Limerick 1
4Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate emergency operating procedure for the reactor core isolation cooling system maximum safe operating water level in the pump room
The NRC identified a Green NCV of TS 6.8.1, "Administrative Controls - Procedures," because Exelon did not maintain adequate procedures in that T-103, "Secondary Containment Control," contained an inappropriately high maximum safe operating flooding level for the Unit 1 RCIC room. Limerick revised the T-103 RCIC maximum safe operating flood level from 42 inches to a value of 27 inches.

This finding is more than minor because it affected the Mitigating Systems cornerstone objective of ensuring availability, reliability, and capability of the RCIC system. This finding is of very low safety significance because it did not represent a loss of safety system function, an actual loss of safety function of a single train for greater than its TS allowed outage time, or a total loss of any safety function that contributes to external event initiated core damage sequences. (1R06)
Inspection Report# : 2005003*(pdf)*

Barrier Integrity

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Corrective Actions for a Degraded Remote Shutdown Panel Switch
The NRC identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Limerick's staff did not promptly identify and correct a condition adverse to quality associated with failure of a remote shutdown panel switch during surveillance testing. Limerick replaced the defective remote shutdown panel hand switch and performed a satisfactory post maintenance test.

This finding is greater than minor because it was associated with the Barrier Integrity cornerstone attribute of Barrier Performance, and affected the cornerstone objective of ensuring the availability and reliability of components used for containment isolation. This finding is of very low safety significance because it did not represent a degradation of the radiological barrier provided by the control room, spent fuel pool, or standby gas treatment system, did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere, and did not represent an actual open pathway from the containment or an actual reduction in defense-in-depth for atmospheric pressure control or hydrogen control.

The inspectors identified that a contributing cause of the finding is related to the problem evaluation subcategory of the Problem Identification and Resolution cross-cutting area, in that Limerick staff did not adequately assess and correct the cause of a December 2004 remote shutdown panel switch failure. (Section 4AO2)
Inspection Report# : 2005003*(pdf)*

Emergency Preparedness

Significance: G Nov 15, 2005
Identified By: NRC
Item Type: NCV NonCited Violation

Emergency Response Organization Exercise Performance Issue
The inspectors identified that the Exelon exercise evaluators failed to identify an ERO exercise performance issue that had the apparent effect of unnecessarily prolonging a simulated radiological release to the environment. Specifically, the exercise scenario presented conditions of fuel damage and the failure of one MSIV to close. Operators inappropriately opted to de-pressurize the reactor using the main condenser bypass valves rather than the SRVs. This created a pathway that allowed radiation from the failed fuel to be released to the environment.
Inspection Report# : 2005009*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : March 03, 2006