McGuire 1
2Q/2003 Plant Inspection Findings

Initiating Events

Significance: G Mar 22, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Main Turbine Valve Movement Test Procedure
A self-revealing NCV was identified for failure to meet TS 5.4.1 by failing to follow PT/1/A/4250/004A, Turbine Valve Movement Test, on February 1, 2003, due to an operator incorrectly raising governor valve demand when the procedure required lowering governor valve demand. This resulted in a reactivity excursion and reactor power increase. Although this finding contributed to the likelihood of a reactor trip, this issue was determined to be of very low safety significance because mitigation equipment was not affected. This error in following procedural guidance in response to a recognized plant condition is indicative of a human performance deficiency. (Section 1R22.1)
Inspection Report# : 2003002*(pdf)*

Mitigating Systems

Significance: G Jun 21, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Corrective actions not adequate to prevent second fire from occurring on the roof of EDG 1A
The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, for corrective actions that were not adequate to prevent a second fire from occurring on the roof of the Unit 1 emergency diesel generator (EDG) building when the EDG 1A was operated on two separate occasions. The licensee's immediate corrective action for the initial emergency diesel generator roof fire were inadequate to prevent a second fire from recurring. This finding is greater than minor because it was associated with protection against one of the external factors (fire) attribute and affected the objective of the mitigating systems cornerstone to ensure the availability, reliability and capability of systems that respond to initiating events. In addition, this finding could have resulted in an unnecessary challenge to plant operators during response to initiating events requiring the EDGs for mitigation (i.e., loss of offsite power events). The additional challenge to operators could have resulted in reduced availability, reliability, and capability of the EDGs during these events. This finding was determined to be of very low safety significance because neither fire caused the EDG 1A to be inoperable.
Inspection Report# : 2003003*(pdf)*

Significance: G Mar 22, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Maintenance Procedure for FWST Level Instrument Freeze Protection System

Inadequately installed freeze protection resulted in freezing of the refueling water storage tank (FWST) level instrument lines during adverse cold weather on January 24, 2003. A self-revealing NCV of Technical Specification 5.4.1.a was identified for failure to follow a maintenance procedure for work on the FWST level instrument freeze protection system. The finding is greater than minor because the safety function that these channels provide to the automatic switchover feature was lost. This finding was of very low safety significance because of the short time interval that the three channels were inoperable. (Section 1R01)
Inspection Report# : 2003002*(pdf)*

Significance: G Mar 22, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Corrective Action to prevent Gas Accumulation in the Residual Heat Removal System Following Refueling Outage
An NCV was identified for failure to comply with 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, regarding repetitive gas accumulation in the ECCS piping following refueling outages. This finding is greater than minor because some gas would be directed through the ECCS pumps, thereby affecting their reliability. This finding was of very low safety significance due to the determination that the majority of the gas would have been released from the ECCS piping into the containment volume via back leakage through the ECCS sump valves upon sump realignment and prior to sweeping the gas to the ECCS pumps. Since the resolution for a previous ECCS venting problem was not adequate, this finding is indicative of a potential corrective action thoroughness deficiency. (Section 1R15)
Inspection Report# : 2003002*(pdf)*

Significance: G Dec 21, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Performance of Unit 1 ECCS Recirculation Sump Inspection
An NCV of Technical Specification (TS) 5.4.1.a. was identified for the inadequate performance of a Unit 1 containment cleanliness inspection which partially implements TS 3.5.2.8 to ensure debris is not present in the area of the ECCS sump. Prior to this identification, the licensee had previously completed inspections for debris in accordance with Nuclear Site Directive (NSD) 104, Material Condition/Housekeeping, Cleanliness/Foreign Material; however, the licensee's containment inspections failed to identify the adverse condition. 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 due to potential blocking of the ECCS sump. The finding was of very low safety significance based on corrective actions taken to contain the fibrous insulation prior to entering a Mode of operation where the ECCS sump was required to be operable. (Section 1R20)
Inspection Report# : 2002004*(pdf)*

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 Sep 14, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadequate Corrective Actions to Prevent Recurrence of ND Pump Discharge Check Valve Sticking Open
A self-revealing non-cited violation of 10 CFR 50, Criterion XVI, was identified for a failure of licensee corrective actions to effectively modify the Unit 2A residual heat removal (ND) pump discharge check valve (2ND-23) to preclude it from sticking open following a similar event on the opposite Train valve in April 1999. This resulted in valve 2ND-23 sticking open during system flushing in April 2002, rendering both trains of ND inoperable. If left uncorrected, this issue could have become a more significant safety concern, because it could have affected the functional capability of the ND system. This finding, which was evaluated using Phase II of the SDP and reviewed by a regional Senior Reactor Analyst, was determined to be of very low safety significance. This determination reflects the fact that this issue only becomes a potential problem during the injection phase of a large break loss of coolant accident when the Train of ND with the stuck open check valve fails to start and/or run following the associated safety injection signal. (Section 4OA3.2)
Inspection Report# : 2002003*(pdf)*

Barrier Integrity

Significance: G Jun 21, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Maintenance Procedure for Hydrogen Mitigation System
A self-revealing, non-cited violation of Technical Specification 5.4.1.a was identified for failure to follow maintenance instructions for work on the hydrogen mitigation system. This violation was caused by a human performance error which rendered a train of the hydrogen mitigation system inoperable while the redundant train was removed from service due to maintenance. This finding is greater than minor because the safety function that this system provides to minimize containment pressure excursion in post accident environments was lost. This finding was of very low safety significance due to the short time interval when both trains were inoperable. (Section 1R12)
Inspection Report# : 2003003*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: G Mar 22, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to conduct adequate surveys of the Unit 1 and Unit 2 Main Plant Vent Particulate Radionuclides
The licensee failed to have proper sample line configuration and flow characteristics to assure sample representativeness of particulate radionuclides collected for monitoring and quantifying the Unit 1 and Unit 2 Main Plant Vent airborne effluents in accordance with the Selected Licensee Commitment (SLC) Manual Table 11.7.11-1. An NCV of 10 CFR 20.1501(a) was identified. This violation is greater than minor in that the failure to have proper sample line configurations and flow characteristics could result in non-representative collection of particulate radionuclides used to evaluate doses to members of the public from airborne effluent releases. This issue is associated with the process attributes of the Public Radiation Safety Cornerstone and affected the cornerstone objective to protect public from exposure to radiation. The violation is of very low safety significance because current operations have resulted in negligible release of particulate radionuclides and resultant doses to the public (Section 2PS1.1).
Inspection Report# : 2003002*(pdf)*

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 : September 04, 2003