



Home > Nuclear Reactors > Operating Reactors > Reactor Oversight Process > Plant Summaries > Limerick 1 > Quarterly Plant Inspection Findings

Limerick 1 – Quarterly Plant Inspection Findings

3Q/2017 – Plant Inspection Findings

On this page:

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness
- Occupational Radiation Safety
- Public Radiation Safety
- Security

Initiating Events

Mitigating Systems

Significance: G Mar 31, 2017

Identified By: NRC

Item Type: FIN Finding

Failure to Implement Human Performance Tools Results in Draining of Emergency Diesel Generator Jacket Water System

The inspectors identified a Green self-revealing finding for the failure of Exelon personnel to follow procedures related to human performance tools which resulted in the inadvertent opening of a valve on the 'D13' emergency diesel generator (EDG). Specifically, Exelon personnel did not correctly identify and maintain a distance barrier from the diesel generator jacket water drain valve during a maintenance activity which resulted in the draining of the jacket water system and unplanned inoperability and unavailability of the 'D13' EDG. Exelon refilled the jacket water system, restored 'D13' EDG to an operable condition, and entered the issue into the corrective action program as IR 3986305. This finding is more than minor because it adversely affected the configuration control attribute of the mitigating systems cornerstone to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the valve mispositioning caused the 'D13' EDG to be inoperable and unavailable. Using IMC 0609, Appendix A, Exhibit 2, the inspectors determined that this finding was of very low safety significance (Green). Specifically, the finding did not represent a loss of system or function and did not represent the loss of a single train for greater than technical specification allowed outage times or greater than 24 hours. The inspectors determined that this finding has a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because Exelon personnel did not properly implement error reduction tools.

Inspection Report# : 2017001 (*pdf*)

Significance: G Dec 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Demonstrate Effective Preventive Maintenance Under 50.65 (a)(2) for the Instrument Airsystem

The inspectors identified a Green NCV of 10 Code of Federal Regulations (CFR) 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," because Exelon did not demonstrate that the performance of the Unit 1 instrument air system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against licensee-established goals in accordance with 10 CFR 50.65(a)(1).

Specifically, the inspectors identified that the instrument air system reliability performance monitoring did not properly account for instrument air compressor failures such that the system exceeded the performance criteria established by Exelon's procedures. Exelon entered the issue into the corrective action program (CAP) as IR 3961244.

This issue is more than minor because it adversely affected the equipment performance attribute of the mitigating systems cornerstone to ensure the availability and reliability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the instrument air system reliability performance monitoring did not accurately account for multiple functional failures that resulted in the system exceeding the performance criteria established by Exelon's procedures. Additionally, this finding was similar to example 7.d of IMC 0612, Appendix E, in that appropriate preventive maintenance under 10 CFR 50.65 (a)(2) was not demonstrated. Using IMC 0609, Appendix A, Exhibit 2, the inspectors determined that this finding was of very low safety significance (Green). Specifically, the finding did not represent a loss of system or function and did not represent the loss of a single train for greater than technical specification allowed outage times or greater than 24 hours. The inspectors determined that the finding has a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because Exelon's staff did not implement the procedures for reliability performance criteria evaluation. Specifically, Exelon did not verify that the established performance criteria for train reliability accurately monitored the scope of the function and demonstrated the effectiveness of maintenance when performing functional failure determinations and the periodic 10 CFR 50.65(a) (3) assessment. [H.8] (Section 1R12)

Inspection Report# : 2016004 ([pdf](#))

Significance: G Dec 31, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Control Structure Chiller Unit Trip Caused by Failure to Implement Procedures

A self-revealing Green NCV of LGS Units 1 and 2 technical specification 6.8.1 was identified when Exelon did not properly implement a surveillance procedure. Specifically, operators secured cooling water to the operating 'A' control structure chilled water system (CSCWS) chiller unit which resulted in the unit automatically tripping to prevent damage. Operators restored cooling water flow in accordance with procedures. Exelon entered the issue into the corrective action program as IR 2720374.

This finding is more than minor because it is associated with the human performance attribute of the mitigating systems cornerstone to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the loss of cooling water to the 'A' CSCWS chiller unit resulted in a trip of the unit on high condenser pressure and rendered the chiller unavailable. Using IMC 0609, Appendix A, Exhibit 2, the inspectors determined that this finding was of very low safety significance (Green). Specifically, the finding did not represent a loss of system or function and did not represent the loss of a single train for greater than technical specification allowed outage times or greater than 24 hours. The inspectors determined that this finding has a cross-

cutting aspect in the area of Human Performance, Avoid Complacency, because operators did not recognize and plan for the possibility of mistakes and inherent risk and did not use appropriate error reduction tools. [H.12] (Section 40A2)

Inspection Report# : 2016004 (*pdf*)

Barrier Integrity
Emergency Preparedness
Occupational Radiation Safety
Public Radiation Safety
Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Current data as of : November 29, 2017

Page Last Reviewed/Updated Monday, November 06, 2017

Listen