UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BLVD
ARLINGTON, TEXAS 76011-4511

February 21, 2012

Mr. M.E. Reddemann
Chief Executive Officer
Energy Northwest
P.O. Box 968, Mail Drop 1023
Richland, WA 99352-0968

Subject: COLUMBIA GENERATING STATION - NRC INTEGRATED INSPECTION REPORT 05000397/2011005 ERRATA

Dear Mr. Reddemann:

An administrative error was identified in the Summary of Findings section documented in NRC Inspection Report 05000397/2011005, dated February 13, 2011. The Summary of Findings section erroneously lists a Severity Level IV non-cited violation as one of the findings. This section was corrected to remove part of this sentence. As a result of this correction, please replace page 2 of the enclosure to NRC Inspection Report 05000397/2011005, with the enclosed page.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and its enclosure, will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Wayne C. Walker, Chief
Project Branch A
Division of Reactor Projects

Docket No.: 05000397
License No.: NPF-21

Enclosure: Inspection Report 05000397/2011005 ERRATA

cc w/Enclosure: Electronic Distribution

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SUMMARY OF FINDINGS

IR 05000397/2011005; 09/25/2011 – 12/31/2011; Columbia Generating Station, Integrated Resident and Regional Report; Maintenance Effectiveness; Operability Evaluations; Surveillance Testing; Event Followup.

The report covered a 3-month period of inspection by resident inspectors and announced baseline inspections by region-based inspectors. Three Green non-cited violations and one Green Finding were identified. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using Inspection Manual Chapter 0609, "Significance Determination Process." The cross-cutting aspect is determined using Inspection Manual Chapter 0310, "Components Within the Cross Cutting Areas." Findings for which the significance determination process does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

A. NRC-Identified Findings and Self-Revealing Findings

Cornerstone: Initiating Events

- Green. The inspectors reviewed a self-revealing finding for the licensee's failure to follow work instructions. Specifically, mechanics failed to properly implement Work Order 01188696, Task 7, when fabricating the gagging device used to maintain main condenser hotwell surge volume bypass valve closed during planned maintenance. As a result, on November 2, 2011, a rapid, unexpected rise in hotwell level and conductivity and a rapid drop in condensate storage tank level occurred. Subsequent review revealed that the gagging device installed on the main condenser hotwell surge volume bypass valve failed, which allowed a vacuum drag flow path of condensate storage tank water to the main condenser hotwell. Following identification, the licensee re-fabricated a gagging device in accordance with engineering's specifications. This issue was entered into the licensee's corrective action program as Action Request AR 00251720.

  The finding was more than minor because it affected the design control attribute of the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the inspectors determined this finding to be of very low safety significance (Green) because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. The inspectors determined that this finding had a cross-cutting aspect in the area of human performance associated with the decision making component because the licensee failed to implement roles and authorities as designed when fabricating the gagging device for COND-V-170 [H.1(a)] (Section 1R12).