Harris 1
2Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2006
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Follow Procedure During Service Water Control Valve Preventive Maintenance
A Green self-revealing NCV of Technical Specification (TS) 6.8.1 was identified for the failure to follow procedures while performing maintenance on a service water valve which supports the train "A" essential services chilled water (ESCW) system chiller. This deficiency led to the valve actuator disconnecting from the valve, and rendered the train "A" ESCW system chiller inoperable. The licensee entered this failure to follow procedure into the Corrective Action Program (CAP).

This finding is more than minor because it affected the reliability objective of the equipment performance attribute under the Mitigating Systems Cornerstone in that it affected the mitigating availability of the train "A" ESCW chiller. This finding was determined to be of very low safety significance (Green) because it did not represent a loss of system safety function, the single train of the ESCW system affected did not lose functionality for greater than the TS allowed outage time, and the finding was not potentially risk-significant due to external events. This finding is associated with the cross-cutting area of human performance because maintenance personnel improperly executed plant procedures. (Section 1R15)

Inspection Report# : 2006003*(pdf)*

Significance: TBD Jun 30, 2006
Identified By: Self-Revealing
Item Type: AV Apparent Violation
Failure to Maintain Adequate Procedures Such That a Required Torque Was Not Provided for a Threaded Fastener on an ESCW System Chiller
A self-revealing AV was identified for the failure to maintain adequate procedures for the performance of maintenance on the ESCW system chillers. Specifically, procedures lacked sufficient details to perform maintenance on the chiller's pre-rotational vane actuator. This deficiency led to the train "A" ESCW system chiller being incapable of starting and inoperable for a period of time greater than allowed by the TS.

This issue is more than minor because it affected the reliability objective of the equipment performance attribute under the Mitigating Systems Cornerstone in that it affected the mitigating availability of the train "A"ESCW chiller. The finding was determined to have potential safety significance greater than very low because of the resultant reduced functional capability of the ESCW system to mitigate events, and the length of time the condition existed. This significance of this AV will remain indeterminate pending completion of the significance determination process. A contributing cause of this issue is associated with the cross-cutting area of human performance, in that the maintenance organization did not generate specific, written procedures to perform ESCW maintenance. (Section 1R15)

Inspection Report# : 2006003*(pdf)*

Significance: G Sep 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Adequate ESCW Design Change
Green. An NRC-identified non-cited violation of 10CFR50, Appendix B, Criterion III, "Design Control" was identified for failure to ensure that adequate design control measures were implemented on an ESCW system design change (Engineering Change 51444). The inadequate design change resulted in both trains of the essential services chilled water (ESCW) system being inoperable for a period of time greater than allowed in Technical Specification 3.7.13. The ESCW system was inoperable because check valves were installed in the service air supply lines to the expansion tanks which were incapable of maintaining expansion tank pressure upon loss of the non-safety service air system pressure. The inadequate design change of the ESCW system is more than minor because it affects the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). The finding is also associated with the Mitigating Systems Cornerstone attribute of design control. The significance determination process (SDP) of NRC Inspection Manual Chapter 0609, Appendix A was used to determine the safety significance of the finding. Since the degradation of the ESCW system represented a loss of system safety function, a Phase 2 SDP analysis was required. The Phase 2 SDP analysis determined that the significance of the finding was potentially greater than green because the degradation of the ESCW system existed for more than 30 days, and the

ESCW system is a support system for the high head safety injection (HHSI) system, which affects several core damage sequences. Therefore, a Phase 3 evaluation for the finding was performed. Based upon data which showed that the chillers' check valves leaked at a low enough rate that the chillers would operate for at least 24 hours before causing loss of function of the systems they support, the finding was considered to have very low safety significance. The cause of the finding is related to the organization aspect of the human performance cross-cutting area. Specifically, the engineering organization's lack of understanding of design control requirements with regard to manual actions led to implementation of the inadequate ESCW system modification.
Inspection Report# : 2005004*(pdf)*

Significance: G Jul 01, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROMPTLY CORRECT CONDITION ADVERSE TO QUALITY AFFECTING EDGs
Green. The inspectors identified a non-cited violation of 10 CFR 50 Appendix B Criterion XVI for failure to promptly correct a condition adverse to quality related to operational indicator lights on the emergency diesel generator (EDG) local engine control panel. The approved modification to fix the condition has been rescheduled five times. Indicator light changeout has resulted in several trips of EDG dc control power breakers, causing partial loss of dc control power to the effected EDG. In February 2005, an EDG pneumatic control system problem was identified that compounded the effect on the EDGs from the indicator light changeout problem.

The issue is greater than minor because it affected the equipment performance attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding was determined to be of very low safety significance because it involved a design deficiency which did not result in a loss of function. The two degraded conditions, the indicator light changeout problem and the EDG pneumatic control system problem, combined to increase the likelihood of an EDG failure. The cause of this finding is identified as a performance aspect of the problem identification and resolution cross-cutting area, in that the failure to promptly correct the light changeout problem resulted in additional partial losses of EDG control power.
Inspection Report# : 2005006*(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: G Sep 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain an Acceptable Program for Periodic Calibration of Emergency Plan ARMs in Accordance with 10CFR20.1101
Green. An NRC-identified non-cited violation of 10 CFR 20.1101 was identified for failure to maintain an acceptable program for periodic calibration of Area Radiation Monitor (ARM) detectors as required by 10 CFR 20.1501(b). For seven ARM detectors that are referenced in the Emergency Plan, the licensee eliminated the periodic calibrations and designated the equipment as ‘run to failure'.

The identified issue is more than minor in that the failure of the specific ARM equipment could impair licensee actions to support emergency response activities. This finding involving radiological monitoring is related to the Emergency Preparedness Cornerstone. The change from a periodic calibration frequency to no calibration frequency (i.e. ‘run-to-failure') would not ensure that equipment and instrumentation needed to support emergency response activities were being properly maintained. This finding was evaluated using the Emergency Preparedness SDP and was determined to be of very low safety significance based on the identified ARM detectors still being within the calibration frequency that was previously established.
Inspection Report# : 2005004*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Jul 01, 2005
Identified By: NRC
Item Type: FIN Finding
IDENTIFICATION AND RESOLUTION OF PROBLEMS
The inspectors determined that the licensee was effective in identifying problems and entering them into the CAP. The threshold for problem evaluation was low based on observed samples, independent walkdowns and staff interviews. The inspectors determined that the licensee properly prioritized issues and performed evaluations that were technically accurate and sufficiently detailed. Formal root cause evaluations were thorough and well documented. One example was noted where a safe shutdown molded case circuit breaker failure was not evaluated for potentially generic concerns. Corrective action implementation was generally timely, effective and appropriate to the problem. In the sample reviewed, the inspectors noted frequent investigation extensions and several examples where corrective action timeliness goals were not met, which was consistent with observations within the last licensee Self Evaluation Unit program assessment. The vendor quality initiative and modification timeliness initiative were examples where detailed self-critical evaluation identified improvements to CAP implementation problems. Management emphasized the need for staff to identify and resolve issues using the CAP. A safety conscious work environment was evident.

Inspection Report# : 2005006*(pdf)*

Last modified : August 25, 2006