Byron 1
2Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ASSESS RISK ASSOCIATED WITH THE ISOLATION OF A PRESSURIZER PORV AFTER CLOSING ITS ASSOCIATED BLOCK VALVE.
The inspectors identified a finding of very low significance regarding the licensee's failure to assess the increase in risk in accordance with 10 CFR 50.65(a)(4) that resulted following the isolation of a pressurizer power operated relief valve (PORV) by closing its associated block valve. The primary cause of this finding was related to the cross-cutting area of human performance. Despite the availability of a computer software tool that would have indicated additional evaluation was required, the risk evaluation was completed. Following identification of this issue, the licensee performed a risk review and determined that the plant was not in the condition of core life when immediate actuation of the pressurizer PORVs are required; therefore, isolation of the pressurizer PORV did not result in an increased online risk. This finding was more than minor because it affected the human 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. This finding was of very low safety significance because there was no design deficiency, no actual loss of safety function, no single train loss of safety function for greater than the Technical Specification allowed outage time, and no risk due to external events. The inspectors determined this to be a Non-Cited Violation of 10 CFR 50.65(a)(4).
Inspection Report# : 2003003*(pdf)*

Significance: G May 23, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to maintain auxiliary feedwater instrumentation piping water solid
A finding of very low safety significance was identified involving a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," that related to the design basis requirement to maintain auxiliary feedwater instrumentation piping water solid, not being correctly translated into specifications, drawings, procedures, or instructions. This resulted in a void developing in the piping to the suction pressure transmitters 1(2)PT-AF055, which perform a safety-related function to sense low suction pressure and initiate a swap over to the essential service water system on loss of the condensate storage tank. The finding was more than minor because a lack of coordination between design requirements and procedural guidance affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance because it did not represent an actual loss of a safety function as the automatic switchover would still have occurred prior to the pumps losing suction pressure.
Inspection Report# : 2003004*(pdf)*

Significance: G May 23, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Design basis calculations contained errors or did not exist
A finding of very low safety significance was identified associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," that related to the coordination, content, and control of design basis engineering calculations. Specifically, the inspectors identified a number of concerns related to the coordination, content, and control of existing calculations (including the failure to coordinate calculation inputs and assumptions as existing design basis calculations are revised or as additional calculations are originated), the use of incorrect or unsupported inputs or assumptions in design basis calculations, the absence of calculations to support some aspects of the current design basis, the failure to appropriately supercede certain calculations or to denote other calculations as historical documents, and, in certain instances, errors in existing calculations. As a result of these issues, the current design basis calculations, as well as the existing calculation control processes, may not be adequate to ensure that the design basis will continue to be maintained. Although none of the specific deficiencies identified during the inspection resulted in immediate operability concerns, it was concluded that the auxiliary feedwater system design basis was not being adequately controlled by the existing calculations nor by the licensee's processes for coordination and control of the calculations. This finding was more than minor based on the potential that the lack of adequate control and quality of design basis calculations could result in the ability of the auxiliary feedwater system to perform its safety functions to be degraded. Design basis calculations were routinely used in support of design changes, operating procedures, test acceptance criteria, and operability determinations. This finding is assessed as Green because it did not represent an actual loss of the auxiliary feedwater system's safety function.
Inspection Report# : 2003004*(pdf)*

Significance: G May 23, 2003
Identified By: NRC
Item Type: FIN Finding
Commitment to have placards on the main control board concerning minimum flow for the auxiliary feedwater pumps not maintained
A finding of very low safety significance was identified involving not maintaining a commitment to the NRC to have placards on the main control board. The placards provided guidance to operators to ensure the auxiliary feedwater pumps had sufficient recirculation flow prior to reducing flow to the steam generators below 100 gpm [gallons per minute], such that the pumps remained protected from being run at shutoff conditions that would have resulted in pump damage. This finding was more than minor because this lack of guidance could have affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance because it did not represent an actual loss of a safety function.
Inspection Report# : 2003004*(pdf)*

Significance: G 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)*

Barrier Integrity

Significance: G Mar 19, 2003
Identified By: NRC
Item Type: FIN Finding
FAILURE TO ADEQUATELY EVALUATE THE OPERABILITY OF THE NONACCESSIBLE AREA EXHAUST FILTER PLENUM VENTILATION SYSTEM DURING A WORK ACTIVITY.
The inspectors identified a finding of very low safety significance regarding the licensee's failure to appropriately assess the operability of the nonaccessible area exhaust filter plenum ventilation system during a work activity to repair the discharge flow control damper for the 0A auxiliary building heating, ventilation and air conditioning system (VA) nonaccessible filter plenum exhaust fan. The primary cause of this finding was related to the cross-cutting area of human performance. The licensee failed to recognize that failing open an inlet damper within the system resulted in the associated train being inoperable. This finding was more than minor because it involved an inadequate operability evaluation of the nonaccessible area exhaust filter plenum ventilation system, which if left uncorrected, would have become a more significant safety concern, in that, it would impact the operators' ability to combat an accident and minimize offsite exposure for certain accidents. This finding is of very low safety significance because it only represented a degradation of the radiological barrier function provided for the auxiliary building. No violations of NRC requirements occurred.
Inspection Report# : 2003002*(pdf)*

Significance: G 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 that occurred on 5/13/2002 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)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : September 04, 2003