Comanche Peak 1
2Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Aug 20, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadvertent TS 3.0.3 Entry Due to Inoperable CRACS Trains
A self-revealing non-cited violation of Technical Specification 3.0.3 was identified when both trains of the Units 1 and 2 control room air conditioning system (CRACS) were inoperable for longer than the 7 hours specified without placing both units in Mode 3. Specifically, on August 20, 2003, the licensee discovered that Unit 1 and Unit 2 CRACS units had been inoperable according to TS 3.7.11 for several hours prior to discovery, because support systems required for operability had been removed from service for routine maintenance and surveillance. The appropriate systems were restored to make one train of CRACS operable prior to an actual power reduction, but the total duration with less than one operable train exceeded the time to enter Mode 3, as required by Technical Specification 3.0.3. Corrective actions included issuing a Shift Order; issuing lessons learned to operators and schedulers; and reviewing operations and work control procedures for improvement. This event was entered into the licensee's corrective action program as SMF-2003-2463.

This violation is greater than minor because it involves a failure to perform required actions of a Technical Specification and affects an attribute and objective of the mitigating systems cornerstone in that the lack of proper configuration control affected the capability of the CRACS to respond to initiating events. The violation is considered to have a very low safety significance (Green) because it affected only the mitigating system cornerstone and did not represent an actual loss of safety function.
Inspection Report# : 2003004*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: SL-IV May 28, 2004
Identified By: Self Disclosing
Item Type: VIO Violation
Entry into a high radiation area without a briefing on radiation dose rates
On November 4, 2003, an individual entered a high radiation area without contacting radiation protection personnel for a briefing on the dose rates in the area, despite verbal and posted instructions to the contrary. Dose rates within the room were as high as 250 millirems per hour at 30 centimeters from the source of radiation. The licensee was alerted to the situation when the individual's electronic dosimeter alarmed because the dose rate setpoint was exceeded. The occurrence was a violation of Technical Specification 5.7.1.e. The violation involved the act of a low-level individual; however, the licensee failed to promptly provide information concerning the violation to appropriate NRC personnel, in accordance with Section VI.A.1.d(1) of the NRC Enforcement Policy. Therefore, the finding could not be treated as a noncited violation.

The failure to contact radiation protection personnel for a briefing on radiation dose rates prior to entering a high radiation area is a performance deficiency because it resulted in the licensee's failure to meet a requirement in its technical specifications. Because there are willful aspects of the violation, it is subject to traditional enforcement. The willful aspects notwithstanding, the inspector used the Occupational Radiation Safety Significance Determination Process described in Manual Chapter 0609, Appendix C, to analyze the significance of the finding. The inspector determined that the finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. The finding was entered into the licensee's corrective action program as SMF-2003-3594, and the individual was appropriately disciplined. This finding also had crosscutting aspects associated with human performance.

Inspection Report# : 2004003*(pdf)*

Significance: G Apr 09, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Two examples of a Technical Specification 5.7.1e violation for failure of personnel to receive a briefing on radiation dose rates prior to entry into a high radiation area
The NRC reviewed two examples of a self-revealing noncited violation of Technical Specification 5.7.1e for the failure of personnel to receive a briefing on radiation dose rates prior to entering a high radiation area. On February 10, 2004, an individual entered the Waste Monitor Tank Room X-185, a posted high radiation area, without being briefed on dose rates in the area and received an electronic dosimeter dose rate alarm. On February 18, 2004, an individual entered the piping penetration Train A, Room 077B, a posted high radiation area, without being briefed on the dose rates in the area before being stopped by another worker.

The failure to be briefed about radiation dose rates prior to entering a high radiation area is a performance deficiency. The finding was greater than minor because it was associated with the Occupational Radiation Safety cornerstone attribute of Program and Process and affected the cornerstone objective to ensure adequate protection of a worker's health and safety from exposure to radiation. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was determined to be of very low safety significance because the finding was not associated with as low as is reasonably achievable issues, there was no overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. The two examples of the finding were entered into the licensee's corrective action program as SMF-2004-062 and SMF-2004-0471.
Inspection Report# : 2004003*(pdf)*

Significance: G Apr 09, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Two examples of a 10 CFR 20.1501 violation for failure to perform a radiological survey
The NRC identified two examples of a noncited violation of 10 CFR 20.1501a because the licensee failed to perform surveys to identify dose rates and contamination levels of potential radiological hazards. On January 8, 2004, workers performing decontamination of a pole that was used for filter compaction alarmed the contamination monitors while exiting the radiologically controlled area. The licensee identified that the pole had contact dose rates of 150 millirem per hour; however, the inspector determined that the pole was not surveyed for contamination. In addition, on April 5, 2004, the inspector identified dose rates as high as 250 millirem per hour on contact and 80 millirem per hour at 30 centimeters on a containment spray line in Piping Area X-213. The posted survey map outside the room indicated general area dose rates near the pipe of between 1 and 5 millirem per hour.

The failure to perform surveys to evaluate the magnitude and extent of radiation levels and the concentrations or quantities of radioactive materials are performance deficiencies. The finding is greater than minor because they are associated with the Occupational Radiation Safety cornerstone attribute of Program and Process and affected the cornerstone objective to ensure adequate protection of a worker's health and safety from exposure to radiation. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was determined to be of very low safety significance because it was not associated with as low as is reasonably achievable issues, there was no overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. The two examples of the finding were entered into the licensee's corrective action program as SMF-2004-0069 and SMF-2004-1264.
Inspection Report# : 2004003*(pdf)*

Significance: G Apr 09, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Technical Specification 5.4.1 violation for failure to follow radiation work permit requirement
The inspector reviewed a self-revealing noncited violation of Technical Specification 5.4.1 for failure to follow a radiation work permit requirement. On April 4, 2004, scaffold builders constructed scaffolding up into an area of containment that had not been surveyed by radiation protection personnel and received an electronic dosimeter dose rate alarm.

The failure to follow radiation work permit requirements is a performance deficiency. The finding was greater than minor because it was associated with the Occupational Radiation Safety cornerstone attribute of Program and Process and affected the cornerstone objective to ensure adequate protection of a worker's health and safety from exposure to radiation. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was determined to be of very low safety significance because the finding was not associated with as low as is reasonably achievable issues, there was no overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. The finding was entered into the licensee's corrective action program as SMF-2004-1202.
Inspection Report# : 2004003*(pdf)*

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

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