McGuire 2

Initiating Events

Significance: G Mar 23, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Steam Pressure Loop Instrument Test Resulting in Reactor Trip
Licensee Identified Violation of Technical Specification 5.4.1., which requires that written procedures shall be implemented covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Regulatory Guide 1.33 requires procedures for surveillance tests. On July 16, 2001, maintenance technicians failed to follow surveillance procedure IP/2/A/3001/002E and improperly isolated the wrong channel, initiating a Unit 2 reactor trip. This issue was more than minor because it had a actual impact on safety, in that, it initiated a reactor trip. This issue was determined to be of low safety significant because although it did initiate a reactor trip, it did not affect mitigating equipment and the impact of the reactor trip was minimal. This event is in the licensee corrective action program as PIP M-01-3139 (Section 4OA7)
Inspection Report# : 2001005*(pdf)*

Significance: G Mar 23, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadequate Maintenance Procedure Resulted in NC System Leakage Event
Licensee Identified Violation of Technical Specification 5.4.1., which requires that written procedures shall be established covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Regulatory Guide 1.33 requires procedures for maintenance. On January 15, 2002, work procedures for maintenance on valve 1NV414 were performed that did not contain adequate precautions to control plant conditions. This resulted in a Unit 2 reactor coolant system leak. This issue had a credible impact on safety because the leak exceeded TS allowed values. This issue was determined to be of very low safety significance because the source of the leak was promptly isolated by operators, the leak was within the capacity of makeup flow to the VCT, leakage was directed to a boric acid tank, and the leak did not disable any mitigating systems. This issue was entered into the licensee's corrective action program as PIP M-02-0177 (Section 4OA7).
Inspection Report# : 2001005*(pdf)*

Mitigating Systems

Significance: G 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)*

Significance: G Mar 23, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Performance of ECCS Recirculation Sump Inspection (Section 1R20)

A Non-Cited Violation of Technical Specification (TS) 5.4.1.a. was identified for the inadequate performance of a surveillance inspection of the Unit 2 Emergency Core Cooling System (ECCS) sump. The licensee had completed this TS required inspection, but failed to identify or evaluate an abnormal amount of hardened boric acid deposits platted out within the sump. The finding was more than minor because it could have had a credible impact on safety by reducing the reliability of the ECCS pumps during accident scenarios when undissolved pieces of the boric acid could enter the suction of the pumps and cause possible damage to the pumps. The finding was of very low safety significance based on the determination that mitigation systems were previously capable of performing their safety function. (Section 1R20). A licensee identified second example of this NRC identified NCV was identified in IR 02-02 (Section 4OA7). Specifically, the performance of PT/1/A/4700/056, Unit 1 Containment Building Civil Structures Inspection, failed to identify the accumulation of boron and other foreign material within in the ECCS sump until corrective actions by the licensee identified it on April 18, 2002. The finding was of very low safety significance because mitigation systems were concluded to have been past operable based on engineering analysis performed by the licensee.
Inspection Report# : 2001005*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Mar 23, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Control Two Areas as Locked High Radiation Areas
Contrary to TS 5.7.2, during fuel movement on March 2, 2002, two areas were identified by the licensee with general area dose rates exceeding 1000 mrem/hr which were not controlled as locked high radiation areas and were accessed by individuals. This issue was determined to be of very low safety significance based on the location of the elevated dose rates relative to the individuals' work areas, appropriate worker actions including exiting the area when elevated dose rates were initially detected, and monitoring results which indicated no significant unexpected exposures were received by the workers. This issue is documented in the licensee's corrective action program as PIPs M-02-01017 and M-02-01018 (Section 4OA7).
Inspection Report# : 2001005*(pdf)*

Significance:  Mar 23, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure of an Individual to Respond Appropriately to an Alarming ED
Contrary to TS 5.7.1, on February 27, 2002, an individual worker in the Unit 2 Reactor Building, posted as a high radiation area, failed to respond appropriately to his Electronic Dosimeter (ED) integrated dose alarm. This issue was determined to be of very low safety significance based on monitoring results which indicated the worker was in low dose rate areas within the posted high radiation area when the alarm sounded and no over-exposures occurred. This issue is documented in the licensee's corrective action program as PIP M-02-00907 (Section 4OA7).
Inspection Report# : 2001005*(pdf)*

Public Radiation Safety

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 : March 25, 2003