

McGuire 2

1Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 14, 2002

Identified By: NRC

Item Type: FIN Finding

Not Considering the TS Bases Required Operating Time in an Operability Determination

A finding was identified for not considering the Technical Specification (TS) bases required operating time in an operability determination for equipment in a degraded condition. Following the discovery of a refrigerant leak on the A control room area chiller, the licensee concluded that the condition did not affect operability. However, in making the determination, the licensee did not consider the design bases of the control room area chilled water system to maintain the control room temperature for 30 days of continuous occupancy. Upon considering the TS bases operating time without establishing compensatory measures, the licensee declared the train inoperable. Not considering the TS bases operating requirements in operability determinations with equipment in degraded conditions could become a more significant safety concern because it may result in TS LCOs not being met. This finding was determined to be of very low safety significance (Green) because the A train control room area chiller was not inoperable for greater than its TS allowed outage time. (Section 1R15).

Inspection Report# : [2002003\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Mar 22, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to conduct adequate surveys of the Unit 1 and Unit 2 Main Plant Vent Particulate Radionuclides

The licensee failed to have proper sample line configuration and flow characteristics to assure sample representativeness of particulate radionuclides collected for monitoring and quantifying the Unit 1 and Unit 2 Main Plant Vent airborne effluents in accordance with the Selected Licensee Commitment (SLC) Manual Table 11.7.11-1. An NCV of 10 CFR 20.1501(a) was identified. This violation is greater than minor in that the failure to have proper sample line configurations and flow characteristics could result in non-representative collection of particulate radionuclides used to evaluate doses to members of the public from airborne effluent releases. This issue is associated with the process attributes of the Public Radiation Safety Cornerstone and affected the cornerstone objective to protect public from exposure to radiation. The violation is of very low safety significance because current operations have resulted in negligible release of particulate radionuclides and resultant doses to the public (Section 2PS1.1).

Inspection Report# : [2003002\(pdf\)](#)

Physical Protection

Miscellaneous

Significance: N/A Aug 29, 2002

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION & RESOLUTION

The inspectors concluded that, in general, problems were properly identified, evaluated, and corrected. The licensee was effective at identifying problems and entering them in the corrective action process. Generally, issues were prioritized and evaluated appropriately, and in a timely fashion. The evaluations of significant problems were of sufficient depth to determine the likely root or apparent causes, as well as address the potential extent of the circumstances contributing to the problem and provide a clear basis to establish corrective actions. Corrective actions that addressed the causes of problems were generally identified and implemented. Reviews of sampled operating experience information were comprehensive. Licensee audits and assessments were found to be adequately broad based and effective in providing management a tool for identifying adverse trends. Previous non-compliance issues documented as non-cited violations were properly tracked and resolved via the corrective action program. The results of the last comprehensive corrective action program audit conducted by the licensee were properly entered and dispositioned in the corrective action program. Based on discussions with plant personnel and the apparently low threshold for items entered in the corrective action program database, the inspectors concluded that workers at the site generally felt free to raise safety concerns to their management. The inspectors identified that an element of the corrective action program had not been fully developed, in that limited quarterly trending of issues was performed.

Inspection Report# : [2002007\(pdf\)](#)

Last modified : May 30, 2003