# Brunswick 1
# 3Q/2005 Plant Inspection Findings

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## Initiating Events

**Significance:** G Jun 30, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**INAPPROPRIATE USE OF TECHNICAL SPECIFICATION 3.0.5 IN MODE 5 OPERATIONS**
Green. A self-revealing non-cited violation of Technical Specification (TS) 3.0.5., which allows some inoperable equipment, declared as such through a TS Action, to be returned to service solely for the purpose of demonstrating operability, was identified for failure to properly utilize this TS when returning a control rod to service following maintenance with Unit 1 in Mode 5 (Refueling). This resulted in the failure to meet the required actions of TS 3.9.2, Refuel Position One-Rod-Out Interlock, and TS 3.9.4, Control Rod Position Indication, with the unit in Mode 5.

The finding is greater than minor because it is associated with the equipment configuration control attribute of the Initiating Events Cornerstone and affects the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions while shutdown. This finding is of very low safety significance because, using Appendix G of the SDP, it did not constitute a finding that required quantitative assessment. The cause of this finding is a performance aspect of the human performance cross-cutting area, in that the cause was attributed to operator knowledge of the requirements of TS 3.0.5 and communication errors between Maintenance and Operations.
Inspection Report# : 2005003*(pdf)*

**Significance:** G Jun 30, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**INADEQUATE CONDENSATE SYSTEM OPERATING PROCEDURE**
Green. A self-revealing non-cited violation of Technical Specification (TS) 5.4.1.a. Procedures, was identified for failure to provide adequate condensate system procedural guidance to preclude the reactor feed pumps from tripping on low suction pressure during plant operations. The inadequate procedures contributed to a Unit 2 automatic reactor scram on April 9, 2005, due to low reactor vessel level.

The finding is greater than minor because it is associated with the procedure quality attribute of the Initiating Events Cornerstone and affects the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during power operations. This finding is of very low safety significance because, although it contributes to the likelihood of a reactor trip, it does not contribute to the likelihood that mitigation equipment or functions would be unavailable.
Inspection Report# : 2005003*(pdf)*

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## Mitigating Systems

**Significance:** G Sep 30, 2005
Identified By: Self-Revealing
Item Type: FIN Finding
**Failure to Properly Control the EDG Control Switch**
Green. A self-revealing finding was identified for failure to properly control the emergency diesel generator control switch to assure reliability of the offsite power source to the plant's emergency buses. As a result, Brunswick Units 1 and 2 experienced a loss of power to emergency bus E-1 on May 12, 2005 when it's feeder breaker from the offsite power source opened following a voltage transient initiated by a fault on another emergency bus. The licensee entered this issue into the corrective action program.

This finding is greater than minor because it is associated with the operating equipment lineup attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because it did not represent an actual loss of safety function of a single train for greater than the TS allowed outage time.
Inspection Report# : 2005004*(pdf)*

**Significance:** G Aug 12, 2005

Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Generate an A/R for Abnormal Conditions Identified in Work Orders**
A non-cited violation (NCV) of 10CFR50, Appendix B, Criterion XVI was identified because the licensee failed to promptly identify a condition adverse to quality in that licensee personnel failed to generate an Action Request (A/R) for abnormal conditions identified in the comment section of work orders associated with OPM-GEN005, "Diesel Generator Electrical Inspections."

This finding is greater than minor because it is associated with the reactor safety Mitigating System Cornerstone and affects the configuration control attribute of the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). A phase one evaluation determined that the performance deficiency was of very low safety significance because the abnormal conditions did not effect the operability of the affected components. This finding also involved the cross-cutting aspects of problem identification and resolution (PI&R) in that the licensee failed to properly identify or address these issues in the corrective action system. [An additional example of this NCV was identified in IR 05000325,324/2005004 with the additional title of Failure to Identify a Vulnerability to Spurious Tripping of EDG during the Start Sequence.]
Inspection Report# : 2005010*(pdf)*

**Significance:** G Mar 31, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**Failure to identify Condition Adverse to Quality on Emergency Bus Relay Covers**
Green. A self-revealing finding and non-cited violation of 10CFR50, Appendix B, Criterion XVI, was identified for failure to promptly identify a condition adverse to quality associated with mispositioned relay covers for several General Electric HGA relays on emergency bus E-1. The finding resulted in relay 1-E1-AE7-CL-B, which provides a confirmatory bus strip signal to the emergency diesel generator (EDG) 1 output breaker, being failed in the operated state. This caused emergency diesel generator EDG 1 to be in an inoperable condition from March 29, 2004 until the condition was discovered on August 16, 2004. The finding is greater than minor because it is associated with equipment performance and affected the functional capability of the system to respond to initiating events. The finding was evaluated using NRC Inspection Manual Chapter 0609 Appendix A. A Phase 3 Significance Determination Process analysis determined this finding to be of very low safety significance based on the limited number of hours the EDG load rating would have been exceeded. The finding is related to the cross-cutting area of problem identification and resolution due to the failure to identify a condition adverse to quality.
Inspection Report# : 2005002*(pdf)*

**Significance:** G Dec 31, 2004
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**Inadequate Storage of Standby Liquid Control System Nitrogen Accumulator Repair Kits**
Green. A self-revealing finding and non-cited violation of 10CFR50, Appendix B, Criteron XIII, was identified for failure to store Unit 1 standby liquid control system (SLC) nitrogen accumulator repair kits in a condition which did not prevent deterioration. The licensee's material evaluation of the commercially dedicated part did not include special storage requirements and, therefore, the parts were stored, from at least 1999 until March 2004, in a condition which made them susceptible to developing leaks along folds in the nitrogen accumulator bladders. This resulted in accumulator nitrogen leakage into the Unit 1 standby liquid control system and was determined to be the cause of the 1 B standby liquid control pump being discovered in an inoperable condition on July 8, 2004.

This finding is more than minor because it is associated with equipment performance and affected the functional capability of the system to respond to initiating events. This finding was evaluated using MC 0609 Appendix A. A Phase 3 Significance Determination Process analysis determined this finding to be of very low safety significance (Green) because the redundant train of the Unit 1 SLC system remained operable. The licensee's corrective actions included replacing all of the affected nitrogen accumulator bladders.
Inspection Report# : 2004005*(pdf)*

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# Barrier Integrity

**Significance:** G Jun 30, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**INADEQUATE DESIGN CONTROL FOR DIGITAL FEEDWATER CONTROL SYSTEM MODIFICATION**
Green. A self-revealing non-cited violation of 10CFR50, Appendix B, Criterion III, Design Control, was identified for failure to assure that Technical Specification (TS) requirements for the feedwater and main turbine high water trip function remained operable with the introduction of a filtered time constant for reactor vessel level. As a result, instrumentation associated with TS 3.3.2.2, Feedwater and Main Turbine High Water Level Trip Instrumentation, were inoperable from April 30, 2004 for Unit 1 and April 30, 2003 for Unit 2 until the time constant filters were removed on April 10, 2005

This finding is greater than minor because it is associated with the design control attribute of the Barrier Integrity Cornerstone and affects the cornerstone objective of providing reasonable assurance that physical design barriers (i.e., fuel cladding) protect the public from radionuclide releases caused by events. This finding is of very low safety significance because it could affect the fuel cladding, but could not effect the integrity of the reactor cooling system. The cause of this finding is identified as a performance aspect of the human performance cross-cutting area, in that the cause was attributed to a lack of sufficient questioning attitude from engineering personnel, related to the impact of a parameter change on all system output responses.
Inspection Report# : 2005003*(pdf)*

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

Physical Protection information not publicly available.

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## Miscellaneous

Last modified : November 30, 2005