

Byron 1

Initiating Events

Mitigating Systems



Significance: Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

ADEQUATE ACCEPTANCE CRITERIA FOR GENERIC LETTER 89-13 HEAT EXCHANGER INSPECTIONS

The inspectors identified a finding of very low safety significance regarding inadequate acceptance criteria for the licensee's Generic Letter 89-13 heat exchanger inspections. The inspectors identified this issue during observations and review of the licensee's inspection of an auxiliary feedwater system heat exchanger. The finding was more than minor because it adversely affected the licensee's ability to ensure that safety-related heat exchangers would be available, reliable, and capable of responding to initiating events to prevent undesirable consequences. The finding was very low safety significance because the as-found and as-left conditions of the heat exchangers did not reveal any actual concerns with the operability of the heat exchangers. This was determined to be a Non-Cited Violation of 10 CFR 50 Appendix B, Criteria V.

Inspection Report# : [2002006\(pdf\)](#)

Significance: SL-IV Jun 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE 50.59 EVALUATION RESULTED IN THE CCW SYSTEM NOT MEETING SINGLE FAILURE CRITERIA FOR A THERMAL BARRIER HEAT EXCHANGER RUPTURE EVENT

The inspectors identified a Severity Level IV Non-Cited Violation. In July 1998, the licensee implemented a change to the Updated Final Safety Analysis Report (UFSAR) that involved an unreviewed safety question and for which prior NRC approval was not obtained per the requirements of 10 CFR 50.59 in effect at the time. Specifically, the licensee changed the UFSAR and failed to adequately evaluate: 1) an elimination of performance requirements for valve 1/2CC-9438 associated with isolation of a loss of coolant accident following a thermal barrier heat exchanger rupture; 2) a decrease in the number, from two to one, of valves in the component cooling water return line that were relied upon to meet the performance requirements of General Design Criteria 44 and 54, and; 3) a substitution of operator manual actions for a remote manual valve closure. This change to the facility, as described in the UFSAR, created the possibility for a new accident not previously evaluated in the UFSAR. Because the Significance Determination Process (SDP) is not designed to assess the significance of violations that potentially impact or impede the regulatory process, this issue was dispositioned using the traditional enforcement process in accordance with Section IV of the NRC Enforcement Policy. However, the results of the violation, that is, the elimination of performance requirements for one of two valves relied upon to isolate a loss of coolant accident involving a thermal barrier heat exchanger rupture, were assessed using the SDP. The severity level of the violation was then based upon the SDP assessment for the results of the violation. The results of the violation were considered to have more than minor safety significance, in that, the results of the violation had a credible impact on safety by affecting the operability, availability, reliability, or functioning of the component cooling water system. However, the results of the violation did not cause a loss of function of the component cooling water system per the guidance of Generic Letter 91-18, "Resolution of Degraded and Non-Conforming Conditions." Therefore, the results of the violation were determined to be of very low safety significance, a Green finding, and the violation of 10 CFR 50.59 was classified as a Severity Level IV violation. Because this non-willful violation was non-repetitive, and was captured in the licensee's corrective action program, this issue is being treated as a Non-Cited Violation, consistent with the NRC Enforcement Policy.

Inspection Report# : [2002005\(pdf\)](#)



Significance: Mar 31, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO ASSESS AND MANAGE THE RISK ASSOCIATED WITH THE SAFETY INJECTION COMMON HEADER WELDING ACTIVITY

The inspectors identified(self-revealing) that the licensee failed to perform a maintenance risk assessment prior to performing a maintenance activity on the common suction header for the Unit 1 SI pumps. This finding was determined to be of very low safety significance because the failure did not result in the actual loss of the safety system function. A Non-Cited Violation of 10 CFR 50.65 (a)(4), for the failure to perform a risk assessment was identified.

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

G**Significance:** Feb 11, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE POST MAINTENANCE TESTING FOLLOWING THE REPLACEMENT OF THE 1B AUXILIARY FEEDWATER PUMP CONTROL SWITCH

The inspectors identified that following the replacement of the 1B auxiliary feedwater pump control switch, the licensee's post maintenance test failed to demonstrate that the pump auto-start feature would perform satisfactorily in service. This finding was determined to be of very low safety significance, because the failure did not result in an actual loss of the safety function of the auxiliary feedwater system. A Non-Cited Violation of 10 CFR 50 Appendix B, Criteria XI, for the failure to perform an adequate post maintenance test was identified.

Inspection Report# : [2002002\(pdf\)](#)

Barrier Integrity

G**Significance:** Sep 30, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

OPERATOR FAILED TO COMMUNICATE ABNORMAL INDICATIONS WHILE ATTEMPTING TO SHUT A PRIMARY SAMPLE SYSTEM CONTAINMENT ISOLATION VALVE

A finding of very low safety significance was identified through a self-revealing event when an operator failed to recognize inappropriate indication of a pressurizer liquid sample line isolation valve and failed to communicate this appropriately to the unit supervisor. The primary cause of this finding was related to the cross-cutting area of Human Performance. This finding was more than minor because it involved misinterpretation of an erroneous valve position indication and the human performance attribute of the Barrier Integrity cornerstone. This finding was very low safety significance because it did not represent a degradation of a radiological barrier and it did not result in an open pathway in the physical integrity of the reactor containment. No violation of USNRC requirements occurred.

Inspection Report# : [2002006\(pdf\)](#)G**Significance:** Mar 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW THE PROCEDURE FOR THE INSTALLATION OF THE 1B STEAM GENERATOR MANWAY COVER

The inspectors identified that the installation of the 1B steam generator hot and cold leg manway covers was not completed in accordance with applicable maintenance procedures. The failure to properly install the steam generator manway covers adversely affected the reactor coolant system integrity. This finding was determined to be of very low safety significance because the failure did not result in an increase in the likelihood of a significant loss of reactor coolant. A Non-Cited Violation of Technical Specification 5.4.1.a, for the failure to follow the maintenance procedure associated with steam generator manway closure installation was identified.

Inspection Report# : [2002003\(pdf\)](#)G**Significance:** Mar 11, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW THE POWER DESCENSION PROCEDURE

The inspectors identified (self-revealed) that the licensee failed to follow Byron General Operating Procedure 100-4, "Power Descension," during the plant shutdown on March 11, 2002, by not placing the steam dump controls in the steam pressure mode prior to tripping the turbine generator, which resulted in an unanticipated lifting of the steam generator power operated relief valves. This finding was determined to be of very low safety significance because the unanticipated lifting of the steam generator power operated relief valve did not result in an actual open pathway in the containment. A Non-Cited Violation of Technical Specification 5.4.1.a, for the failure to follow the procedure was identified.

Inspection Report# : [2002005\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : March 25, 2003