

## Palo Verde 3

# 3Q/2006 Plant Inspection Findings

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## Initiating Events

**Significance:**  Jun 30, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **EMERGENCY DIESEL TRIP DURING TESTING**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified for the failure of maintenance personnel to follow procedures. Specifically, on April 2, 2006, maintenance personnel failed to follow Procedure 73ST-9DG02, "Class 1E Diesel Generator and Integrated Safeguards Test, Train B," by installing a jumper on the incorrect relay while testing the overcurrent trip. This resulted in an emergency diesel generator trip and de-energization of safety-related Bus PBB-S04. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2880952.

The finding is greater than minor because it is associated with the human performance cornerstone attribute of the initiating events cornerstone and affects the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using the Manual Chapter 0609, "Significance Determination Process," Appendix G, "Shutdown Operations Significance Determination Process," Checklist 2, the finding is determined to have very low safety significance because the finding did not result in non-compliance with low temperature over pressure protection Technical Specifications, nor did it degrade the ability of containment to remain intact following an accident. Additionally, the finding did not degrade the licensee's ability to terminate a leak path, add reactor coolant system inventory, recover decay heat removal once it is lost, or establish an alternate core cooling path. Lastly, the finding did not increase the likelihood of a loss of reactor coolant system inventory, decay heat removal, or offsite power. The cause of the finding is related to the crosscutting element of human performance in that maintenance personnel did not follow procedures due to self-imposed schedule pressures.

Inspection Report# : [2006003\(pdf\)](#)

**Significance:**  Jun 30, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **FAILURE TO FOLLOW PROCEDURES RESULTING IN SPENT FUEL POOL DRAIN DOWN AND SPILL IN THE FUEL BUILDING**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified for the failure of operations personnel to follow procedures. Specifically, between April 7 and April 12, 2006, operations personnel did not follow Procedure 40OP-9PC06, "Fuel Pool Clean Up and Transfer," Revision 37, Appendix AU, resulting in Valve PCN-V119, "Cleanup Header Return to the Fuel Canal," being improperly aligned. This resulted in an inadvertent transfer of approximately 1200 gallons of spent fuel pool water to the transfer canal and a spill of contaminated water onto the 120 foot and 100 foot elevations of the fuel building. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2884054.

The finding is greater than minor because it is associated with the configuration control and human performance cornerstone attributes of the initiating events cornerstone and affects the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. This finding cannot be evaluated by the significance determination process because Manual Chapter 0609, "Significance Determination Process," Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and Appendix G, "Shutdown Operations Significance Determination Process," do not apply to the spent fuel pool. This finding is determined to be of very low safety significance by NRC management review because radiation shielding was provided by the spent fuel pool water level, the spent fuel pool cooling and fuel building ventilation systems were available, and there were multiple sources of makeup water. The cause of the finding is related to the crosscutting

element of human performance in that operations personnel did not follow procedures due to poor human error prevention techniques.

Inspection Report# : [2006003\(pdf\)](#)

**Significance:** G Jun 30, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **FAILURE TO FOLLOW GTG SURVEILLANCE PROCEDURE CAUSES LOSS OF POWER TO SAFETY-RELATED BUS**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified for the failure of operations personnel to follow procedure. Specifically, on May 6, 2006, operations personnel failed to achieve a current of approximately zero amperes through Breaker NAN-S03A prior to opening the offsite supply breaker to Bus PBA-S03 as required by Procedure 40OP-9GT01, "Gas Turbine Generator Isochronous Test." This resulted in the loss of power to safety-related Bus PBA-S03 and an actuation of emergency diesel generator Train A. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2891404.

The finding is greater than minor because it is associated with the human performance cornerstone attribute of the initiating events cornerstone and affects the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using the Manual Chapter 0609, "Significance Determination Process," Appendix G, "Shutdown Operations Significance Determination Process," Checklist 2, the finding is determined to have very low safety significance because the finding did not result in non-compliance with low temperature over pressure protection Technical Specifications, nor did it degrade the ability of containment to remain intact following an accident. Additionally, the finding did not degrade the licensee's ability to terminate a leak path, add reactor coolant system inventory, recover decay heat removal once it is lost, or establish an alternate core cooling path. Lastly, the finding did not increase the likelihood of a loss of reactor coolant system inventory, decay heat removal, or offsite power. The cause of the finding is related to the crosscutting element of human performance in that poor attention to detail by operations personnel resulted in the loss of power to a safety bus.

Inspection Report# : [2006003\(pdf\)](#)

## **Mitigating Systems**

**Significance:** TBD Sep 26, 2006

Identified By: NRC

Item Type: AV Apparent Violation

### **INADEQUATE TEST CONTROL TO PROMPTLY IDENTIFY UNACCEPTABLE PERFORMANCE TEST RESULTS**

A finding with five apparent violations was identified associated with fouling of safety-related heat exchangers cooled by the emergency spray pond system. Between 1995 and May, 2006, the licensee failed to recognize that improperly implemented chemistry controls for the emergency spray pond system caused a significant condition adverse to quality which degraded the performance of all emergency diesel generators and emergency cooling water systems. The degraded performance was primarily due to heat exchanger fouling caused by adding excessive amounts of chemicals. The conditions that existed also had the potential to cause scaling after an accident starts. In one instance, it is estimated that this resulted in degrading the performance of Emergency Cooling Water Heat Exchanger 2B to the point where it would not have been capable of performing its intended safety function for approximately 6.8 months in 2003.

An apparent violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," was identified because the two procedures that were performed to measure essential cooling water heat exchanger performance were implemented in a way that was inadequate to ensure the timely determination that the requirements and acceptance limits contained in applicable design documents were met.

The performance deficiency associated with these apparent violations was more than minor because it impacted the equipment performance attribute of the Mitigating Systems Cornerstone objective to maintain the availability and reliability

of systems needed to mitigate accidents. Specifically, Essential Cooling Water (EW) Train B in Unit 2 was estimated to have been incapable of performing its function under existing conditions for approximately 6.8 months. A Phase 2 significance determination process concluded that this finding has potential safety significance greater than very low safety significance because some accident sequences, notably loss of coolant accidents, were expected to elevate the ultimate heat sink temperature to the point where the degraded essential cooling water heat exchanger would be challenged. This was expected to cause failure of the essential chiller, and the resulting loss of room cooling to safety-related equipment increased the plant risk. In addition, there is uncertainty associated with the amount of scaling that could occur on any of the affected heat exchangers for all three units during 24 hours of an accident scenario. Additional information was needed to perform a final Phase 3 assessment, due to the complexity of the issue

Inspection Report# : [2006011\(pdf\)](#)

**Significance:** TBD Sep 26, 2006

Identified By: NRC

Item Type: AV Apparent Violation

### **50.59 REVIEWS NOT PERFORMED OR INADEQUATE FOR MULTIPLE CHANGES TO SPRAY POND CHEMISTRY CONTROL PROCEDURE**

A finding with five apparent violations was identified associated with fouling of safety-related heat exchangers cooled by the emergency spray pond system. Between 1995 and May, 2006, the licensee failed to recognize that improperly implemented chemistry controls for the emergency spray pond system caused a significant condition adverse to quality which degraded the performance of all emergency diesel generators and emergency cooling water systems. The degraded performance was primarily due to heat exchanger fouling caused by adding excessive amounts of chemicals. The conditions that existed also had the potential to cause scaling after an accident starts. In one instance, it is estimated that this resulted in degrading the performance of Emergency Cooling Water Heat Exchanger 2B to the point where it would not have been capable of performing its intended safety function for approximately 6.8 months in 2003.

An apparent violation of 10 CFR 50.59 was identified for making nine revisions to Procedure 74DP-9CY04, "System Chemistry Specification," a procedure described in the Updated Final Safety Analysis Report, between 1998 and 2004 without performing evaluations of the potential impact of the changes on the safety-related components in the spray pond system; the changes revised spray pond chemistry parameter limits which were subsequently determined to have contributed to heat exchanger fouling.

The performance deficiency associated with these apparent violations was more than minor because it impacted the equipment performance attribute of the Mitigating Systems Cornerstone objective to maintain the availability and reliability of systems needed to mitigate accidents. Specifically, Essential Cooling Water (EW) Train B in Unit 2 was estimated to have been incapable of performing its function under existing conditions for approximately 6.8 months. A Phase 2 significance determination process concluded that this finding has potential safety significance greater than very low safety significance because some accident sequences, notably loss of coolant accidents, were expected to elevate the ultimate heat sink temperature to the point where the degraded essential cooling water heat exchanger would be challenged. This was expected to cause failure of the essential chiller, and the resulting loss of room cooling to safety-related equipment increased the plant risk. In addition, there is uncertainty associated with the amount of scaling that could occur on any of the affected heat exchangers for all three units during 24 hours of an accident scenario. Additional information was needed to perform a final Phase 3 assessment, due to the complexity of the issue

Inspection Report# : [2006011\(pdf\)](#)

**Significance:** TBD Sep 26, 2006

Identified By: NRC

Item Type: AV Apparent Violation

### **INADEQUATE IDENTIFICATION AND CORRECTIVE ACTION FOR DEGRADED EW HEAT EXCHANGER PERFORMANCE**

A finding with five apparent violations was identified associated with fouling of safety-related heat exchangers cooled by the emergency spray pond system. Between 1995 and May, 2006, the licensee failed to recognize that improperly implemented chemistry controls for the emergency spray pond system caused a significant condition adverse to quality which degraded the performance of all emergency diesel generators and emergency cooling water systems. The degraded performance was primarily due to heat exchanger fouling caused by adding excessive amounts of chemicals. The conditions that existed also had the potential to cause scaling after an accident starts. In one instance, it is estimated that this resulted in degrading the performance of Emergency Cooling Water Heat Exchanger 2B to the point where it would not have been capable of performing its intended safety function for approximately 6.8 months in 2003.

An apparent violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," was identified. On March 19, 2002, performance testing for Essential Cooling Water Heat Exchanger 2B indicated that the system would not be capable of performing its design function, but this significant condition adverse to quality was not promptly identified, the cause determined, or corrective actions taken to restore the required heat exchanger performance. The failure to correct this degraded performance contributed to the continued degradation and eventual loss of function for an estimated period of 6.8 months.

The performance deficiency associated with these apparent violations was more than minor because it impacted the equipment performance attribute of the Mitigating Systems Cornerstone objective to maintain the availability and reliability of systems needed to mitigate accidents. Specifically, Essential Cooling Water (EW) Train B in Unit 2 was estimated to have been incapable of performing its function under existing conditions for approximately 6.8 months. A Phase 2 significance determination process concluded that this finding has potential safety significance greater than very low safety significance because some accident sequences, notably loss of coolant accidents, were expected to elevate the ultimate heat sink temperature to the point where the degraded essential cooling water heat exchanger would be challenged. This was expected to cause failure of the essential chiller, and the resulting loss of room cooling to safety-related equipment increased the plant risk. In addition, there is uncertainty associated with the amount of scaling that could occur on any of the affected heat exchangers for all three units during 24 hours of an accident scenario. Additional information was needed to perform a final Phase 3 assessment, due to the complexity of the issue

Inspection Report# : [2006011\(pdf\)](#)

**Significance:** TBD Sep 26, 2006

Identified By: NRC

Item Type: AV Apparent Violation

#### **INADEQUATE DESIGN CONTROL TO ENSURE NO EW HEAT EXCHANGER SCALING**

An apparent violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified for failure to correctly evaluate the scaling potential of the safety-related heat exchangers cooled by the emergency spray pond during a design basis accident. An error in the SEQUIL calculation caused the licensee to incorrectly conclude that scaling would not occur under the conditions established in the chemistry control program.

The performance deficiency associated with these apparent violations was more than minor because it impacted the equipment performance attribute of the Mitigating Systems Cornerstone objective to maintain the availability and reliability of systems needed to mitigate accidents. Specifically, Essential Cooling Water (EW) Train B in Unit 2 was estimated to have been incapable of performing its function under existing conditions for approximately 6.8 months. A Phase 2 significance determination process concluded that this finding has potential safety significance greater than very low safety significance because some accident sequences, notably loss of coolant accidents, were expected to elevate the ultimate heat sink temperature to the point where the degraded essential cooling water heat exchanger would be challenged. This was expected to cause failure of the essential chiller, and the resulting loss of room cooling to safety-related equipment increased the plant risk. In addition, there is uncertainty associated with the amount of scaling that could occur on any of the affected heat exchangers for all three units during 24 hours of an accident scenario. Additional information was needed to perform a final Phase 3 assessment, due to the complexity of the issue

Inspection Report# : [2006011\(pdf\)](#)

**Significance:**  Sep 26, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **TWO EXAMPLES OF FAILURE TO TRANSLATE SPRAY POND DESIGN ASSUMPTIONS INTO PLANT PROCEDURES CONTROL**

Two examples of a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," were identified involving the failure to adequately translate the design basis of the spray ponds into procedures. Design Calculation 13-MC-SP-0307, "SP/EW System Thermal Performance Design Basis Analysis," Revision 7, which demonstrated that the spray pond system could adequately limit spray pond temperature during a design basis accident did not account for any reduced heat capacity caused by sediment buildup. However, this fact was not translated into procedures, so approximately 400 cubic yards of sediment had built up in each of the six spray ponds when the team questioned the impact to the heat removal function. Also, the same calculation demonstrated that sufficient water was available to provide adequate cooling during a design basis accident, but did not account for any leakage from the ponds. The team determined that the licensee

did not translate this into a procedure to ensure that the condition of the spray pond was maintained such that leakage did not occur. Procedure 81DP-0ZZ01, "Civil System, Structure, and Component Monitoring Program," Revision 11, was used to monitor the condition of the pond structures. The team identified that it examined only the exposed concrete surfaces, which constituted about 7 percent of the surface area and almost none of the water-containing volume. Cracks had been identified and repaired in this area, but the inspections were not expanded to the underwater surfaces. This issue was documented in Condition Report/Disposition Requests 2906671 and 2910912.

Failure to adequately translate the design basis of the spray ponds into procedures was a performance deficiency. This finding was determined to be more than minor because, if left uncorrected, the finding could become a more significant safety concern. This finding affected the Mitigating Systems Cornerstone. This performance deficiency screened as having very low safety significance in a Phase 1 significance determination process because the licensee was able to demonstrate that the sediment would not have resulted in a loss of safety function, and that significant leakage did not exist. The licensee was able to revise the calculation to take credit for heat absorption by the concrete walls, and scheduled inspections by divers of underwater portions of the ponds to follow sediment removal

Inspection Report# : [2006011\(pdf\)](#)

**Significance:**  Sep 26, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **MULTIPLE EXAMPLES OF INADEQUATE OPERABILITY ASSESSMENTS FOR HEAT EXCHANGER DEGRADATION**

A noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," with multiple examples was identified for failure to adequately assess the impact to operability of degraded heat exchangers in the emergency diesel generators and essential cooling water system. Specifically, the licensee failed to follow Procedure 40DP-9OP26, "Operability Determination and Functional Assessment," Revision 16, in assessing indications of degraded heat exchanger performance, an activity affecting quality. Key support organizations were not always involving operations personnel with questions that had a potential to affect the operability of safety-related equipment, or were informing operators only after the support organization had fully evaluated the condition, delaying actions that were required to be prompt. Also, operations personnel did not always insist on a rigorous evaluation. This issue was documented in Condition Report/Disposition Requests 2918892, 2901815, and 2898237.

Failure to adequately implement the operability assessment process was a performance deficiency. This finding was more than minor because it impacted the equipment performance attribute of the Mitigating Systems Cornerstone objective to maintain the availability and reliability of systems needed to mitigate accidents. This finding screened as having very low safety significance in a Phase 1 significance determination process, because the examples used for this violation were confirmed not to involve any loss of safety function. This finding had cross-cutting aspects in the area of human performance because the licensee did not follow their systematic process for operability decision making when information was not brought to the right decision makers

Inspection Report# : [2006011\(pdf\)](#)

**Significance:**  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO EVALUATE DEGRADED CONDITIONS TO ENSURE OPERABILITY**

The inspectors identified two examples of a noncited violation of Technical Specification 5.4.1.a for the failure of engineering personnel to follow procedures. On April 17, 2006, engineering personnel failed to follow Procedure 81DP-0DC13, "Deficiency Work Order," resulting in shutdown cooling Train B being declared operable without fully addressing a potential degraded condition associated with the potential for missing parts from a submersible remaining in plant systems. On May 10, 2006, engineering personnel did not perform evaluations and dispositions required by Procedure 81DP-0DC13 to justify a degraded condition for continued use of a pipe support associated with shutdown cooling line Train A. These issues were entered into the licensee's corrective action program as Condition Report/Disposition Requests 2902258 and 2892737.

The finding is greater than minor because it would become a more significant concern if left uncorrected in that Technical Specification required structures, systems, and components (SSCs) may not be operable as required for applicable plant

conditions. The performance deficiency associated with this finding was representative of a broader concern related to how the licensee ensures the operability of SSCs required to comply with Technical Specifications. Specifically, the licensee's programs and processes for assessing degraded conditions have not been implemented with the rigor and thoroughness necessary to ensure compliance with regulatory requirements. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance because the condition only affected the mitigating systems cornerstone and did not represent an actual loss of safety function. The cause of the finding is related to the crosscutting element of human performance in that engineering personnel did not follow procedures, resulting in the failure to perform required evaluations and dispositions for deficient conditions.  
Inspection Report# : [2006003\(pdf\)](#)

**Significance:**  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO FOLLOW PROCEDURES RESULTED IN DECLARING BOTH TRAINS OF LOW PRESSURE SAFETY INJECTION INOPERABLE**

The inspectors identified a noncited violation of Technical Specification 5.4.1.a for the failure of operations personnel to follow Procedure 73ST-9SI03, Leak Test of SI/RCS Pressure Isolation Valves, which resulted in declaring both trains of low pressure safety injection inoperable. Specifically, on May 10, 2006, operations personnel inappropriately allowed safety-injection header pressure to exceed 1850 psig, which rendered the associated low pressure safety injection pumps inoperable. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2892697.

The finding is greater than minor because it is associated with the human performance cornerstone attribute of the mitigating systems cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance because the condition only affected the mitigating systems cornerstone and did not represent an actual loss of safety function. The cause of the finding is related to the crosscutting element of human performance in that operations personnel did not follow procedures and apply the necessary rigor and questioning attitude to requirements and associated decisions because of self-imposed schedule pressures.

Inspection Report# : [2006003\(pdf\)](#)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **INADEQUATE DIESEL FIRE PUMP BATTERY SURVEILLANCE**

The inspectors identified a noncited violation of Technical Specification 5.4.1.d for an inadequate surveillance test for the diesel fire pump batteries. Specifically, since 1995, the method described in Procedure 38FT-9FP02, "Fire Protection System Monthly Diesel Fire Battery Test," Revision 4, to verify the specific gravity of the diesel fire pump batteries was inadequate in that the specific gravity was not directly measured, but was verified by a correlation to open circuit voltage. This methodology could result in a measured battery voltage that would be higher than the true specific gravity would provide. The cause was due to an inadequate engineering evaluation to develop the correlation used in the surveillance procedure. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2875906.

The finding is greater than minor because it is associated with the procedure quality cornerstone attribute of mitigating systems cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet and Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," the finding is determined to have very low safety significance because the fire pump battery performance and reliability is minimally affected since the batteries were replaced every two years, and the required capacity of the batteries is approximately 60 percent of a newly installed battery.

Inspection Report# : [2006002\(pdf\)](#)

**Significance:**  Feb 03, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **UNTIMELY CORRECTIVE ACTIONS FOR FEEDWATER PUMP RESISTOR FAILURES**

A self-revealing, noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to correct, and preclude repetition of, a significant condition adverse to quality involving the failure of the turbine driven auxiliary feedwater pump. Specifically, the licensee failed to perform a timely evaluation to determine the cause of the Units 2 and 3 turbine driven auxiliary feedwater pump governor power supply resistor failures. Approximately 7 months following the Unit 2 and 3 failures, the Unit 2 turbine driven auxiliary feedwater pump governor failed again due to the same resistor failure. The licensee entered the deficiency into their corrective action program as Condition Report Disposition Request 2871541 for resolution.

The finding is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the availability of systems that respond to initiating events. The failure of the Unit 2 turbine driven auxiliary feedwater pump governor power supply resistor affected the availability of the auxiliary feedwater system. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," the finding is determined to have very low safety significance because it only affected the mitigating systems cornerstone and did not result in an actual loss of safety function. The cause of the finding is related to the cross-cutting element of problem identification and resolution, in that, delays in the evaluation of the resistors failures allowed a subsequent failure prior to completion of the corrective actions. (Section 40A2e(2)(i))

Inspection Report# : [2006008\(pdf\)](#)

**Significance:**  Feb 03, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO PROMPTLY CORRECT AN ADVERSE TREND OF CONTAMINATED OIL SAMPLES**

A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the failure to correct an adverse trend of contaminated oil samples in a timely manner. Specifically, on April 1, 2005, the licensee identified an increasing trend of incorrect lubricant oil additions and contaminated oil samples and entered the deficiency in their corrective action program. As of January 2006, the inspectors concluded that the corrective actions taken as a result of the identified oil control deficiency were untimely, in that, 9 months later the frequency of new instances of oil control problems documented in the corrective action program remained unchanged. The licensee entered the deficiency into their corrective action program as Condition Report Disposition Request 2785915 for resolution.

The finding is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the associated cornerstone objective to ensure the reliability and availability of systems that respond to initiating events. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because it only affected the mitigating systems cornerstone and did not result in the loss-of-safety function of a single train or system. The cause of the finding is related to the cross-cutting element of problem identification and resolution, in that, poor work practices resulted in multiple oil contamination events and the corrective actions taken were ineffective in promptly correcting the condition. (Section 40A2e(2)(ii))

Inspection Report# : [2006008\(pdf\)](#)

**Significance:**  Feb 03, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO MEET MAINTENANCE TEST REQUIREMENTS**

A noncited violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," was identified for failure to perform required testing of the Unit 3 essential cooling water system Pump EWP01 breaker in accordance with requirements and acceptance limits. Pump EWP01 breaker test procedure established tolerances and acceptance criteria for the breaker sub-component clearances that were documented as not being met. The licensee entered the deficiency into their corrective action program as Condition Report Disposition Request 2865792 for resolution.

This finding was more than minor since it affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The failure to meet recommended tolerances and acceptance limits specified was similar to Manual Chapter 0612, Appendix E, more than minor example 2.c., in that, the issue was repetitive and affected multiple breakers tested. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because the condition was a qualification deficiency confirmed not to result in loss of function. The cause of the finding is related to the cross-cutting element of human performance in that maintenance personnel failed to properly implement maintenance procedures, and the deficient conditions were not identified by supervisory review of the completed procedures. (Section 40A2e(2)(iii))

Inspection Report# : [2006008\(pdf\)](#)

**Significance:**  Feb 03, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **FAILURE TO IDENTIFY A MAINTENANCE RULE FUNCTIONAL FAILURE**

A noncited violation of 10 CFR 50.65(a)(2) was identified for the failure to demonstrate that the performance or condition of the low pressure safety injection/shutdown cooling Pump 2A was adequate. Specifically, in May 2005, the licensee failed to accurately account for 15 hours of unavailability time for the low pressure safety injection/shutdown cooling Pump 2A, which when re-evaluated, exceeded the performance trigger to enter (a)(1) monitoring. The licensee entered this deficiency into their corrective action program as Condition Report Disposition Request 2865315 for resolution.

The finding is more than minor because it affects the equipment performance attribute of the mitigating systems cornerstone objective to maintain availability and reliability of structures systems and components needed to respond to initiating events and had a credible impact on safety. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding is determined to have very low safety significance because there was no design deficiency and the low pressure safety injection/shutdown cooling Pump 2A failure did not exceed the allowed technical specification outage time. The cause of the finding is related to the cross-cutting element of human performance in that the initial evaluation and subsequent supervisory reviews failed to identify the need for additional monitoring of the low pressure safety injection/shutdown cooling Pump 2A. (Section 40A2e(2)(v))

Inspection Report# : [2006008\(pdf\)](#)

**Significance:** N/A Feb 03, 2006

Identified By: NRC

Item Type: FIN Finding

#### **PERFORMANCE DECLINE IN PROBLEM IDENTIFICATION AND RESOLUTION**

The inspectors reviewed approximately 175 condition reports, 65 work orders, associated root and apparent cause evaluations, and other supporting documentation to assess problem identification and resolution activities. Overall, performance declined when compared to the previous problem identification and resolution assessment. Significant delays in evaluation of the significance of an identified problem, as well as identification of appropriate corrective actions, resulted in large corrective action backlogs, some repeat events, and examples of continued noncompliance. The delays in completion of corrective actions continued to result in a significant number of self-disclosing and NRC-identified violations and findings. While the licensee initiated actions to address the substantive cross-cutting issues in human performance and problem identification and resolution, the majority of the corrective actions were not complete and some of the initial completed actions were not effective. Also, competing priorities between resources and the backlog of corrective actions created a condition where many corrective actions were significantly delayed in their completion, contributing to failures to adequately implement the corrective action process.

The team concluded that while a safety-conscious work environment exists at your facility, isolated concerns were raised by your staff during the interviews. These concerns were associated with not having sufficient personnel to accomplish long-term improvements, a loss of trust that management would not subject the staff to negative consequences for raising issues, some confusion about when to place an adverse condition into your corrective action program, and a decrease in confidence that the corrective action program will adequately address problems. (Section 40A2).

Inspection Report# : [2006008\(pdf\)](#)



**Significance:**  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROMPTLY CORRECT AN ADVERSE CONDITION WITH THE REFUELING WATER TANK INSTRUMENT PIT**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to correct a condition adverse to quality involving the refueling water tank instrument pit. Specifically, in August 2003, the licensee inadvertently cancelled the work orders to correct deficiencies associated with flooding of the refueling water tank instrument pit. This error was identified by the licensee in October 2004; however, corrective actions were inadequate to ensure timely correction of the adverse condition. Additionally, two of the three work orders were inappropriately closed with no work performed following the inspectors' identification of the issue in August 2005. After identification by the inspectors, the licensee installed temporary modifications to prevent water intrusion into the pit. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2838845.

The finding is greater than minor because it is associated with the protection against external factors cornerstone attribute of the mitigating systems cornerstone and affects the associated cornerstone objective to ensure the reliability and availability of systems that respond to initiating events. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding required a Phase 3 analysis by a senior reactor analyst, since the finding was potentially risk significant due to external initiating event core damage sequences. A senior reactor analyst performed a qualitative assessment and concluded that the finding had very low safety significance. The cause of the finding is related to the crosscutting element of problem identification and resolution in that corrective actions lacked timeliness, adequacy, and thoroughness.

Inspection Report# : [2005005\(pdf\)](#)

**Significance:**  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO DEMONSTRATE EFFECTIVE MAINTENANCE OF HOT LEG RESISTANCE TEMPERATURE DETECTORS**

The inspectors identified a noncited violation of 10 CFR 50.65(a)(2) for the failure to demonstrate that the performance or condition of three reactor coolant system resistance temperature detectors had been effectively controlled and monitored against licensee-established goals. Specifically, the licensee failed to identify, and properly account for, three detector functional failures occurring from May 31, 2004 to June 23, 2005. Consequently, the licensee did not establish appropriate goal setting and monitoring for the detectors. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2856282.

The finding is greater than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the associated cornerstone objective to ensure the reliability and availability of systems that respond to initiating events. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance because the condition only affected the mitigating systems cornerstone and did not represent an actual loss of safety function. The cause of the finding is related to the crosscutting element of problem identification and resolution in that the licensee failed to identify the need to perform a maintenance rule functional failure review for failed resistance temperature detectors.

Inspection Report# : [2005005\(pdf\)](#)

**Significance:**  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO CORRECT AN IDENTIFIED ADVERSE CONDITION ASSOCIATED WITH MAINTENANCE DEPARTMENT GUIDELINES**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to correct a condition adverse to quality involving the use of Maintenance Department Guidelines. Specifically,

instrumentation and controls personnel did not complete actions used as a basis for closure for Condition Report/Disposition Request 2715129. In addition, the extent of condition review did not identify the continued active use of Maintenance Department Guidelines to perform quality related activities. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2830633.

The finding is greater than minor because it is associated with the procedure quality cornerstone attribute of the mitigating systems cornerstone and affects the associated cornerstone objective to ensure the reliability and availability of systems that respond to initiating events. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance because the finding did not result in the loss of safety function of any component, train, or system. The cause of the finding is related to the crosscutting element of problem identification and resolution in that maintenance personnel did not implement timely corrective actions and performed a poor extent of condition review.

Inspection Report# : [2005005\(pdf\)](#)

**Significance: SL-IV** Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO SUBMIT LER TO REPORT SHUTDOWN REQUIRED BY TECHNICAL SPECIFICATIONS**

The inspectors identified a noncited Severity Level IV violation of 10 CFR 50.73 for the failure to submit a licensee event report within 60 days to report the completion of a plant shutdown required by the Technical Specifications. A second similar example of a violation of the same regulation was identified by the licensee. Specifically, the licensee was required to submit a licensee event report by May 17, 2005, to report the completion of a plant shutdown required by the Technical Specifications that occurred on March 18, 2005. This licensee event report was submitted on November 7, 2005.

Additionally, the licensee was required to submit a licensee event report by April 10, 2005, to report the completion of a plant shutdown that occurred on February 9, 2005. A revised licensee event report was submitted on January 6, 2006. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Requests 2829976 and 2844019.

The finding was determined to be applicable to traditional enforcement because the NRC's ability to perform this regulatory function was potentially impacted by the licensee's failure to report the event. The finding was determined to be a Severity Level IV violation in accordance with Section D.4 of Supplement I of the NRC Enforcement Policy. The finding is not suitable for evaluation using the significance determination process, but has been reviewed by NRC management and is determined to be a finding of very low safety significance. The cause of the finding is related to the crosscutting element of problem identification and resolution in that the transportability review, conducted by regulatory affairs personnel, failed to identify an additional example of a missed reportable event that was subsequently identified by the NRC.

Inspection Report# : [2005005\(pdf\)](#)

**Significance:**  Dec 16, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**IMPROPER DESIGN CONTROL FOR EMERGENCY CORE COOLING SYSTEM SUMP AND REFUELING WATER TANK SWAPOVER**

The inspectors identified a noncited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," related to potential air entrainment into the emergency core cooling system suction header from the refueling water tank. Specifically, the inspectors determined that the water level in the refueling water tank could fall below the level of the tank discharge pipe and associated vortex breaker during the transfer from the refueling water tank to the containment sump during design basis accidents. As a result, air could be drawn into the emergency core cooling system piping under accident conditions. This issue was applicable to both trains of all three units. Contrary to proper design control, engineering personnel failed to effectively implement design requirements to prevent potential air entrainment into the emergency core cooling system.

The inspectors considered this finding to be more than minor, in accordance with NRC Manual Chapter 0612, "Power Reactor Inspection Reports," since it potentially affected the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and it affected the attributes of design and configuration control. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the inspectors determined that the issue was of very low safety significance (Green) because

there was no actual loss of safety function. Because the violation was determined to be of very low safety significance and has been entered into the corrective action program as condition report/disposition request (CRDR 2835132), this violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. The inspectors also determined this issue had cross-cutting aspects of human performance. Specifically, the licensee's attention to detail was lacking and there was poor inter- and intra-group coordination.

Inspection Report# : [2005012\(pdf\)](#)

**Significance:**  Dec 16, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### **IMPROPER DESIGN CONTROL FOR REFUELING WATER TANK LEVEL INSTRUMENT CALIBRATION**

The inspectors identified a noncited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," for failure to translate design basis information into the calibration of refueling water tank level instruments. Without this information, operators were unaware that a Technical Specification listed minimum level in this tank may not provide sufficient usable volume of water for emergency core cooling system operation. Specifically, engineers failed to density compensate these instruments for allowable ranges of both temperature and boric acid concentration of the tank. Contrary to proper design control, the licensee failed to effectively implement design requirements to ensure operability of the refueling water tank.

This issue was determined to affect the Mitigating Systems cornerstone and was more than minor based upon review of Example 3.j of Manual Chapter 0612, Appendix E. The errors were considered more than a minor calculation error because the deficiencies required re-performance of the calculations, significantly reduced the overall margin, and could be applicable to other such instrumentation calculations. However, engineering personnel demonstrated that while there was a loss of margin, there was no actual loss of function because of the inaccuracies in the RWT level instrument calibrations. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the inspectors determined that the issue was of very low safety significance (Green) because there was no actual loss of safety function. Because the violation was determined to be of very low safety significance and has been entered into the corrective action program as condition report/disposition request (CRDR 2840920), this violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy.

Inspection Report# : [2005012\(pdf\)](#)

**Significance:**  Dec 16, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO PROPERLY IMPLEMENT STATION PROCEDURE FOR EQUIPMENT OPERABILITY (TECHNICAL SPECIFICATION 5.4.1.a)**

The inspectors identified three examples of a (Green) noncited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." Specifically, these examples involved the licensee's failure to follow a procedure and to provide appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished, consistent with the facility's administrative procedure for the operability determination process. In the first case an engineer evaluated a concern in a condition report/disposition request without notifying the control room so an operability assessment could be performed. In the other cases, there was inadequate guidance given to operators to address when an operability assessment would be required.

The inspectors considered this finding to be more than minor, in accordance with Manual Chapter 0612, since it potentially affected the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and it affected the attributes of procedure quality and human performance. However, subsequent evaluations completed by the licensee verified that actual safety functions were not lost in any of these examples. The inspectors performed a Phase 1 significance determination, using NRC Manual Chapter 0609, and determined this issue screens out as having very low safety significance (Green) because a safety function was not lost. Because the violation was determined to be of very low safety significance and has been entered into the corrective action program as Condition Report/Disposition Request 2838626, this violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. The inspectors also determined this issue had cross-cutting aspects of human performance. Specifically, the licensee's attention to detail was lacking and there was poor inter- and intra-group coordination.

The inspectors identified an additional example of the Green noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," described in NRC Supplemental Inspection Report 05000528; 05000529; 05000530/2005012, for the failure to establish an adequate procedure and implement existing procedures involving implementation of the operability determination process. The inspectors also identified examples where information provided to operations from engineering was not sufficiently accurate or complete to support operational decision making with respect to capacitor service life and the overall impact of the identified degraded or non-conforming capacitors. On November 1, 2005, the licensee inappropriately determined that the operability determination process was not applicable for a degraded capacitor condition that had the potential to impact Class 1E inverter operability. Consequently, the degraded condition was evaluated outside the operability determination process. Because the finding is of very low safety significance and has been entered into the corrective action program as Condition Report/Disposition Request 2838626. The cause of the finding is related to the crosscutting element of human performance in that communications between the engineering and operations organizations was inadequate.

Inspection Report# : [2005012\(pdf\)](#)

**Significance:** N/A Dec 16, 2005

Identified By: NRC

Item Type: FIN Finding

**SUMMARY FINDING. 95002 INSPECTORS ASSESSMENT OF IR2004-14 SEVERITY LEVEL III VIOLATION FOR 50.59 ISSUE**

The U.S. Nuclear Regulatory Commission (NRC) performed this supplemental inspection, in part, to assess the licensee's evaluation and corrective actions associated with an inappropriate change to an emergency core cooling system procedure without prior NRC approval. This procedure change rendered portions of the system inoperable because of voiding. This performance issue was previously characterized as a Severity Level III violation of 10 CFR 50.59 and was originally identified in NRC Inspection Report 05000528; 529; 530/2004014. During this supplemental inspection, performed in accordance with Inspection Procedure 95002, the inspectors determined that the licensee's evaluation identified the primary root causes of the performance issue to be: (1) The site procedure revision process (01AC-0AP02) was inadequate, in that, the procedure allowed 'pre-screening' of changes that could potentially bypass performing a 10 CFR 50.59 screening for changes to the facility as described in the licensing basis; and (2) The corrective action program implementation was ineffective. The licensee also identified overlap and interface problems between the corrective action program, the engineering evaluation request program, and the instruction change request program. These issues, in conjunction with inadequate training to recognize a corrective action condition, contributed to the failure of station personnel to initiate a corrective action program input document in 1992 for the potential pipe voiding concern. The inspectors concluded that the licensee's evaluation and implemented corrective actions were appropriate to reasonably prevent repetition of the 10 CFR 50.59 violation.

Given the licensee's acceptable performance in addressing the inappropriate procedure change and 10 CFR 50.59 program deficiencies, the Severity Level III violation is closed.

Inspection Report# : [2005012\(pdf\)](#)

**Significance:** N/A Dec 16, 2005

Identified By: NRC

Item Type: FIN Finding

**SUMMARY FINDING. 95002 INSPECTORS ASSESSMENT OF IR2004-14 (YELLOW) 10CFR50, APP B, CRITERION III VIOLATION**

The NRC performed this supplemental inspection, in part, to assess the licensee's evaluation and corrective actions associated with potential air entrainment into the emergency core cooling system. The licensee failed to incorporate original design requirements into the plant to maintain piping between the containment sump isolation valves filled with water. This performance issue was previously characterized as a 10 CFR 50, Appendix B, Criterion III, violation having substantial safety significance (Yellow), and was originally identified in NRC Inspection Report 05000528; 529; 530/2004014. The inspectors determined that the licensee's evaluation identified a direct cause, nine root causes, and nine contributing causes of the performance issue. The evaluation was also used to develop an extensive list of corrective actions. The inspectors found the licensee's methods of evaluation to be appropriate.

The NRC concluded that, while the licensee performed an adequate root cause evaluation of the Design Control violation, certain corrective actions were incomplete at the time of this inspection. Specifically, the team determined that for each of

the root and contributing causes, not all corrective actions were sufficiently developed to ensure that the identified performance deficiencies were adequately addressed. In addition, some of the corrective actions were narrowly focused, or the implementation of those actions was not fully effective. Also, the team concluded that criteria and reviews were not established, for auditing or followup, to ensure that corrective actions were effective in improving performance in the affected areas. Consequently, the team did not have assurance that the planned corrective actions were sufficient to address the causes for the performance deficiencies associated with the violation. Therefore, the (Yellow) violation (VIO 2004/014-01) will remain open for further NRC review.

Inspection Report# : [2005012\(pdf\)](#)

**G**

**Significance:** Mar 16, 2005

Identified By: NRC

Item Type: FIN Finding

### **FAILURE TO TRACK CONTROL ROOM DISCREPANCIES**

The inspectors identified a finding for the failure to follow administrative guidelines provided to operations personnel for identifying, documenting, and tracking main control room deficiencies. Specifically, approximately 75 control room instrument and control room meter face plates in Units 1, 2, and 3 were degraded and were not individually tracked in the control room discrepancy log. Furthermore, discrepancy labels containing the control room discrepancy log number and description of the discrepancy were not placed adjacent to or as close as possible to each affected device. This issue was entered into the corrective action program as Condition Report/Disposition Request 2782501.

The finding is determined to be greater than minor because if left uncorrected, it could become a more significant safety concern in that the condition could cause an operator to take an inappropriate action based on expected plant response or conversely cause an operator not to take action when action is required. The senior reactor analyst determined that this finding was not appropriate to be evaluated using the significance determination process since this finding was associated with multiple human performance actions. Based on management review, the finding is determined to have very low safety significance because it only affected the mitigating systems cornerstone, and there was no adverse impact to plant equipment.

Inspection Report# : [2005002\(pdf\)](#)

**Y**

**Significance:** Dec 09, 2004

Identified By: NRC

Item Type: VIO Violation

### **FAILURE TO MAINTAIN DESIGN CONTROL OF CONTAINMENT SUMP RECIRCULATION PIPING**

The team identified an apparent violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to establish measures to assure design basis information was translated into specifications, drawings, procedures, and instructions. Specifically, the licensee failed to maintain the safety injection sump suction piping full of water in accordance with the Updated Final Safety Analysis Report. This nonconformance had the potential to significantly affect the available net positive suction head described in the Updated Final Safety Analysis Report for the high pressure safety injection and containment spray pumps, since the analysis assumed the piping would be maintained full of water.

{NOTE: Finding remains open - IP 95002 results pending 12/16/2005}

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. The NRC assessed this finding through Phase 3 of the Significance Determination Process and made a preliminary determination that the issue had substantial safety significance (Yellow). After considering the information developed during the inspection and the results of testing sponsored by the licensee, the NRC has concluded that this inspection finding is appropriately characterized as Yellow. The final Significance Determination Process letter was issued on April 8, 2005. This issue will be inspected within the scope of a supplemental 95002 inspection in August - September, 2005.

Inspection Report# : [2004014\(pdf\)](#)

## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

**Significance:**  Mar 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **FAILURE TO FOLLOW RADIATION EXPOSURE PERMIT INSTRUCTIONS**

The inspector reviewed a self-revealing, noncited violation of Technical Specification 5.4.1.a, resulting from two radiation workers' failure to follow radiation exposure permit instructions. On November 22, 2005, two radiation workers, without notifying radiation protection staff, used a pneumatic grinder with a wire wheel inside of the Unit-1 Steam Generator No. 2 cold leg pipe. As a result of the wire wheel grinding, both workers were contaminated. Radiation protection staff members were not made aware of the contamination event until the workers alarmed the PM-7 portal monitor upon attempting egress from the 140-foot radiological controlled area. One worker received unplanned and unintended internal dose of 6 millirem. The other worker did not receive an internal dose. As corrective action, the licensee counseled the two workers and their supervision, and informed the contractor's management.

The finding was greater than minor because it was associated with one of the cornerstone attributes (exposure control) and the finding affected the occupational radiation safety cornerstone objective, in that a failure to follow radiation exposure permit instructions resulted in additional radiation dose. The inspector determined that the finding had no more than very low safety significance because: (1) it did not involve an ALARA finding, (2) there was no personnel overexposure, (3) there was no substantial potential for personnel overexposure, and (4) the finding did not compromise the licensee's ability to assess dose. The finding also had crosscutting aspects related to human performance, in that, radiation workers failed to follow the radiation exposure permit instructions, which directly resulted in the finding.

Inspection Report# : [2006002\(pdf\)](#)

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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 : December 21, 2006