Limerick 1 3Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: Sep 27, 2003 Identified By: NRC Item Type: NCV NonCited Violation Did Not Follow Chemistry Procedure CH-1010

The inspectors identified a finding of very low safety significance that is also a NCV of TS 6.8.1, "Procedures," because chemistry staff did not follow procedures. Specifically, spray pond water samples were not analyzed for soluble manganese within the required weekly frequency and when manganese in the spray pond water was above 100 parts-per-billion (ppb), the actions specified in the procedure were not taken.

The finding is more than minor because it is similar to example 4.a in App. E of NRC IMC 0612. This finding was determined to have very low safety significance by Phase 1 of the Reactor Inspection Findings for At-Power Situations Significance Determination Process because the performance deficiency did not result in a loss of safety function and is not potentially risk significant due to a seismic, flood, fire, or severe weather initiating event.

The inspectors also identified that a contributing cause of this finding involved a human performance error because neither a chemistry technician nor the technician's supervisor followed the steps prescribed by the procedure.

Inspection Report# : 2003004(pdf)

Significance: Jun 28, 2003 Identified By: NRC Item Type: FIN Finding Performing Preventive Maintenance Prior to Required Surveillance Testing of Recirculation Pump Trip Breakers and Safety-Related Battery Chargers

The insp. identified a finding of very low significance (Green) because Exelon's practice of performing preventive maintenance prior to required surveillance testing of recirc pump trip breakers and safety-related battery chargers masked the as-found conditions of these components, and this practice had not been evaluated.

The finding is considered more than minor because it affected the ability to detect component degradation which would adversely impact the reliability of the RPT breakers and battery chargers to respond to initiating events and prevent undesirable consequences. This finding is of very low safety significance because it involved inadequate testing and did not degrade the capability of these components to perform their safety functions.

The inspectors also identified that a contributing cause of this finding was related to the cross-cutting area of Problem Identification and Resolution. After the inspectors noted the MSIV preconditioning issue in February 2003, Exelon's

corrective action included a review of other outage-related activities for unacceptable preconditioning. Exelon's corrective action was narrow in scope and did not identify the RPT breaker and battery charger preconditioning issues. Inspection Report# : 2003003(pdf)

Significance: Mar 29, 2003 Identified By: NRC Item Type: NCV NonCited Violation Average Power Range Monitor Operability During Testing

The inspectors identified a finding of very low significance (Green) that is also a non-cited violation of 10 CFR 50, Appendix B, Criterion V "Procedures," because Exelon's procedure governing local power range monitor (LPRM) maintenance did not include provisions to ensure that the associated average power range monitor (APRM) remained operable. Specifically, the procedure did not include steps to ensure the APRM remained within the technical specification required accuracy when changing the LPRM input configuration to the APRM and at the completion of the maintenance.

This finding was determined to have very low safety significance because it did not result in an actual loss of safety function, and it did not screen as risk significant due to a seismic, fire, flooding, or severe weather initiating event. (Section 1R19)

Inspection Report# : 2003002(pdf)

Significance: Dec 28, 2002

Identified By: NRC

Item Type: FIN Finding

Preventive Maintenance on the 10 Bus Transformer Load Tap Changer was Deficient

The inspectors identified a finding of very low safety significance because the work order for preventive maintenance on the 10 Bus transformer load tap changer was deficient, in that, it did not address the impact on operations as required by Exelon procedures. This led to unplanned inoperability of the offsite power source. This finding was determined to be of very low safety significance by the Reactor Inspection Findings for At-Power Situations Significance Determination Process because it did not result in an actual loss of safety function of a system or train, and it did not screen as risk significant due to a seismic, fire, flooding, or severe weather initiating event. Inspection Report# : 2002006(pdf)



Significance: Nov 04, 2002 Identified By: NRC Item Type: FIN Finding **Post Maintenance Testing**

The inspectors identified a finding of very low safety significance, because Exelon maintenance personnel did not follow the work order for conducting preventive maintenance on the feedwater control system. Consequently, a wire that was disconnected during the activity was improperly restored, which disabled the setpoint setdown function of the feedwater control system. The wiring error led to a post-scram high reactor level and a trip of the reactor feed pumps, which caused the loss of the power conversion system function following the scram. This finding involved a human performance error by the maintenance technician because he did not restore the setpoint setdown function to service in a manner specified by the maintenance work order.

This finding was determined to have very low safety significance using a Phase 3 analysis. (Section 1R19)

Inspection Report# : 2002005(pdf)



Identified By: NRC Item Type: FIN Finding

Unit 1 "A" Reactor Feed Pump Discharge Valve Breaker

The inspectors identified a finding of very low safety significance, because Exelon maintenance technicians did not follow maintenance procedures and improperly assembled the Unit 1 "A" reactor feed pump discharge valve breaker during preventive maintenance activities. Consequently, the breaker did not properly respond and its associated feed pump discharge valve could not be closed when demanded by control room operators during post-scram feedwater system manipulations. This complicated the operators' ability to control the reactor level while performing post-scram emergency operating procedures. This finding involved a human performance error because maintenance technicians did not assemble the breaker in the manner specified by the maintenance procedure.

This finding was determined to be of very low safety significance by the Reactor Inspection Findings for At-Power Situations Significance Determination Process because it did not result in an actual loss of safety function of a non-Technical Specification Train of equipment for greater than 24 hours, and it did not screen as risk significant due to a seismic, fire, flooding, or severe weather initiating event. (Section 1R12) Inspection Report# : 2002005(pdf)

Barrier Integrity

Significance: Sep 27, 2003 Identified By: NRC Item Type: NCV NonCited Violation

Did Not Meet 10CFR 55.53(fg)(2) When Reactivating Senior Operators to Support Fuel Handling

The inspectors identified a non-cited violation of 10CFR55.53(f)(2) regarding the licensee's method used to reactivate senior operator licenses to support refueling. The operator licenses were reactivated without the required direct supervision being present during the shift under-instruction time.

This finding was determined to be more than minor but of very low safety significance. It is more than minor because it is similar to example 2h in App. E of IMC 0612. The performance deficiency is related to operator license conditions. The performance deficiency involved more than 20% of the senior operator license reactivations to support refueling operations not meeting the requirements of 10CFR55.53(f)(2). Accordingly, the performance deficiency was determined to be of very low safety significance.

Inspection Report# : <u>2003004</u>(*pdf*)

Significance: Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Performed Core Alterations Without Maintaining Secondary Containment Integrity

A self-revealing NCV of TS 3.6.5.1.2 was identified because Exelon did not maintain refueling area secondary containment integrity while performing core alterations during a refueling outage.

The finding is more than minor because the issue was associated with the human performance attribute of the Barrier Integrity cornerstone, and it affected the cornerstone objective. The Barrier Integrity cornerstone objective was affected because secondary containment functionality was not maintained when required by TSs. This finding was determined

to be of very low safety significance (Green) by NRC IMC 0609, App. G, Shutdown Operations Significance Determination Process. The plant conditions while secondary containment was breached did not require a phase 2 assessment and therefore screened as Green per the Appendix G, Section 1 guidance.

The inspectors also noted that a contributing cause of this finding was related to a human performance error because operators did not properly verify TSs compliance when breaching secondary containment. Inspection Report# : 2003004(pdf)



Significance: Jun 28, 2003

Identified By: NRC Item Type: NCV NonCited Violation

Exelon's Main Steam Isolation Valve Stroke Time Test Methodology

The inspectors identified a finding of very low significance (Green) that is also a violation of 10 CFR 50 Appendix B, Criterion XI, "Test Control," because Exelon's MSIV stroke time test procedure did not include sufficient steps to assure that, when the MSIVs are in-service in Operational Conditions 1, the MSIV full closure times will meet TS requirements.

The finding was considered more than minor, in that the issue was associated with the Maintain Functionality of Containment Procedure Quality attribute of the Barrier Integrity cornerstone, and it affected the cornerstone objective. The Barrier Integrity cornerstone objective was affected because the inadequate testing procedures adversely affect assurance that the containment would protect the public from radionuclide releases caused by accidents or events. This finding was also associated with the Procedure Quality attribute of the Mitigating Systems cornerstone, and it affected the cornerstone objective. The cornerstone objective was affected because the testing did not ensure the reliability of the MSIV's to respond to initiating events to prevent undesirable consequences.

This finding was determined to have very low safety significance (Green) by Phase 2 of the Reactor Inspection Findings for At-Power Situations Significance Determination Process. This finding was determined to be of very low safety significance because the issue involved inadequate testing and did not degrade the MSIVs capability to perform its safety function. Therefore, no mitigation equipment or sequences in Phase 2 were adversely impacted. Inspection Report# : 2003003(pdf)

Significance: Mar 29, 2003

Identified By: NRC Item Type: FIN Finding

Main Steam Isolation Valve Surveillance Test Preconditioning

The inspectors identified a finding of very low significance (Green) because Exelon's practice of performing preventative maintenance prior to required surveillance testing of the MSIVs masked the as-found conditions of the valves and this practice had not been evaluated by Exelon.

This finding was determined to be of very low safety significance because the issue involved inadequate testing and did not degrade the MSIVs capability to perform its safety function. (Section 1R22) Inspection Report# : 2003002(pdf)

Emergency Preparedness

Significance: SL-IV Sep 27, 2003 Identified By: NRC Item Type: NCV NonCited Violation

Did Not Perform a 10 CFR 50.54(q) Review Resulting in Removal of a Provision Without Prior NRC Approval

The inspector identified a SL IV NCV of 10 CFR 50.54(q) because the licensee decreased the effectiveness of its emergency plan in one area by removing a provision to provide volunteer bus drivers to two school districts within the 10 mile Emergency Planning Zone for evacuating students during a radiological event. The change was implemented without NRC approval.

Changing emergency plan provisions without prior NRC approval impacts the NRC's ability to perform its regulatory function and is therefore processed through traditional enforcement as specified in Section IV.A.3 of the Enforcement Policy, issued May 1, 2000 (65 FR 25388). According to Supplement VIII of the Enforcement Policy, this finding was determined to be a SL IV violation because it involved a failure to meet a requirement not directly related to assessment and notification. This NCV was also determined to have very low safety significance since Exelon had maintained a list of volunteers that would have been able to perform the function if needed.

Inspection Report# : <u>2003004</u>(*pdf*)

Significance: SL-IV Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Did Not Retain a Record of the 10 CFR 50.54(q) Review of the Deleted Portions of the Emergency Plan

The inspector identified a SL IV non-cited violation of 10 CFR 50.54(q). During the implementation of a new Standard Emergency Plan, Exelon did not retain a record that determined whether a decrease-in-effectiveness had or had not occurred when Exelon generated the new Standard Emergency Plan that deleted portions of the previous Combined Limerick/Peach Bottom Emergency Plan.

Changing emergency plan provisions without documentation impacts the NRC's ability to perform its regulatory function and is therefore processed through traditional enforcement as specified in Section IV.A.3 of the Enforcement Policy, issued May 1, 2000 (65 FR 25388). According to Supplement VIII of the Enforcement Policy, this finding was determined to be a SLI IV because it involved a failure to meet a requirement not directly related to assessment and notification.

Inspection Report# : 2003004(pdf)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : December 01, 2003