Monticello

Initiating Events

Significance: N/A Sep 30, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
HOT SHORTS, OPEN CIRCUITS, OR SHORTS TO GROUND IN THE ASSOCIATED CIRCUITS MAY PREVENT OPERATION OF SAFE SHUTDOWN EQUIPMENT.
One violation of very low significance identified by the licensee has been reviewed by the inspectors. Corrective actions taken or planned by the licensee appear reasonable.
Inspection Report# : 2001008*(pdf)*

Significance: G Aug 14, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
DESIGN CONTROL ISSUE ASSOCIATED WITH TURBINE BUILDING HELB BARRIER WALLS.
The inspectors reviewed a licensee event report (LER) which discussed inadequate high energy line break (HELB) barrier walls in the plant turbine building. The lack of proper design control for these walls constituted a Non-Cited Violation (NCV) of 10 CFR, Part 50, Appendix "B" requirements. This finding was of very low safety significance because of the low probability associated with the postulated HELB event and consequential failures of both divisions of essential 480 Vac power.
Inspection Report# : 2001007*(pdf)*

Significance: G May 30, 2001
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW ESTABLISHED PROCEDURES.
On May 9, 2001, the inspectors reviewed plant operations' response to an unplanned power reduction to approximately 55 percent reactor power, which resulted from the inadvertent isolation of a condensate demineralizer. The failure of an operator to perform "manual air surge backwash" was determined to be a failure to follow procedures in accordance with Technical Specification 6.5. and a Non-Cited Violation was issued. This finding was of very low safety significance because of the availability of sufficient mitigating systems, and operator action could be credited for mitigating the event.
Inspection Report# : 2001005*(pdf)*

Mitigating Systems

Significance: G Jun 21, 2002
Identified By: NRC
Item Type: NCV NonCited Violation

Failure to Meet the Separation Criteria for Redundant Cabling and Equipment in Fire Zone 12A, Intake Structure Pump Room
The inspectors identified a NCV of 10 CFR Part 50, Appendix R, Section III.G.2 associated with a failure to protect redundant trains of equipment and cabling in the intake structure area. Specifically, the inspectors identified the presence of intervening combustible between two trains of Emergency Service Water (ESW) system. The two trains were separated by more than 20 feet and the fire area contained detection and suppression capabilities. This finding was determined to be more than minor because it affected the mitigating system cornerstone objective. This finding was evaluated using the SDP and determined to be Green. Because the finding was of very low safety significance, and was captured in the licensee's corrective action system, this finding is being treated as a NCV consistent with Section VI.A.1 of the NRC Enforcement Policy.
Inspection Report# : 2002011*(pdf)*

Significance: G Jun 21, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Procedures C.4-b-8.5.A, "Plant Fire," C.4-C, "Shutdown Outside the Control Room," and Other Related Procedures Associated with Responding to a Plant Fire Were Not Appropriate to the Circumstances.
The inspectors identified a NCV of 10 CFR Part 50, Appendix B, Criterion V associated with a failure to ensure that some operations procedures were appropriate to the circumstances. Specifically, the inspectors determined that some operations procedures did not clearly identify the minimum set of actions necessary to ensure a safe shutdown of the reactor, following a fire, and ensure that adequate emergency lighting and communications were available to support those operator actions. This finding was determined to be more than minor because it could reasonably be viewed as a precursor to a significant event where required operator actions may not be accomplished in a timely manner due to inadequate operations procedures, and a lack of emergency lights and radios. Using the IMC 0609, Appendix F, this finding is characterized as Green because it did not affect detection, manual suppression capability, automatic suppression capability, fire barriers, or 20-foot separation.
Inspection Report# : 2002011*(pdf)*

Significance: G Jun 21, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain Full Area Detector Coverage in Zones 12A, 14A, 13B, 19A, and 19B.
The inspectors identified a NCV of 10 CFR 50.48 associated with inadequate fire detection capabilities in serval fire areas. Specifically, the inspectors identified inadequate number and spacing of smoke detectors in two 4160-volt switchgear rooms and inadequate number and spacing of heat activated detectors in the reactor feed pump (RFP) area. This finding was determined to be more than minor because it could reasonably be viewed as a precursor to a significant event where a delay in fire detection in safety related switchgear and RFP areas could result in a more severe fire and render more equipment inoperable. In addition, the finding affected the mitigating system cornerstone objective in that the necessary number of detectors were needed to ensure the reliability, availability, and capability of systems that respond to initiating events to prevent undesirable consequences. Since the finding did not affect the 3-hour fire barrier separating redundant safe shutdown functions (IMC 0609, Appendix F, Figure 4-5), this finding was characterized as Green.
Inspection Report# : 2002011*(pdf)*

Significance: G Jun 21, 2002
Identified By: NRC
Item Type: NCV NonCited Violation

Failure to maintain Complete Sprinkler Coverage in Fire Zones 13A and 13B.
The inspectors identified a NCV of 10 CFR 50.48 associated with inadequate fire suppression capabilities in several fire zones. Specifically, the inspectors determined that the sprinkler systems in fire zones 13A and 13B did not provide complete coverage of the areas. This finding was determined to be more than minor because it can be reasonably viewed as a precursor to a significant event where an uncontrolled fire in these areas could spread and potentially cause damage to the redundant trains of safe shutdown equipment in other fire zones. Since the finding did not affect the 3-hour fire barrier separating redundant safe shutdown functions (IMC 0609, Appendix F, Figure 4-5), this finding is Green.
Inspection Report# : 2002011*(pdf)*

Significance:  Jun 21, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Enter Conditions Adverse to Quality into the Corrective Action Program and to Correct Conditions Adverse to Quality.
The inspectors identified a Green NCV of 10 CFR Part 50, Appendix B, Criterion XVI, associated with a failure to document conditions adverse to quality in the corrective action program and a failure to resolve several fire protection-related conditions adverse to quality entered into the corrective action program. Specifically, some findings, developed as a part of an internal self-assessment, were not entered into the corrective action program and other conditions adverse to quality, associated with transfer of fire protection requirements out of the Technical Specifications and inspection findings, were not corrected. This finding is more than minor because if left uncorrected, the finding would become a more significant safety concern. Failure to enter fire protection non-compliance items and failure to resolve the items entered into the corrective actions program could potentially affect the availability, reliability, and capability of fire protection safe shutdown equipment and response efforts. This finding is not suitable for SDP analysis. However, the inspectors determined that this finding was of very low significance (Green) because each associated performance deficiency, identified during this inspection, was of very low significance. Therefore, the finding was characterized as Green.
Inspection Report# : 2002011*(pdf)*

Significance: SL-IV Jun 21, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform Written Safety Evaluations and Sumit a Summary to the NRC for Changes Made to the FPP, FHA, and SSA from 1984 to 2001.
The inspectors identified a Severity Level IV NCV of 10 CFR 50.59 associated with a failure to control and maintain changes made to the fire protection program (FPP) since 1984. Because violations of 10 CFR 50.59 are considered to be violations that could potentially impede or impact the regulatory process, they are dispositioned using the traditional enforcement process instead of the SDP. Since the SDP is not designed to assess the significance of violations that could potentially impact or impede the regulatory process, the "results of a 10 CFR 50.59 violation" are assessed using the SDP and the severity level of the 10 CFR 50.59 violation is then based on this significance determination. In this case, the licensee's failure to control and evaluate changes to components of the FPP resulted in the implementation of the program in a manner different then approved by the NRC, as documented in relevant Safety Evaluation Reports (SERs). Examples of these differences are presented in other sections of this report. The inspectors concluded that the issue had a credible impact on safety because the licensee's failure to control and evaluate changes to the FPP could adversely affect the reliability, capability, and availability of safe shutdown capabilities, as discussed in the other sections of this report. However, based upon a review of the current plant configuration and an assessment of the impacts of the examples discussed in this report, the inspectors determined that the licensee's failure to properly control and evaluate changes to be of very low safety significance. Therefore, the issue was determined to be of very low safety significance, i.e., a Green finding.

Inspection Report# : 2002011*(pdf)*

Significance: G May 04, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE DEBRIS CONTROL IN ECCS CORNER ROOMS CHALLENGES INTERNAL FLOODING ANALYSIS.
Inspectors identified debris in the emergency core cooling system (ECCS) corner rooms which potentially could have had an adverse effect on installed flood protection equipment during an internal flooding event. The lack of adequate debris control procedures and instructions was determined to be a Non-Cited Violation (NCV) of Criterion V, 10 CFR 50, Appendix B. The finding was determined to be of very low safety significance and within the licensee's response band due to the very low risk associated with the event that was identified during a case specific Phase 3 SDP.
Inspection Report# : 2002004*(pdf)*

Significance: G Nov 26, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE TEST PROCEDURE FOR LPCI 5 MINUTE TIMER BYPASS SWITCH MODIFICATION.
The inspectors reviewed the preoperational test for the Division II Low Pressure Core Injection 5 Minute Timer Bypass Modification. During the testing evolution, an error associated with a jumper bypass in the test procedure resulted in the loss of shutdown cooling to the reactor vessel. The failure of the licensee to adequately provide procedural controls for this test jumper bypass is contrary to the requirements of Regulatory Guide 1.33, Revision 2, Appendix A, and constitutes a Non-Cited Violation of Technical Specification 6.5.A.1. The finding was of very low safety significance because of the low decay heat load present in the reactor and the licensee's ability to manually recover shutdown cooling in a short period of time.
Inspection Report# : 2001010*(pdf)*

Significance: G Nov 16, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
TECHNICAL SPECIFICATION SURVEILLANCE TEST REQUIREMENTS NOT MET.
The team identified an example of inadequate corrective action for surveillance test procedures failing to meet Technical Specification (TS) requirements. One Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," was identified. The issue was of very low safety significance since there was no current apparent impact on operability of the affected safety systems.
Inspection Report# : 2001016*(pdf)*

Significance: G Oct 24, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
INADVERTENT REACTOR VESSEL PARTIAL DEPRESSURIZATION.
The team identified that operator actions in the inadvertent venting of the reactor while in hot shutdown conditions due to deficient procedure constituted a significant human performance error. The issue was of very low safety significance since the actual impact on plant safety was minimal.
Inspection Report# : 2001016*(pdf)*

Significance: G Oct 23, 2001
Identified By: NRC
Item Type: FIN Finding
SCRAM RESPONSE COMPLICATED BY LOCK UP OF BOTH FEEDWATER REGULATING VAVLES.
The inspectors monitored the licensee's response to an inadvertent reactor scram which occurred on October 23, 2001. The lock up of both feedwater regulating valves in the fully open position complicated operating crew response to the scram. The finding was of very low safety significance because the impact on the operating crew was minimal, and operator action was available to restore system functions.
Inspection Report# : 2001009*(pdf)*

Significance: G Oct 01, 2001
Identified By: NRC
Item Type: FIN Finding
INADEQUATE POST-MAINTENANCE TESTING FOLLOWING CIRCUIT BREAKER OVERHAUL.
The inspectors reviewed licensee post-maintenance testing activities associated with restoration of a 480 Vac load center supply breaker following a 10-year overhaul. This finding was of very low safety significance because the loss of function of the No. 13 diesel generator was of a short duration.
Inspection Report# : 2001009*(pdf)*

Significance: G Sep 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ESTABLISH PROCEDURAL GUIDANCE TO PREVENT THE ALLOWABLE ACCUMULATION OF WATER ALLOWED BETWEEN THE DIESEL GENERATOR BUILDING AND AN ERECTED BERM.
The inspectors identified a procedure deficiency for mitigation of flooding events. Licensee procedures related to flooding failed to establish a maximum allowable level of water accumulation between an erected berm and emergency diesel generator buildings. Excessive accumulation of water would cause hydraulic lift of the floor causing failure of the associated diesel generator. The lack of procedural controls to adequately respond to flooding of the emergency diesel generator constituted a Non-Cited Violation of 10 CFR, Part 50, Appendix B, Criterion V, "Instruction, Procedures and Drawings." These findings were of very low safety significance because of the low probability of occurrence of a flooding event that would rise to the elevation required to cause hydraulic lift of the emergency diesel generator floor.
Inspection Report# : 2001008*(pdf)*

Significance: G Aug 03, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to include actions in operating procedures to ensure that design basis requirements were not exceeded
Design calculation CA-97-157, indicated that the residual heat removal (RHR) pump rooms would exceed the environmental qualification (EQ) design basis temperature limit of 140 degrees Fahrenheit for the RHR pumps following a loss of coolant accident (LOCA) if two RHR pumps continued to run more than 25.7 hours. There was no operating procedure requiring the shutdown of one pump prior to exceeding the 25.7 hour limit.
Inspection Report# : 2001015*(pdf)*

Significance: G May 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FIRE PROTECTION ADMINISTRATIVE CONTROLS.
The inspectors identified a room in Fire Zone 3-B, adjacent to safety-related switchgear and the standby liquid control system, that did not have fire detection or suppression equipment and contained a significant amount of transient combustibles. The lack of fire protection administrative controls constituted a Non-Cited Violation of 10 CFR, Part 50, Appendix "R" requirements. This finding was of very low safety significance because a fire in this room would affect only one safe shutdown train, and did not impact the 3-hour fire barrier between safe shutdown trains.
Inspection Report# : 2001005*(pdf)*

Significance: G Mar 01, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE PROCEDURE FOR SCRAM DISCHARGE VOLUME LEVEL CALIBRATION.
During observation of an instrument calibration, the inspectors identified that licensee procedures for calibration of the reactor SCRAM discharge volume high level instruments were inadequate in that they did not require verification of proper valve alignment after calibration of individual instruments. The failure to include the verification requirement in the procedure was considered a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." This finding was determined to have very low safety significance because verification of the position of the valves after all individual instruments were calibrated confirmed that they were properly aligned. This problem was reported to the NRC in Licensee Event Report 2001-001.
Inspection Report# : 2001011*(pdf)*

Significance: G Jan 19, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
INOPERABLE SNUBBERS NOT DECLARED INOPERABLE AS REQUIRED BY TECHNICAL SPECIFICATIONS.
On January 19, 2001, the licensee identified that they were not in compliance with the ASME Boiler & Pressure Vessel Code, Section XI, 1986 Edition. The licensee determined that they had failed to involve the Authorized Nuclear Inservice Inspector (ANII) in repair and replacement activities for safety-related snubbers. One noncited violation was identified against Technical Specification 3.6.H.2.c for failure to take actions required by the technical specifications for inoperable snubbers. In addition, two non-cited violations were identified for failure to report via 10 CFR 50.72 and for the failure to follow procedures in accordance with Technical Specification 6.5. Later, on January 24, the licensee determined that a plant shutdown was required by Technical Specifications. The risk significance of this finding was determined to be very low because the licensee was able to determine through engineering evaluations that the as-found condition of the snubbers had no adverse effect on the supported components and that they would retain their structural integrity in the event of a design basis seismic event. (Section 1R14.2)
Inspection Report# : 2001002*(pdf)*

Significance: G Jan 19, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO MAKE NOTIFICATIONS AS REQUIRED BY 10 CFR 50.72.

Comments listed under NCV 50-263/01-02-01.
Inspection Report# : 2001002*(pdf)*

Significance: G Jan 19, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW ESTABLISHED PROCEDURES FOR SURVEILLANCE AND TESTING AS REQUIRED BY TECHNICAL SPECIFICATIONS.
Comments listed under NCV 50-263/01-02-01.
Inspection Report# : 2001002*(pdf)*

Significance: N/A Nov 17, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to perform a 10 CFR 50.59 screening or evaluation for USAR changes made in accordance with 10 CFR 50.68
No color. The licensee failed to follow the station procedure requirements for preparing a 10 CFR 50.59 screening or evaluation for Updated Safety Analysis Report (USAR) changes that resulted from implementation of criticality accident controls in accordance with 10 CFR 50.68. This is considered a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V. This violation was identified by the NRC and promptly entered by the licensee into the corrective action program as Condition Report 20004536. There was no significant impact to the cornerstone because the licensee's Safety Review Item evaluation ensured that criticality accident monitoring requirements were met by demonstrating full compliance with 10 CFR 50.68. Changes to the USAR necessitated by the Safety Review Item were required to be made in accordance with 10 CFR 50.59, but were not.
Inspection Report# : 2000017*(pdf)*

Significance: N/A Nov 17, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to peform an adequate 10 CFR 50.59 evaluation for modification of interlock circuits described in the USAR
No color. The licensee failed to follow station procedure requirements for preparing a 10 CFR 50.59 evaluation that resulted from a modification that bypassed the Emergency Core Cooling System load shed trip/lockout signal to the Residual Heat Removal Service Water (RHRSW) pumps following a design basis Loss of Coolant Accident. The evaluation failed to address the appropriateness of bypassing the interlock and the acceptability of deleting the USAR wording which described the interlock. This is considered a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V. This violation was identified by the NRC and promptly entered by the licensee into the corrective action program as Condition Report 20004494. There was no significant impact to the cornerstone because it hypothesized the extremely low probability, simultaneous occurrence of a Loss of Coolant Accident and Loss of Offsite Power. Loss of offsite power, in conjunction with a loss of coolant accident would require load shedding and sequencing, which would trip running RHRSW pumps and necessitate clearing the interlock in order to restart them.
Inspection Report# : 2000017*(pdf)*

Significance: G Aug 15, 2000
Identified By: NRC
Item Type: FIN Finding
COMPENSATORY ACTIONS FOR INACCESSIBLE VALVE.
GREEN. The inspectors identified that the licensee may be unable to implement compensatory actions for operator

workarounds associated with the inboard residual heat removal to waste surge tank valve due to the inaccessibility of plant areas during accident conditions. The risk significance of this issue was determined to be very low because Emergency Operating Procedures provided alternate actions that would be taken in the event that the compensatory actions for valve operation were unsuccessful. The alternate actions would have assured that core cooling would have been maintained.
Inspection Report# : 2000006*(pdf)*

Significance: G Jun 07, 2000
Identified By: NRC
Item Type: FIN Finding
DESIGN DEFICIENCY IN STANDBY GAS TREATMENT SYSTEM.
GREEN. On February 21, 2000, the licensee identified a design deficiency associated with the Standby Gas Treatment System which would allow a small portion of secondary containment atmosphere to bypass the filter train during an event. The impact on offsite dose due to the additional bypass leakage pathway was determined to be minimal. The risk significance of this issue was very low since the effectiveness of filtration systems during severe accidents was small. The event was documented in Licensee Event Report (LER) 50-263/2000-005.
Inspection Report# : 2000004*(pdf)*

Significance: G Jun 07, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
TIMELY ACTIONS FOR INOPERABLE SECONDARY CONTAINMENT DAMPERS NOT TAKEN.
GREEN. On February 28, 2000, the licensee identified that the previous practice of removing the Standby Gas Treatment System control power impacted the ability of the secondary containment isolation dampers to perform their isolation function. The licensee's failure to understand the interactions between the Standby Gas Treatment System and the secondary containment isolation dampers resulted in the damper's eight-hour limiting condition for operation being exceeded on several occasions. The risk significance of this issue was very low since the effectiveness of secondary containment isolation systems during severe accidents was small. The inspectors identified a noncited violation for failure to comply with the requirements of Technical Specification 3.7.B.1.a.
Inspection Report# : 2000004*(pdf)*

Barrier Integrity

Significance: N/A Feb 13, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
REFUELING TESTING IDENTIFIES CONTAINMENT ISOLATION VALVE LEAKAGE GREATER THAN ALLOWED BY THE TECHNICAL SPECIFICATIONS.
Licensee Identified Violation. See Inspection Report 50-263/02-02(DRP) Section 4OA3.2 and description for closure of LER 50-263/2001-012, "Refueling Testing Identifies Containment Isolation Valve Leakage Greater Than Allowed by the Technical Specifications."
Inspection Report# : 2002002*(pdf)*

Significance: N/A Aug 14, 2001
Identified By: Licensee

Item Type: NCV NonCited Violation
FAILURE TO REMOVE TORUS BELLOWS SHIPPING BOLTS.
Violations of very low significance identified by the licensee have been reviewed by the inspectors. Corrective actions taken or planned by the licensee appear reasonable.
Inspection Report# : 2001007*(pdf)*

Significance: G Mar 01, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CORRECTIVE ACTIONS FOR SUSPECT RELAYS.
Corrective actions for an earlier problem with some Struthers-Dunn relays were not effective in preventing a similar failure of a Struthers-Dunn relay in October 2000 that rendered a train of the control room ventilation system inoperable. The failure to take effective corrective actions for the earlier event was determined to be a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." This finding was determined to have very low safety significance because the other train of control room ventilation remained operable. The problem with the relay in October 2000 was documented in Licensee Event Report 2000-015.
Inspection Report# : 2001011*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Mar 14, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
RADIATION WORKER VIOLATED RADIATION WORK PERMIT REQUIREMENTS.
The inspector reviewed incidents related to access control deficiencies and radiation worker practices. During an on-the-job training tour of vital areas, workers failed to follow the requirements of the radiation work permit resulting in a small unintended dose. The failure of the workers to follow licensee procedures constitutes a Non-Cited Violation of Technical Specification 6.5.1. The finding was of very low safety significance as the event did not involve an overexposure or a substantial potential for an overexposure and did not compromise the licensee's ability to assess personnel dose.
Inspection Report# : 2002003*(pdf)*

Public Radiation Safety

Physical Protection

Significance: G Jun 12, 2000
Identified By: NRC
Item Type: FIN Finding
COMPUTER ACCESS LEVELS COULD ALLOW BADGE DATA CHANGE WITHOUT VALIDATION.
GREEN. Several security supervisors or staff had computer access levels that could allow badge data to be changed, or badges to be fabricated and activated, without another individual validating the accuracy of the data. This situation could have allowed a single individual to bypass some security controls.
Inspection Report# : 2000012*(pdf)*

Significance: G Jun 12, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
UNTIMELY ACTIONS BY SUPERVISOR FOR FFD ISSUE.
GREEN. The inspector identified a Non-Cited Violation [of 10 CFR 26.24(3) and the licensee's fitness for duty Guideline No. 1] for failure of a supervisor to take timely action on a Fitness-For-Duty Issue. A licensee supervisor received information from an employee that the odor of alcohol was detected on another employee. The supervisor took no further action to evaluate the situation until 1 and ½ hours after receiving the information.
Inspection Report# : 2000012*(pdf)*

Miscellaneous

Significance: G Aug 14, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW TECHNICAL SPECIFICATIONS RELATING TO THE INSERVICE TESTING OF ECCS CHECK VALVES.
The inspectors reviewed a LER associated with a February 24, 2001, plant shutdown and cooldown to cold shutdown required by Technical Specifications (TS). The licensee identified multiple check valves in various safety-related systems which had been inadequately tested, rendering the associated systems or system trains inoperable. The failure to perform appropriate check valve testing as required was determined to constitute a NCV of the licensee's TS, Section 4.15.B. This finding was of very low safety significance because the licensee's subsequent testing demonstrates that all the components in question would have been capable of performing their safety functions during accident conditions.
Inspection Report# : 2001007*(pdf)*

Significance: G Aug 14, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW TECHNICAL SPECIFICATIONS RELATING TO INSERVICE INSPECTION AND REPLACEMENT OF SRV TOPWORKS.
The inspectors reviewed a LER associated with a January 29, 2001, plant shutdown initiated due to TS. The licensee identified that safety relief valve topworks replacement activities had not been performed in compliance with the ASME Boiler and Pressure Vessel Code, rendering all the safety relief valves (SRV) inoperable. The failure to conduct SRV topworks replacement activities in accordance with the applicable sections of the ASME Boiler and Pressure

Vessel Code was determined to constitute a NCV of the licensee's TS, Section 3.15.A.1. This finding was of very low safety significance because the licensee's subsequent analyses demonstrated that the SRVs would have been capable of performing their safety functions during accident conditions.
Inspection Report# : 2001007*(pdf)*

Significance: N/A Mar 01, 2001
Identified By: NRC
Item Type: FIN Finding
CORRECTIVE ACTION PROGRAM ADEQUATE.
The team identified that the licensee was generally effective at identifying problems and putting them into the corrective action program. A probing series of audits and self-assessments of the corrective action program and oversight by offsite and onsite review groups in the past year have resulted in the implementation of many program improvements and the planning of additional changes for the near future. These enhancements included strengthened procedural guidance, standardization of root cause evaluations, increased accountability for timeliness goals, and earlier involvement of licensed operators in the initial evaluation of equipment concerns. Notwithstanding these implemented and planned improvements, the team and NRC inspectors conducting reviews of the problem identification and resolution process as part of the routine baseline inspection program, have continued to identify examples of inadequate problem identification and evaluation, untimely problem evaluation and resolution, and ineffective corrective actions. The inspectors did not find any reluctance by station employees to raise safety concerns.
Inspection Report# : 2001011*(pdf)*

Significance: N/A Nov 01, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
SRO OPERATING WITHOUT 10 CFR 55 LICENSE
An individual was found to be directing control room licensed operators with an expired senior reactor operator license.
Inspection Report# : 2000018*(pdf)*

Last modified : August 29, 2002