Comanche Peak 2
3Q/2010 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Control Reactor Coolant System Pressure During Solid Plant Operations
A self-revealing noncited violation of Technical Specification 5.4.1.a was identified for the failure of operators to follow procedural requirements for maintaining reactor coolant system pressure. Specifically, a reactor operator adjusted charging flow during solid plant operations and failed to control the reactor coolant system pressure increase. As a result, a power operated relief valve lifted to provide low temperature overpressure protection of the reactor coolant system. The licensee entered the finding into the corrective action program as Condition Report CR 2009 005542.

The finding is more than minor because it is associated with the human performance attribute of the initiating events cornerstone and affects the cornerstone objective to limit those events that upset plant stability and challenge critical safety functions during shutdown operations. Specifically, the inadvertent lifts of the power operated relief valves could lead to a loss of reactor coolant system inventory and pressure control. Using NRC Manual Chapter 0609, Appendix G, Attachment 1, Checklist 2, the finding was determined to be of very low safety significance because the licensee maintained adequate mitigation capability for the current plant state and the event was not characterized as a loss of control condition. The finding has a human performance crosscutting aspect associated with decision making because the licensee did not formally define the role of the reactor operator maintaining reactor coolant system pressure.
Inspection Report# : 2009005 *(pdf)*

Significance: G Jun 22, 2008
Identified By: NRC
Item Type: FIN Finding
Instrument Tubing Failure Causes Plant Trip
The inspectors reviewed a self-revealing finding for the licensee's failure to follow a tubing installation specification when installing condenser vacuum instrument tubing. Specifically, the installation did not follow Tubing Specification CPSES-I-1018 for general flexibility or thermal growth considerations, ultimately resulting in tubing failure. The tubing failure caused turbine trip instrumentation to fail low, causing a Unit 2 turbine and reactor trip. The licensee entered the finding into their corrective action program and modified the instrument tubing in both Units 1 and 2 to prevent another failure.

The finding is greater than minor because it is associated with the Initiating Events Cornerstone attribute of design control and affected the cornerstone objective, in that it caused a turbine and reactor trip that challenged critical safety functions. The finding is of very low safety significance because, although the likelihood of a reactor trip increased, all mitigating systems were available. The cause of this finding is related to the human performance cross-cutting component of Work Practices, in that, the licensee failed to provide proper oversight of contractors such that nuclear safety is supported.

Inspection Report# : 2008003 *(pdf)*

Mitigating Systems

Significance: G Sep 18, 2010
Identified By: NRC
Item Type: FIN Finding
"Failure to Correctly Evaluate Diesel Generator Past Operability"
The inspectors identified a finding for the failure of the licensee to adequately evaluate the past operability of the Unit 2 Train B diesel generator when its governor functioned in a droop mode during isochronous operations. As a result, the licensee's evaluation incorrectly concluded that the diesel generator was always operable. The licensee entered the finding into the corrective action program as Condition Report CR-2010-008760.

The finding was more than minor because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern in that the licensee could have used the inadequate operability evaluation to incorrectly declare a diesel generator operable with a similar performance issue in the future. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not result in the loss of safety function for the diesel generator. The finding has a human performance crosscutting aspect associated with decision-making, in that, licensee personnel failed to use conservative assumptions.

Inspection Report# : 2010004 *(pdf)*

Significance: G Sep 18, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
"Failure to Promptly Identify and Correct a Diesel Generator Frequency Degradation"
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action" for the failure of the licensee to promptly identify and correct a diesel generator operating in a droop condition instead of the isochronous mode during emergency conditions. As a result, the ability of the diesel generator to provide power to mitigating equipment at the design frequency was degraded for approximately three years. The licensee entered the finding into the corrective action program as Condition Report CR 2010 003305.

The finding was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective, in that, the capability of the diesel generator to provide power to mitigating equipment was adversely affected by operating at a frequency lower than 60 hertz. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not result in the loss of safety function for the mitigating equipment supported by the diesel. The finding has a human performance crosscutting aspect associated with work practices, in that, licensee personnel proceeded in the face of unexpected circumstances during diesel generator surveillances when frequency was abnormal.

Inspection Report# : 2010004 *(pdf)*

Barrier Integrity

Significance: G Sep 18, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
"Failure to Consider Temperature Effects on Air Accumulator Overpressure Protection"
The inspectors identified a noncited violation of 10 CFR 50 Appendix B, Criterion III, "Design Control" for the failure to consider the temperature effect on the pressurization of safety-related air accumulators for containment isolation valves in the main steam line penetration room. As a result, the accumulators could exceed their design pressure during a steam line break. The licensee entered the finding into the corrective action program as Condition Report CR-2010-006349.

The finding was more than minor because it was associated with the design control attribute of the barrier integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical barriers protect the public from radionuclide releases caused by events. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not result in an actual open pathway in the physical integrity of reactor containment. The finding did not have a crosscutting aspect because the performance deficiency was not representative of current licensee performance

Inspection Report# : 2010004 *(pdf)*

Significance: G Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate procedure for environmentally qualified actuator refurbishment
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, for the failure of the licensee to translate environmental qualification requirements for motor operated valve and damper actuators into procedures. Specifically, actuator refurbishment procedures directed the removal of conduit plugs, drain plugs, and T-drains, but did not require them to be re-installed in the correct configuration. As a result, multiple actuators were not in their specified condition for environmental qualification. After evaluation, the licensee determined that the actuators were still environmentally qualified in the as-found configuration. The licensee entered the finding into the corrective action program as Condition Report CR 2009 000848.

The finding was more than minor because it was associated with the containment configuration control attribute of the barrier integrity cornerstone and adversely affected the cornerstone objective, in that, the licensee's procedure for actuator refurbishment did not provide reasonable assurance that actuators would continue to be environmentally qualified in order to protect the public from radionuclide releases caused by accidents or events. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not represent an actual open pathway in the physical integrity of reactor containment. The finding has a human performance cross cutting aspect associated with resources because the licensee failed to maintain complete and accurate procedures.

Inspection Report# : 2009005 *(pdf)*

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Close the Containment Airlock Outer Door
A self-revealing noncited violation of Technical Specification 5.4.1.a was identified for the failure of maintenance personnel to follow procedural requirements for closing the containment personnel airlock outer door. As a result, the containment personnel outer door was left open for over an hour and the containment integrity function of the door was compromised. The licensee entered the finding into the corrective action program as Condition Report CR 2009 005275.

The finding is more than minor because it is associated with the containment barrier performance attribute of the barrier integrity cornerstone and affects the cornerstone objective to provide reasonable assurance that physical barriers protect the public from radionuclide releases caused by events. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the performance deficiency did not result in an actual open pathway in the physical integrity of the containment. The finding has a human performance crosscutting aspect associated with decision making because the licensee did not communicate the basis of the importance of the containment door providing an integrity function to the personnel operating the door.
Inspection Report# : 2009005 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to barricade and post a high radiation area
A self-revealing noncited violation of Technical Specification 5.7.1.a was identified for failure to maintain a high radiation area barricaded and conspicuously posted. The lower valve gallery on the 832-foot elevation of the auxiliary building had been de-posted from a locked high radiation area to radiation area after a resin transfer and flush operation. Radiation protection had mistakenly determined, by a partial radiation survey, that the entire lower valve gallery was a radiation area. Consequently, two workers received unexpected electronic dose rate alarms because the workers entered a high radiation area without knowledge that dose rates measured 900 millirem per hour. The licensee revised Procedure RPI-624, “Resin Transfer Job Coverage,” to provide clear instructions requiring that radiation surveys of the whole system after resin transfers and flushes are completed. The licensee entered the finding into the corrective action program as Condition Report CR 2009 002876.

The failure to barricade and post a high radiation area is a performance deficiency. The finding was more than minor because it was associated with the occupational radiation safety cornerstone attribute (exposure control) of program and process and affected the cornerstone objective, in that, the failure to properly control a high radiation area had the potential to increase personnel dose. Using the occupational radiation safety significance determination process, the inspectors determined the finding to have very low safety significance because: (1) it was not associated with as low as reasonably achievable (ALARA) planning or work controls, (2) there was no overexposure, (3) there was no substantial potential for an overexposure, and (4) the ability to assess dose was not compromised. The finding has a human performance crosscutting aspect associated with resources because the licensee did not ensure that the procedure was complete and accurate.
Inspection Report# : 2009005 *(pdf)*

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Last modified : January 06, 2011