

## Oconee 3

### 3Q/2003 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Failure to Detect Non-Conforming Parts during Receipt Inspections**

A NCV of 10CFR50.55a(g)(4) and 10CFR50, Appendix B, Criterion VII was identified by the inspectors, in that measures taken to preclude the installation of non-conforming replacement parts and the ability to evaluate the suitability of replacement during the Quality Assurance (QA) receipt inspection process were not adequate. Specifically, this was identified for inadequate QA review during receipt inspections that resulted in the licensee installing one non-conforming Control Rod Drive Mechanisms (CRDM) (Split Nut) Flange Ring on Unit 2, and discovering, prior to the installation in Unit 3, 68 CRDMs and 552 CRDM Hold Down Bolts that did not meet the design and procurement specifications. This finding was more than minor because non-conforming material was actually installed in Unit 2. However, it was determined to be of very low safety significance because there was not a loss of system function. (Section 40A5.1C)

Inspection Report# : [2003003\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Sep 27, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Failure to follow a procedure required by TS 5.4.1, resulting in multiple reactor operators/senior reactor operators failing to properly reactivate their licenses**

The inspectors identified a non-cited violation of Technical Specification 5.4.1(a) for failure to follow Operation Management Procedure 1-12, "Maintenance of Licensed Operator, Shift Technical Advisor, and Non-licensed Operator Qualifications," resulting in multiple reactor operators/ senior reactor operators failing to properly reactivate their licenses. This finding is greater than minor because it affected the Mitigating System Cornerstone human performance attribute to ensure that licensed operators are available, reliable, and capable to respond to initiating events to prevent undesirable consequences. The finding was evaluated using the Operator Requalification Human Performance SDP and was determined to be of very low safety significance. Based on more than 20 percent of the reactivated operators failed to meet the requirements as defined in procedure OMP 1-12, the issue was a Green finding. (Section 40A5.6)

Inspection Report# : [2003004\(pdf\)](#)

**Significance:**  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Identify the SSF Degraded Grommets as a Deficient Condition in the PIP Corrective Action Program**

A non-cited violation (NCV) of 10CFR50, Appendix B, Criterion XVI, Corrective Action, was identified by the inspectors for failure to promptly identify the degraded standby shutdown facility (SSF) diesel cooling water seals in the problem investigation process (PIP) program. This finding was considered to be more than minor based on the fact that subsequent analysis of the grommets noted significant degradation and this analysis would likely not have been performed without initiation of the PIP. Therefore, if the cause of the degradation was left uncorrected, the mitigation systems cornerstone objective of ensuring the continued reliability of equipment needed to respond to initiating events would be affected. In addition, continued degradation of the grommets would become a more significant safety concern. This issue was considered to be of low safety significance (Green) because the grommets were replaced during the SSF diesel overhaul before they failed in service. (Section 1R12.2)

Inspection Report# : [2003003\(pdf\)](#)

**Significance:**  May 02, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Identify and Correct the Operability Impact of Previously Discovered Downstream Valve Leakage on Atmospheric Vent Valve 3MS-155**

A non-cited violation of 10 CFR50, Appendix B, Criterion XVI, Corrective Actions, was identified for the failure to identify and correct the operability impact of previously discovered downstream valve leakage on atmospheric vent valve 3MS-155. As a result, 3MS-155 could not be initially opened with its chain operator during testing on April 21, 2003. The finding was more than minor because it affected the availability, reliability, and capability of a mitigating system; specifically, the ability to align the atmospheric dump valve flow path within the required time to mitigate certain reactor accidents. The finding was of very low safety significance because, although affected, the function of 3MS-155 was not lost since it could have been opened (if needed) using an available valve wrench (cheater bar) and ladder. (Section 4OA3.5)

Inspection Report# : [2003010\(pdf\)](#)

**Significance:**  Apr 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Evaluate Combustible Material in the KHU Complex**

A non-cited violation of Paragraph 3.D of the Oconee Operating License was identified for failure to implement and maintain all provisions of the approved fire protection plan which includes Nuclear System Directive (NSD) 313, Control of Flammable and Combustible Material. The temporary storage of wooden crates at the KHU complex was not evaluated and approved by the fire protection engineer as required by NSD 313. Subsequent evaluation determined increase in fire loading necessitated a fire watch tour be performed every six hours. This issue was determined to be of very low safety significance (Green) as it did not result in the impairment or degradation of fire protection features or defense in depth for safe shutdown. (Section 1R05)

Inspection Report# : [2003002\(pdf\)](#)

**Significance:**  Dec 31, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**Failure to Perform Surveillance within the Required Periodicity**

An inadequacy in the licensee's work planning program resulted in a missed Technical Specification (TS) required surveillance test involving the Keowee Hydro Station overhead power path. A non-cited violation of TS surveillance requirements (SR) 3.3.19.1, Channel Functional Test for Degraded Grid Voltage Protection Actuation Logic Channels,

SR 3.8.1.15, 230kV Circuit Breaker Actuation on Switchyard Isolation, and TS 5.5.18, Keowee Hydro Unit Commercial Power Generation Testing Program, was identified when it was discovered that PT/0/A/610/022, Keowee Over Frequency Protection Functional Test, was not performed within the required TS SR frequency. This violation is more than minor because it affected the mitigating system cornerstone objective of equipment reliability, in that, a complex series of tests for the emergency power supply were not performed within the specified frequency. This self-revealing finding was determined to be of very low safety significance based on the fact that there was no unavailability of the Keowee units resulting from the missed surveillances. (Section 1R22.2)

Inspection Report# : [2002005\(pdf\)](#)



**Significance:** Nov 21, 2002

Identified By: Self Disclosing

Item Type: VIO Violation

### **Failure to Properly Install Electrical Connectors on High Pressure Injection Pump Temporary Power Supply Cables**

Contrary to Technical Specification 5.4.1, which requires that written procedures recommended in Regulatory Guide 1.33 shall be implemented, the licensee failed to adequately implement the vendor's written instructions for attaching the "Elastimold" electrical connectors on the "Black" and "Red" phases of the Unit 3 high pressure injection (HPI) pump emergency power supply cable from the auxiliary service water switchgear. Consequently, the "Elastimold" connectors on these two phases were found to be improperly installed (i.e., not screwed on), resulting in the possible loss of HPI pump function during a postulated high energy line break/tornado event recovery.

Inspection Report# : [2003007\(pdf\)](#)

Inspection Report# : [2003008\(pdf\)](#)

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## **Barrier Integrity**

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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**

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## **Miscellaneous**

**Significance:** N/A Jul 11, 2003

Identified By: NRC

Item Type: FIN Finding

**Problem Identification and Resolution Inspection**

The team identified that the licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution. The licensee maintained a low threshold for identifying problems as evidenced by the continued large number of Problem Investigation Process reports (PIPs) entered annually into the CAP. The inspector's independent review did not identify significant adverse conditions which were not in the CAP for resolution.

Evaluation and prioritization of problems was generally effective; although, one example was noted where an evaluation did not thoroughly examine the potential for generic implications. Corrective actions specified for problems were generally adequate; although, several examples were noted where corrective actions were not complete or not comprehensive. Audits and self-assessments continued to identify issues; however, some examples were noted where the issues were not correctly classified for resolution. Previous non-compliance issues documented as non-cited violations were properly tracked and resolved via the CAP. Personnel at the site felt free to raise safety concerns to management and to resolve issues via the CAP.

Inspection Report# : [2003009\(pdf\)](#)

Last modified : December 01, 2003