for returning safety-related battery chargers to an operable status. Specifically, on February 27, 2005, an offsite line experienced a fault and became disconnected, causing a momentary phase-to-phase short and then a continuous open circuit. The transient caused a loss of power to all in-service safety-related battery chargers. Three of the four chargers were restored using the AOP, but one battery charger could not be promptly restored to service because the AOP was inadequate. The licensee took prompt action to enter the item into the corrective action process and change the procedure.

The inspectors concluded that the finding was more than minor because if left uncorrected the item could become a more significant safety concern, and it was associated with the procedure quality attribute of the Mitigating Systems cornerstone. The finding was considered to be of very low safety significance since the finding did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event.

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

**G**

**Significance:** Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." Failure to Take Corrective Actions for a Condition Adverse to Quality**

A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to take actions for a condition adverse to quality. Specifically, in September 2003 a condition report was written to address the susceptibility of fouling of a small mesh strainer installed in a fire protection line which provided emergency cooling to the turbine driven auxiliary feedwater pumps and turbine bearing coolers. The condition report also identified that procedure guidance did not exist for operators to utilize an existing flush valve on the strainer if the strainer became clogged during use. The inspectors identified that in August 2004, the condition report was closed with no actions taken to address this condition adverse to quality. At the end of the inspection, the licensee took corrective actions to ensure that as a minimum, the appropriate procedural guidance existed if the strainer became clogged during use.

The inspectors also concluded the primary cause of this finding was related to the cross-cutting area of problem identification and resolution, because the licensee failed to take any corrective actions to correct this condition adverse to quality.

This finding was more than minor because if left uncorrected the finding could become a more significant safety concern. In addition, the finding affected the mitigating systems cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with the Significance Determination Process, this finding was determined to be a Non-Cited Violation of very low safety significance because it was not a design or qualification deficiency that was confirmed to result in a loss of function per Generic Letter 91-18.

Inspection Report# : [2004012\(pdf\)](#)

**Significance:** SL-IV Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Perform a Safety Evaluation as Required by 10 CFR 50.59, "Changes, Tests and Experiments"**

The inspectors identified a Severity Level IV Non-Cited Violation of 10 CFR 50.59(d)(1) for the licensee's failure to perform a safety evaluation for changes made to the Final Safety Analysis Report. Specifically, the licensee 'screened out' a change to the Final Safety Analysis Report which modified operator response times for the Steam Generator Tube Rupture Chapter 14 Accident Analysis contained in the Final Safety Analysis Report. Specifically, a time requirement for equalizing primary and secondary pressure was removed from the Final Safety Analysis Report. In addition, the licensee changed the time in which isolation of the affected Steam Generator could be achieved from 10

minutes to 30 minutes. At the end of the inspection period the licensee initiated a corrective action to perform a safety evaluation in accordance with 10 CFR 50.59 for this Final Safety Analysis Report change.

Because the Significance Determination Process is not designed to assess the significance of violations that potentially impact or impede the regulatory process, this issue was dispositioned using the traditional enforcement process in accordance with Section IV of the NRC Enforcement Policy. However, the results of the violation were assessed using the Significance Determination Process.

This finding was determined to be more than minor because the inspectors could not reasonably determine that the change would not ultimately require NRC approval. The inspectors determined that even though the change was not adequately evaluated in accordance with 10 CFR 50.59, this violation was of very low safety significance because the design basis safety-related functions of mitigating systems to respond to this initiating event scenario were not adversely affected. The inspectors evaluated the results of the finding using the Significance Determination Process for the mitigating systems cornerstone. The inspectors determined that the results of the finding were of very low safety significance because the finding was not a design or qualification deficiency that was confirmed to result in a loss of function per Generic Letter 91-18. Therefore, the results of the violation were determined to be of very low safety significance and the violation was classified as a Severity Level IV Non-Cited Violation.

Inspection Report# : [2004012\(pdf\)](#)

**Significance:**  Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**10 CFR 50, Appendix B, Criterion XI, "Test Control." Failure to Have Adequate Test Procedures for the Testing of Safety-Related Switches**

A Green finding associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," was identified by the inspectors for the failure to establish and perform testing required to demonstrate that components will perform satisfactorily in service with written test procedures which incorporate applicable requirements and acceptance limits. The licensee performed post-maintenance testing of a component cooling water pump control switch, a safety-related component, without the use of a written test procedure which incorporated the applicable requirements and acceptance limits for testing to demonstrate the component would perform satisfactorily in service. The licensee's extent of condition identified the potential for at least 11 additional activities for which safety-related components did not have the appropriate test procedures established. At the end of the inspection period, the licensee developed actions to correct the identified deficiencies and to ensure licensee personnel were aware of the requirements to use procedures for the testing of safety-related components.

This issue was more than minor because if left uncorrected the finding could become a more significant safety concern. In addition, the finding affected the mitigating systems cornerstone attribute of procedure quality, specifically maintenance and testing (pre-event) procedures, and the cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. In accordance with the Significance Determination Process, this finding was determined to be a Non-Cited Violation of very low safety significance because the finding was not a design or qualification deficiency that was confirmed to result in a loss of function per Generic Letter 91-18.

Inspection Report# : [2004012\(pdf\)](#)

**Significance:**  Nov 19, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Ensure That a Safe Shutdown Procedure Directed Alignment of Instrumentation to a Direct Current Bus with a Battery Charger**

A finding of very low safety significance was identified by the inspectors for failure to align safe shutdown instrumentation to an electrical bus with a battery charger in procedure AOP-10A, "Safe Shutdown - Local Control." Specifically, the procedure aligned Units 1 and 2 safe shutdown instrumentation to a 125Vdc bus that did not have a battery charger available to support the selected instrumentation.

This issue was more than minor because it affected the procedure quality attribute of the Reactor Safety Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. Specifically, the safe shutdown instrumentation associated with this bus, without a battery charger, could potentially become inoperable as the voltage of the battery supplying the bus decreased. Operators could select another bus with a safe shutdown inverter, however, the procedure did not direct this action. To correct this procedural error, the licensee issued Temporary Change Notice 2004-0762. This issue was entered into the licensee's corrective action program as CAP059262 and CE014635. The issue was of very low safety significance because it did not represent an actual loss of a safety function. The issue was a Non-Cited Violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instruction, Procedures, and Drawings," for failure to provide a procedure of a type appropriate to the circumstances.

Inspection Report# : [2004010\(pdf\)](#)

**Significance:**  Nov 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Vendor Breaker Testing Requirements Not Incorporated in Procedure**

The inspectors identified a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because the licensee did not evaluate a Technical Bulletin issued by Westinghouse in March 2004 regarding safety-related breakers and incorporate the

testing instructions specified in the Bulletin into the applicable station procedures.

The finding was greater than minor because it was associated with the procedure quality attribute of the Reactor Safety Mitigating Systems cornerstone and affected the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding is of very low significance as it did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event. The licensee entered the issue into its corrective action program. As part of corrective actions, the licensee evaluated the Technical Bulletin and incorporated the testing instructions into applicable station procedures.

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



**Significance:** Nov 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Corrective Actions for a Part 21 Notification on Diesel Governors Were Not Timely**

The inspectors identified a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because the licensee failed to promptly evaluate and resolve a 10 CFR Part 21 issue from 2001 involving the governors on all four emergency diesel generators (EDGs). The Part 21 issue pertained to the service life of electrolytic capacitors in the governor control system of all four safety-related EDGs. The capacitors in the four EDGs were beyond the service life specified by the vendor in the Part 21 and, in three of four EDGs, the capacitors were beyond the industry's slightly longer replacement interval.

The finding is greater than minor because it was associated with the equipment performance attribute of the Reactor Safety Mitigating Systems cornerstone and affected the associated cornerstone objective of ensuring the availability, reliability, and capability of systems (the EDGs) that respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding is of very low safety significance because it did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event. The licensee entered the issue into its corrective action program and evaluated a recent industry study that indicated a slightly greater service life of the capacitors. In addition, the licensee has made plans to replace the capacitors on an accelerated schedule.

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



**Significance:** Nov 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Implement a Molded-Case Circuit Breaker Test Program**

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," because the licensee failed to implement a program to assure that the installed molded-case circuit breakers (MCCBs) will perform satisfactorily in service.

The finding was greater than minor because it was associated with the Reactor Safety Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, capability of systems that responds to initiating events to prevent undesirable consequences (i.e., core damage). Molded-case circuit breakers provide for breaker coordination, over-current protection, fire prevention, and multiple other safety-related functions. The finding is of very low safety significance because it did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event. The licensee entered the issue into its corrective action program. As part of its corrective actions, the licensee planned to institute an exercising and testing program for safety-related MCCBs.

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



**Significance:** Nov 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Vendor Torque Values Not Listed in Procedure**

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," having very low safety significance. Specifically, the licensee failed to incorporate the vendor's torque requirements for breaker arc chute fasteners into station procedures.

The finding is greater than minor because it was associated with the procedure quality attribute of the Reactor Safety Mitigating System cornerstone and affected the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding is of very low safety significance because it did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event. The licensee entered the issue into its corrective action program and revised the procedure to include the vendor's torque requirements.

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



**Significance:** Sep 30, 2004

Identified By: NRC

Item Type: FIN Finding

### Unit 1 Residual Heat Removal Heat Exchanger Bypass Valve Drifts Open While in Automatic

The inspectors identified a workaround regarding the operation of the Unit 1 residual heat removal system heat exchanger bypass flow control valve in automatic mode during a shutdown loss-of-coolant-accident. The primary cause of this finding was related to the cross-cutting area of problem identification and resolution in two respects. First, the initial extent-of-condition review did not consider the impact of the issue on shutdown plant operations. Second, following initial instrumentation and control troubleshooting efforts, a corrective action item was not assigned to operations personnel to evaluate the issue as a potential operator workaround. This contributed to a 3-month delay in completing the evaluation.

The finding is greater than minor because it affected the equipment performance attribute of the Reactor Safety Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. The finding was considered to be of very low safety significance (Green) because it did not degrade short term (safety injection) decay heat removal capability or reactivity control; result in a design or qualification deficiency or an actual loss of safety function; or involve internal or external initiating events. The finding did not involve a violation of regulatory requirements. The licensee has entered this finding into its corrective action program. In addition, the finding was reviewed by the licensee's Operator Workaround Committee and the Committee classified the problem as an operator challenge in accordance with site procedures.

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

G

Significance: Jul 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### Failure to Test Service Water Headers

The inspectors identified a Non-Cited Violation of 10 CFR 50.55a(g)(4) and 10 CFR 50.55a(g)(5)(iv) associated with failure to perform testing of the buried service water header piping in accordance with the American Society of Mechanical Engineers Code Section XI requirements. The licensee's corrective actions included verifying that quarterly system flow tests provided basis for service water header operability.

This finding was more than minor because it affected the Mitigating Systems Cornerstone objective of equipment reliability and if left uncorrected, could have allowed undetected through-wall flaws to develop in the header piping. These flaws could then continue to grow in size until leakage from the buried headers degraded system operation or if sufficient general corrosion occurs, a gross rupture or collapse of the piping sections could occur. The finding is of very low safety significance and screened as Green using the Significance Determination Process Phase 1 screening worksheet.

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

G

Significance: Jul 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### Non-Code Repair to Service Water (SW) Valve SW 0322

The inspectors identified a Non-Cited Violation of 10 CFR 50.55a(g)(4) associated with failure to conduct non-destructive examinations and repair of valve SW 0322 in accordance with American Society of Mechanical Engineers Code Section XI requirements. The licensee's corrective actions included replacement of the valve during the next opportunity.

This finding was more than minor because it affected the Mitigating Systems Cornerstone objective of equipment reliability and if left uncorrected, could have allowed unacceptable base metal flaws to remain in service. Additionally, the failure to heat treat the weld repairs could have resulted in high welding residual stresses and untempered martensite formation. Untempered martensite is a hard brittle phase of steel (e.g., not flaw tolerant) and can serve to allow rapid crack propagation that could jeopardize the pressure retaining function of the valve body. The finding is of very low safety significance and screened as Green using the Significance Determination Process Phase 1 screening worksheet.

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

G

Significance: Jul 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

### Non-Code Repair to Service Water (SW) Valves SW 32C and SW 32F

The inspectors identified a Non-Cited Violation of 10 CFR 50.55a(g)(4) associated with failure to implement the American Society of Mechanical Engineers Code Section XI examinations and repair requirements for service water pump discharge check valves SW 32C and SW 32F. The licensee's corrective actions included verifying that quarterly surveillance tests verified check valve operability.

This finding was more than minor because it affected the Mitigating Systems Cornerstone objective of equipment reliability and if left uncorrected, the failure to perform the required examinations could have allowed unacceptable base metal flaws to remain in-service. Additionally, the failure to select and follow a repair Code or standard may have resulted in inadequate post weld heat treatments for the weld repairs that could result in high welding residual stresses and untempered martensite formation. Untempered martensite is a hard brittle phase of steel (e.g., not flaw tolerant) and can serve to allow rapid crack propagation which could jeopardize the pressure retaining function of these valve disks. The finding is of very low safety significance and screened as Green using the Significance Determination Process Phase 1

screening worksheet.

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

**G**

**Significance:** Jul 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Correctly Translate Condensate Storage Tank Temperature Limits into Procedures and Instructions**

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," in that the design bases for the maximum Condensate Storage Tank (CST) temperature was not correctly translated into procedures and instructions. Specifically, the Main Steam Line Break (MSLB) Containment Integrity Analysis assumed a maximum value of 100 degrees Fahrenheit for the temperature of the water in the CST, while operations procedures allowed a maximum of 120 degrees Fahrenheit for the CST temperature. This finding applies to both units. The licensee's corrective actions included procedural changes to reflect the correct temperature limit.

This finding was more than minor because an evaluation was required to ensure that accident analysis requirements were met, since the CST was heated up to greater than the maximum analysis value of 100 degrees Fahrenheit during unit startup/shutdown operations with the CST aligned to the operating unit. The finding is of very low safety significance and screened as Green using the Significance Determination Process Phase 1 screening worksheet.

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

**G**

**Significance:** Jul 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Periodically Verify Position of Valves in the Service Water (SW) System**

The inspectors identified a Non-Cited Violation of Technical Specification Surveillance Requirements SR 3.7.8.1 and SR 3.6.3.2 associated with the periodic verification of the position of valves and flanges in the SW system flow paths servicing safety related equipment and in lines associated with containment isolation. Specifically, the licensee did not verify that approximately 100 valves in the SW system flow path servicing safety related equipment that were not locked, sealed, or otherwise secured in position, were in the correct position every 31 days while the Units were in Mode 1, 2, 3, or 4. In addition, the licensee did not verify that 12 containment isolation manual valves were closed and two pipe fittings associated with containment isolation were in place every 31 days while the Units were in Mode 1, 2, 3, or 4. This finding applies to both units. The licensee's corrective actions included locking the appropriate valves and procedural changes.

This finding was more than minor because it was, for the most part, associated with the Mitigating Systems attribute of Configuration Control, which affected the Mitigating Systems Cornerstone objective of ensuring the availability and reliability of the SW system to respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance and screened as Green using the Significance Determination Process Phase 1 screening worksheet.

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

**G**

**Significance:** Jul 16, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Translate Original Design Requirements for the 480-Volt Alternating Current (Vac) System**

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to adequately translate original design requirements for the 480 Vac system into specifications during procurement of new and replacement equipment. The original specifications for equipment such as motors and cables identified the intended service as suitable for a 480 Vac ungrounded system. Specifications for replacement motors did not specify the intended service as an ungrounded system. The licensee's corrective actions included a verification that the identified equipment that did not specify use in a 480 Vac ungrounded system could withstand the overvoltage conditions that can occur on ungrounded systems.

This finding was more than minor because it involved the design control attribute of the Mitigating Systems cornerstone and affected the objective of ensuring the capability of the safety related 480 Vac system in response to initiating events to prevent undesirable consequences. Specifically, the failure to specify the correct service conditions may have resulted in motors being supplied without the enhanced insulation systems required to withstand the overvoltage conditions that can occur on ungrounded systems when a single line to ground occurs. The finding is of very low safety significance and screened as Green using the Significance Determination Process Phase 1 screening worksheet.

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

**Significance:** N/A Mar 24, 2003

Identified By: NRC

Item Type: VIO Violation

**The failure to identify the root cause and implement corrective actions for the AFW/IA issue, a significant condition adverse to quality, so as to prevent recurrence.**

A violation was identified for the licensee's failure to implement adequate corrective actions to effectively address a previous Red finding and preclude recurrence (Inspection Report 50-266/01-17; 50-301/01-17). Specifically, the licensee failed to identify potential common mode failures that existed involving power supplies to the recirculation line air-operated valve and other system components. In addition, the

licensee's corrective actions for the potential common mode failure associated with a loss of instrument air did not preclude repetition. Specifically, the licensee's corrective actions, to upgrade the safety function of the air-operated recirculation valve, failed to ensure that successful operation of the recirculation line air-operated valve was dependent only on safety-related support systems. Following the corrective actions, successful operation of the valve was still dependent upon nonsafety-related power to an interposing relay. Additionally, the corrective actions failed to discover a single failure mechanism involving a system orifice modification.

The issue was more than minor because the failure to implement appropriate corrective actions resulted in the auxiliary feedwater system continuing to rely on nonsafety-related support systems and to be susceptible to a single event causing a total system failure. The failure of nonsafety-related support systems and single event failures are an expected condition during several design basis accidents and should not cause a safety system to fail. The failure of the licensee to implement adequate corrective actions is a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action."

This violation is associated with a previously identified RED finding (IR 50-266;50-30/01-17).  
Inspection Report# : [2002015\(pdf\)](#)

Y

**Significance:** Mar 24, 2003

Identified By: NRC

Item Type: VIO Violation

**Apparent violation of 10 CFR Part 50, Appendix B, Criterion III for the failure to establish appropriate design control measures for the installation of orifices to the AFW recirculation lines**

An apparent violation was identified, in part, through a self-revealing event when decreased auxiliary feedwater pump recirculation flow was noted during post-maintenance testing. Subsequent licensee and NRC review of the event determined that the licensee had installed incorrectly designed orifices in each of the pump recirculation lines. The orifices, due to small clearances, were susceptible to plugging. The primary causes of this finding were inadequacies in the licensee's design process and the licensee's implementation of the process, including the identification of system design requirements and the development of supporting safety evaluations.

The issue has been preliminarily determined to have high safety significance (Red). Following installation of the inadequately designed orifices, the entire auxiliary feedwater system was susceptible to a common mode failure during operations using service water. Failure of auxiliary feedwater during several initiating events could lead to core damage. The installation of the incorrectly designed orifices in the recirculation lines is an apparent violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control."

On December 11, 2003, the final significance determination letter was issued for this finding. It was determined that this is a RED finding for Unit 2 and a YELLOW finding for Unit 1. For tracking purposes, identical findings were opened for Unit 1 (designated as YELLOW) and Unit 2 (designated as RED).

Inspection Report# : [2002015\(pdf\)](#)

R

**Significance:** Feb 28, 2002

Identified By: Licensee

Item Type: VIO Violation

**POTENTIAL COMMON MODE FAILURE OF AUXILIARY FEEDWATER PUMPS DUE TO INADEQUATE PROCEDURAL GUIDANCE**

Units 1 and 2. The licensee identified a potential common mode failure of the auxiliary feedwater pumps due to operator actions specified in plant procedures. The team identified that procedural guidance provided to operators was inadequate to prevent such a common mode failure. In addition, the team identified that the licensee had seven opportunities, from 1981 through 1997, to identify the problem and take appropriate corrective actions. After considering the information developed during the inspection and the information the licensee provided at the April 29, 2002, regulatory conference, the NRC concluded that a violation of 10 CFR Part 50, Appendix B, Criterion XVI, was appropriate for two of the originally proposed seven examples. The failures to provide adequate procedural guidance and to take appropriate corrective actions are both a violation of 10 CFR Part 50, Appendix B, Criteria V and XVI. This issue has been determined to have high safety significance (Red). A common mode failure of the auxiliary feedwater pumps would result in substantially reduced mitigation capability for safely shutting down the plant in response to certain transients. The significance was determined to be high largely due to the relatively high initiating event frequencies associated with the involved transients and the high likelihood of improper operator actions due to the procedural inadequacies. The final significance determination for the Red finding and Notice of Violation were issued to the licensee in a letter dated July 12, 2002.

Inspection Report 50-266/02-15; 50-301/02-15, issued April 2, 2003, documented the NRC decision that this finding is not an Old Design Issue.

Inspection Report# : [2001017\(pdf\)](#)

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

**G****Significance:** Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Implement Adequate Corrective Actions to Preclude Repetition of a Significant Condition Adverse to Quality**

A Green finding associated with a Non-Cited Violation of Title 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to take adequate corrective action to preclude repetition of a significant condition adverse to quality was identified by the inspectors. Specifically, the licensee identified that the root cause of an April 9, 2004, potential loss of a hot leg vent path during nozzle dam installation, a failure to adequately identify, track and maintain licensee commitments to Generic Letter 88-17 in plant procedures, a significant condition adverse to quality. Prior to the start of the Unit 2 Refueling Outage, the inspectors identified that the approved outage shutdown safety analysis contained an orange risk path, during which the licensee would have been unable to close the containment equipment hatch within the time to boil the water around the fuel. The licensee's root cause evaluation for this issue identified the root cause was the same as the April 2004 event; therefore, the licensee's corrective actions from the April 2004 event failed to preclude repetition of the identified cause. The licensee took prompt corrective action to remove these planned activities from the outage schedule to ensure the equipment hatch was closed when the RCS was breached; however, the licensee also identified in the root cause evaluation that this configuration actually occurred in the 1999 Unit 1 Refueling Outage.

The inspectors also determined that a primary cause of this finding was related to the cross-cutting area of Problem Identification and Resolution, because the licensee failed to take adequate corrective actions to preclude repetition of a significant condition adverse to quality.

The issue was more than minor because the finding was associated with preserving the containment boundary attribute of the Barrier Integrity cornerstone and affected the cornerstone objective of providing reasonable assurance that the physical design barriers (Containment) protect the public from radionuclide releases cause by accidents or events. The inspectors evaluated the finding using IMC 0609, Appendix G, Phase 1 Screening, Checklist 3, "PWR Cold Shutdown and Refueling Operation RCS Open and Refueling Cavity Level <23'," specifically Section IV, "Containment Control Guidelines." The finding dealt with the procedures and training to close containment prior to core boiling when the RCS was open. The finding did not meet any of the criteria requiring a Phase 2 or 3 Analysis per Appendix G, Checklist 3, specifically findings that degrade the ability of containment to remain intact following a severe accident. This was in part due to the type of RCS system breach which was scheduled. Therefore, the finding was determined to be of very low significance. The licensee took prompt action to enter the item into the corrective action process, evaluate the issues and develop corrective actions to address the causes of this finding to preclude repetition.

Inspection Report# : [2005004\(pdf\)](#)

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## Emergency Preparedness

**Significance:** SL-III Dec 16, 2003

Identified By: NRC

Item Type: VIO Violation

**10 CFR 50.54, 10 CFR 50.47 apparent violation for failure to maintain a standard scheme of emergency action levels**

The inspectors identified an apparent violation of 10 CFR 50.54(q), associated with emergency planning standard 10 CFR 50.47(b)(4), which will be subject to the NRC traditional enforcement process not the revised Reactor Oversight Process. Specifically, the licensee failed to maintain a standard scheme of emergency action levels (EALs). Eight EALs were changed in 1998 and 1999. The changes decreased the effectiveness of the Emergency Plan in that emergency conditions that would have resulted in classifications at the General Emergency (GE), Alert, and Notification of Unusual Event (NOUE) levels would result in a lesser classification under the current EAL scheme. Approval of the NRC was not obtained prior to the changes being made. Since the identification of the issue by the inspectors, the licensee has revised the eight EALs to be equivalent with those approved by the NRC in 1984.

In a letter dated March 17, 2004, a Notice of Violation and Proposed Imposition of Civil Penalty - \$60,000, was issued.

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

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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

Last modified : August 24, 2005