Limerick 2
3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to scope emergency service water back-up supply to turbine enclosure cooling water into the Maintenance Rule program
The inspectors identified a non-cited violation of 10 CFR 50.65(b)(2)(i) because Exelon did not scope an emergency service water (ESW) valve open function, used in the emergency operating procedures, into its maintenance rule (MR) monitoring program. Exelon did not demonstrate that the valve's performance was effectively controlled through the conduct of appropriate preventative maintenance such that the valve remained capable of performing its intended function. As a result, Exelon did not perform additional corrective actions to determine the cause and correct the condition when the valve failed to open on demand during the last two valve tests in 2002 and 2004. Exelon added the ESW valve open function into the MR program and entered this deficiency into their corrective action program for resolution (IRs 370575 and 370904).

This finding affects the Mitigating Systems Cornerstone because equipment performance problems were such that Exelon could not demonstrate effective control of component performance or condition through preventative maintenance. This finding is more than minor because it is similar to Example 7.d of NRC Inspection Manual Chapter (IMC) 0612 Appendix-E, "Examples of Minor Issues." The finding is of very low safety significance because it did not represent an actual loss of safety function for equipment designated as risk significant, and was not risk significant for external initiating events. (Section 1R12)
Inspection Report# : 2005004*(pdf)*

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate emergency operating procedure for the reactor core isolation cooling system maximum safe operating water level in the pump room
The NRC identified a Green NCV of TS 6.8.1, "Administrative Controls - Procedures," because Exelon did not maintain adequate procedures in that T-103, "Secondary Containment Control," contained an inappropriately high maximum safe operating flooding level for the Unit 1 RCIC room. Limerick revised the T-103 RCIC maximum safe operating flood level from 42 inches to a value of 27 inches.

This finding is more than minor because it affected the Mitigating Systems cornerstone objective of ensuring availability, reliability, and capability of the RCIC system. This finding is of very low safety significance because it did not represent a loss of safety system function, an actual loss of safety function of a single train for greater than its TS allowed outage time, or a total loss of any safety function that contributes to external event initiated core damage sequences. (1R06)
Inspection Report# : 2005003*(pdf)*

Barrier Integrity

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Corrective Actions for a Degraded Remote Shutdown Panel Switch
The NRC identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because Limerick's staff did not promptly identify and correct a condition adverse to quality associated with failure of a remote shutdown panel switch during surveillance testing. Limerick replaced the defective remote shutdown panel hand switch and performed a satisfactory post maintenance test.

This finding is greater than minor because it was associated with the Barrier Integrity cornerstone attribute of Barrier Performance, and affected

the cornerstone objective of ensuring the availability and reliability of components used for containment isolation. This finding is of very low safety significance because it did not represent a degradation of the radiological barrier provided by the control room, spent fuel pool, or standby gas treatment system, did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere, and did not represent an actual open pathway from the containment or an actual reduction in defense-in-depth for atmospheric pressure control or hydrogen control.

The inspectors identified that a contributing cause of the finding is related to the problem evaluation subcategory of the Problem Identification and Resolution cross-cutting area, in that Limerick staff did not adequately assess and correct the cause of a December 2004 remote shutdown panel switch failure. (Section 4AO2)
Inspection Report# : 2005003*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : November 30, 2005