

Comanche Peak 1

3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 23, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate control room heat exchanger surveillance

NRC identified, noncited violation of Technical Specification Requirement 3.7.11.1 was identified because the licensee's surveillance that was performed to demonstrate compliance with the requirement was inadequate. Specifically, the acceptance criteria did not account for all differences between test conditions and accident conditions. The licensee performed an operability assessment to demonstrate current operability.

The failure to provide an adequate surveillance procedure to demonstrate the control room air conditioning system operability was a performance deficiency. The issue was more than minor because, if left uncorrected, it could become a more significant safety concern. Using the Phase 1 significance determination process worksheet, the finding was of very low risk significance because it was a qualification deficiency that 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. The licensee captured the issue in their corrective action program as Smart Form 2005-000937-00.

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

Significance:  Jun 23, 2005

Identified By: Self-Revealing

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\(pdf\)](#)

Significance:  Mar 01, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Abnormal Procedure for Filling the CST during accident conditions

The examiners identified a noncited violation of Technical Specification 5.4.1 associated with an inadequate abnormal operating procedure. Specifically, the examiners determined that Procedure ABN-305, "Auxiliary Feedwater System Malfunction," Revision 5, was not adequate, in that, Attachment 4 of the procedure did not have an accurate list of all the adapters required to complete the connections to the valves listed in the attachment. Additionally, adapters required in Attachment 4 to complete connections to perform an emergency fill of the condensate storage tank with fire protection water were not readily available. This deficiency was discovered while walking down a job performance measure task during examination validation week. The licensed senior operator that was used for the task validation could not locate the required fitting in the nearby cabinets for the valve required to be used to fill the condensate storage tank in the procedure's attachment. Also, the attachment did not mention the specific types of adapters required for each of the different connection sources. The licensee is correcting the procedure to include information on the types of adapters required and the order of preference of these supply points for filling the condensate storage tank and has staged the proper adapters for each of the valve types in the area required by this procedure and has documented this issue in Condition Report/Smart Form SMF-2005-001022-00.

The finding is a performance deficiency in that the licensee failed to identify that the proper equipment was not readily available and the procedure did not correctly identify the required fittings for each of the possible supply valve choices. The finding is more than minor because it affects the Mitigating Systems Cornerstone of procedural quality and equipment performance, in that, it could result in a failure to locate and use the proper equipment to fulfill the abnormal procedure, Attachment 4, when the condensate storage tank is at a low level. 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# : [2005301\(pdf\)](#)

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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 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\(pdf\)](#)

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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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Oct 22, 2004

Identified By: Self-Revealing

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\(pdf\)](#)

Physical Protection

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

Miscellaneous

Significance: N/A Jul 29, 2005

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution Inspection (PI&R) Team's Overall Assessment of the Licensee's PI&R Program

The team reviewed 151 risk significant issues, apparent and root cause analyses, and other related documents, to assess the effectiveness of the licensee's problem identification and resolution processes and systems. The team concluded that the licensee's management systems were generally effective. However, the team identified poor evaluation, prioritization, and corrective actions associated with longstanding safety related Agastat relay problems. A similar performance concern was documented in the last problem identification and resolution assessment. The team also concluded that licensee corrective actions taken to address an historical adverse trend in human performance have not been effective.

The team concluded that the licensee established a safety-conscious work environment at Comanche Peak Steam Electric Station. The team determined that employees and contractors felt free to enter issues into the corrective action program and raise safety concerns to their supervision, to the employees concern program, and to the NRC. All plant personnel, interviewed by the team, stated that potential safety issues were addressed by the licensee. However, the licensee had identified long-term organizational effectiveness issues within the operations department, which continued to challenge the safety-conscious work environment for shift operations personnel. The team concluded that licensee's past actions to improve operations department organizational effectiveness had not been fully effective.

Inspection Report# : [2005009\(pdf\)](#)

Last modified : November 30, 2005