



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION**  
REGION II  
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ATLANTA, GEORGIA 30303-1200

April 4, 2023

John A. Krakuszeski  
Site Vice President  
Duke Energy Progress, LLC  
8470 River Road SE  
M/C BNP04  
Southport, NC 28461-0429

**SUBJECT: REISSUE - BRUNSWICK STEAM ELECTRIC PLANT – INTEGRATED  
INSPECTION REPORT 05000324/2022004 AND 05000325/2022004**

Dear John A. Krakuszeski:

The U.S. Nuclear Regulatory Commission (NRC) identified the need to reissue NRC inspection report 05000324/2022004 and 05000325/2022004 dated February 8, 2023 (ADAMS Accession No. ML23033A525). Specifically, the inspection finding in the report listed the incorrect Unit number in the title of the finding. Additionally, the finding was incorrectly assigned to both the Unit 1 and Unit 2 dockets. This reissued inspection report has corrected this error and the finding title and docket number assignment are now listed properly for Unit 1. As a result, this report is being reissued in its entirety.

On December 31, 2022, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at Brunswick Steam Electric Plant. On February 2, 2023, the NRC inspectors discussed the results of this inspection with you and other members of your staff. The results of this inspection are documented in the enclosed report.

One finding of very low safety significance (Green) is documented in this report. This finding involved a violation of NRC requirements. We are treating this violation as a non-cited violation (NCV) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violation or the significance or severity of the violation documented in this inspection report, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement; and the NRC Resident Inspector at Brunswick Steam Electric Plant.

If you disagree with a cross-cutting aspect assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region II; and the NRC Resident Inspector at Brunswick Steam Electric Plant.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at <http://www.nrc.gov/reading-rm/adams.html> and at the NRC Public Document Room in accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,



Signed by Fannon, Matthew  
on 04/04/23

Matthew S. Fannon, Chief  
Reactor Projects Branch 4  
Division of Reactor Projects

Docket Nos. 05000324 and 05000325  
License Nos. DPR-62 and DPR-71

Enclosure:  
As stated

cc w/ encl: Distribution via LISTSERV

SUBJECT: BRUNSWICK STEAM ELECTRIC PLANT – INTEGRATED INSPECTION  
 REPORT 05000324/2022004 AND 05000325/2022004 Dated April 04, 2023

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**ADAMS ACCESSION NUMBER: ML23090A175**

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NAME	G. Smith	A. Wilson	M. Fannon		
DATE	04/03/23	04/03/23	04/04/23		

**U.S. NUCLEAR REGULATORY COMMISSION  
Inspection Report**

Docket Numbers: 05000324 and 05000325

License Numbers: DPR-62 and DPR-71

Report Numbers: 05000324/2022004 and 05000325/2022004

Enterprise Identifier: I-2022-004-0016

Licensee: Duke Energy Progress, LLC

Facility: Brunswick Steam Electric Plant

Location: Southport, NC

Inspection Dates: October 01, 2022, to December 31, 2022

Inspectors: C. Curran, Resident Inspector  
G. Smith, Senior Resident Inspector  
J. Steward, Senior Resident Inspector  
J. Viera, Senior Operations Engineer

Approved By: Matthew S. Fannon, Chief  
Reactor Projects Branch 4  
Division of Reactor Projects

Enclosure

## SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee’s performance by conducting an integrated inspection at Brunswick Steam Electric Plant, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC’s program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

### List of Findings and Violations

Failure of Unit 1 High Pressure Coolant Injection (HPCI) Controller			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000325/2022004-01 Open/Closed	[H.7] - Documentation	71152A
A self-revealed Green finding and associated Non-Cited Violation (NCV) of Technical Specification (TS) 5.4.1.a was identified for the failure to establish work instructions to verify operability of the HPCI flow controller.			

### Additional Tracking Items

Type	Issue Number	Title	Report Section	Status
LER	05000325/2022-001-00	Licensee Event Report (LER) 2022-001-00 for Brunswick Steam Electric Plant, Unit 1, High Pressure Coolant Injection Inoperable	71153	Closed

## PLANT STATUS

Unit 1 began the period at 100 percent rated thermal power (RTP) and operated there until December 9, 2022, when power was reduced to 70 percent RTP for a planned control rod sequence exchange. Following the sequence exchange, as well as two follow-on rod improvements, the unit was restored to full RTP on December 16, 2022, where the unit essentially operated for the remainder of the period.

Unit 2 began the period at RTP, and operated there until October 6, 2022, when power was reduced to 85 percent RTP due to loss of one of the four off site power lines (Whiteville). System procedures require the turbine output to be less than 830 megawatts when only three of the four off site power lines are available. Following repairs to the Whiteville line, the unit was restored to full RTP on October 7. On November 4, the unit was reduced to 60 percent RTP for turbine control/stop valve closure testing and a rod pattern adjustment. Following completion of the valve testing and rod pattern adjustment, the unit was restored to full RTP on November 6. On November 26, power was reduced to 47 percent RTP as a result of a trip of the 'B' recirculation pump. This put the unit into single loop operation. Investigation revealed that a coolant leak within the variable frequency drive (VFD) caused an electrical short and an ultimate failure of the VFD which caused the recirculation pump trip. Following replacement of all twelve VFD cells, the recirculation pump was restarted, and a controlled power ascension was commenced on November 28. Full RTP was attained on December 8, and the unit continued to essentially operate there for the remainder of the period.

## INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at <http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html>. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors performed activities described in IMC 2515, Appendix D, "Plant Status," observed risk significant activities, and completed on-site portions of IPs. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

## REACTOR SAFETY

### 71111.01 - Adverse Weather Protection

#### External Flooding Sample (IP Section 03.03) (1 Sample)

- (1) On October 12, 2022, the inspectors completed an evaluation and a walkdown of flood protection barriers, mitigation plans, procedures, and equipment to verify consistency with the licensee's design requirements and risk analysis assumptions for coping with external flooding.

#### 71111.04 - Equipment Alignment

##### Partial Walkdown Sample (IP Section 03.01) (1 Sample)

The inspectors evaluated system configurations during partial walkdowns of the following systems/trains:

- (1) '2A' control room emergency ventilation (CREV) train while the '2B' CREV train was out-of-service for planned maintenance on November 9, 2022

#### 71111.11A - Licensed Operator Requalification Program and Licensed Operator Performance

##### Requalification Examination Results (IP Section 03.03) (1 Sample)

- (1) The licensee completed the annual requalification operating examinations required to be administered to all licensed operators in accordance with Title 10 of the *Code of Federal Regulations* 55.59(a)(2), "Requalification Requirements," of the NRC's "Operator's Licenses." During the week of November 7, 2022, the inspector performed an in-office review of the overall pass/fail results of the individual operating examinations and the crew simulator operating examinations in accordance with Inspection Procedure (IP) 71111.11, "Licensed Operator Requalification Program." These results were compared to the thresholds established in Section 3.03, "Requalification Examination Results," of IP 71111.11.

The inspectors reviewed and evaluated the licensed operator examination failure rates for the requalification annual operating exam completed on October 5, 2022.

#### 71111.11Q - Licensed Operator Requalification Program and Licensed Operator Performance

##### Licensed Operator Performance in the Actual Plant/Main Control Room (IP Section 03.01) (1 Sample)

- (1) The inspectors observed and evaluated licensed operator performance in the main control room during a power reduction to 60 percent RTP in order to perform a control rod improvement, conduct main steam line isolation valve and turbine control/stop valve closure testing, and replace a condensate resin bed on November 4, 2022.

#### 71111.12 - Maintenance Effectiveness

##### Maintenance Effectiveness (IP Section 03.01) (5 Samples)

The inspectors evaluated the effectiveness of maintenance to ensure the following structures, systems, and components (SSCs) remain capable of performing their intended function:

- (1) Loss of power to Unit 1 HPCI flow controller on July 25, 2022, (nuclear condition report (NCR) 2434489)
- (2) Unit 1 'D' residual heat removal (RHR) pump trip on March 24, 2022, (NCR 2418646)
- (3) Unit 2 reactor building (RB) radiation monitor (2-D12-RM-K609A) spiked causing RB ventilation isolation on August 6, 2022, (NCR 2437011 and NCR 2437874)

- (4) 480-volt breaker issues on March 12, 2022, (NCR 2419650)
- (5) Unit 1 'C' conventional service water pump shear pin sheared on May 11, 2022, (NCR 2427130)

#### 71111.13 - Maintenance Risk Assessments and Emergent Work Control

##### Risk Assessment and Management Sample (IP Section 03.01) (2 Samples)

The inspectors evaluated the accuracy and completeness of risk assessments for the following planned and emergent work activities to ensure configuration changes and appropriate work controls were addressed:

- (1) Elevated risk due to maintenance on Unit 1 'C' circulating water pump and 'C' conventional service water pump on December 15, 2022
- (2) Emergent failure of Unit 2 balance of plant annunciator power supply on December 22, 2022

#### 71111.15 - Operability Determinations and Functionality Assessments

##### Operability Determination or Functionality Assessment (IP Section 03.01) (6 Samples)

The inspectors evaluated the licensee's justifications and actions associated with the following operability determinations and functionality assessments:

- (1) '1B' RHR valve operability (NCR 2440234)
- (2) Pipe stress calculations not analyzed to maximum allowed temperature (NCR 02426668)
- (3) B1C24 new fuel upper tie plates with nonconforming dimensions (NCR 2413961)
- (4) Pencil sized leak between 2-SW-V160 and 2SW-V193 (NCR 2438788)
- (5) Cracks in the Unit 1 south core spray concrete columns (NCR 2427216)
- (6) Pressure switch (2-FO-PDS-6530-4) as-left reset left low out of tolerance (NCR 2431537)

#### 71111.18 - Plant Modifications

##### Temporary Modifications and/or Permanent Modifications (IP Section 03.01 and/or 03.02) (1 Sample)

The inspectors evaluated the following temporary or permanent modifications:

- (1) Engineering Change 407070 – Install carbon fiber reinforced polymer (CFRP) on buried service water line 1-SW-100/199-30-157

##### Severe Accident Management Guidelines (SAMG) Update (IP Section 03.03) (1 Sample)

- (1) The inspectors verified the site Severe Accident Management Guidelines were updated in accordance with the boiling water reactor generic severe accident technical guidelines and validated in accordance with NEI 14-01, "Emergency Response Procedures and Guidelines for Beyond Design Basis Events and Severe Accidents," Revision 1.



## 71111.19 - Post-Maintenance Testing

### Post-Maintenance Test Sample (IP Section 03.01) (7 Samples)

The inspectors evaluated the following post-maintenance testing (PMT) activities to verify system operability and/or functionality:

- (1) OPT-08.2.2B, "LPCI/ RHR System Operability Test - Loop B," Rev. 110, after hinge pin replacement on the '1B' RHR check valve in accordance with (IAW) work order (WO) 20318536-01
- (2) 2-OP-02, "Reactor Recirculation System Operating Procedure," Rev. 185, following 2B VFD cell replacement IAW WO 2057072
- (3) PMT associated with the 2-SCW-2B-SW-TRVL-SCRN replacement IAW WO 20413408 on October 31, 2022
- (4) PMT associated with the '1B' nuclear service water strainer disassembly inspection IAW WO 20526905 on October 27, 2022
- (5) OPT-07.2.4B, "Core Spray System Operability Test - Loop B," Rev. 86, following tan delta testing of the Unit 1 'B' core spray pump cable IAW WO 20478897-01
- (6) OPT-07.2.4B, "Core Spray System Operability Test - Loop B," Rev. 86, following 1-E21-F031B (core spray min flow bypass valve) breaker and relay preventative maintenance IAW WO 20429155-01
- (7) 1PT-24.1-1, "Service Water Pump and Discharge Valve Operability Test," Rev. 98, following motor operated valve testing on 1-SW-V15 (conventional service water discharge valve) IAW WO 20493391-01

## 71111.22 - Surveillance Testing

The inspectors evaluated the following surveillance testing activities to verify system operability and/or functionality:

### Surveillance Tests (other) (IP Section 03.01) (8 Samples)

- (1) OPT-07.2.4B, "Core Spray System Operability Test – Loop B," Rev. 86, IAW WO 20547794
- (2) OPT-40.2.8, "Main Steam Line Isolation Valve Closure Test," Rev. 35, IAW WO 20556595
- (3) 2PT-40.2.9, "Turbine Control Valve/Stop Valve Closure Test," Rev. 25, IAW WO 20554996
- (4) OPT-15.7, "Standby Gas Treatment System Operability Test," Rev. 46, IAW WO 20550238 and OPT-15.6, "Standby Gas Treatment System Operability," Rev. 36, IAW WO 20562679
- (5) OPT-09.2, "HPCI System Operability Test," Rev. 154, IAW WO 20550240 and WO 20510617
- (6) OPT-08.2.2B, "LPCI/RHR System Operability Test - Loop B," Rev. 110, IAW WO 20550247
- (7) OPT-13.1, "Reactor Recirculation Jet Pump Operability," Rev. 48, performed on November 30, 2022
- (8) 0MST-RHR23Q, "RHR-LPCI ADS CS LL3, PDCI RCIC LL2 DIV II Trip Unit Channel Calibration," Rev. 10, IAW WO 20556157

## **OTHER ACTIVITIES – BASELINE**

### 71151 - Performance Indicator Verification

The inspectors verified licensee performance indicators submittals listed below:

#### MS07: High Pressure Injection Systems (IP Section 02.06) (2 Samples)

- (1) Unit 1 (October 1, 2021, through September 30, 2022)
- (2) Unit 2 (October 1, 2021, through September 30, 2022)

#### MS08: Heat Removal Systems (IP Section 02.07) (2 Samples)

- (1) Unit 1 (October 1, 2021, through September 30, 2022)
- (2) Unit 2 (October 1, 2021, through September 30, 2022)

#### MS09: Residual Heat Removal Systems (IP Section 02.08) (2 Samples)

- (1) Unit 1 (October 1, 2021, through September 30, 2022)
- (2) Unit 2 (October 1, 2021, through September 30, 2022)

### 71152A - Annual Follow-up Problem Identification and Resolution

#### Annual Follow-up of Selected Issues (Section 03.03) (1 Sample)

The inspectors reviewed the licensee's implementation of its corrective action program related to the following issues:

- (1) The Unit 1 HPCI system was declared inoperable upon discovery of the HPCI flow controller without power. It was determined that an intermittent connection in the flow controller fuse holder was the cause.

### 71152S - Semiannual Trend Problem Identification and Resolution

#### Semiannual Trend Review (Section 03.02) (1 Sample)

- (1) The inspectors reviewed the licensee's corrective action program for potential adverse trends in operations and maintenance that might be indicative of a more significant safety issue.

### 71153 - Follow Up of Events and Notices of Enforcement Discretion

#### Event Report (IP Section 03.02) (1 Sample)

The inspectors evaluated the following licensee event reports (LERs):

- (1) LER 05000325/2022-001-00, High Pressure Coolant Injection (HPCI) Inoperable (ADAMS Accession No. ML22255A164). The inspection conclusions associated with this LER are documented in this report under Inspection Results Section 71152. This LER is closed.

## INSPECTION RESULTS

Failure of Unit 1 High Pressure Coolant Injection (HPCI) Controller			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000325/2022004-01 Open/Closed	[H.7] - Documentation	71152A
<p>A self-revealed Green finding and associated Non-Cited Violation (NCV) of Technical Specification (TS) 5.4.1.a was identified for the failure to establish work instructions to verify operability of the HPCI flow controller.</p> <p><u>Description:</u> On July 15, 2022, with Unit 1 in Mode 1 at approximately 96% power for planned maintenance on the 'A' Condensate Deep-bed Demineralizer, the HPCI system was declared inoperable upon discovery of a loss of power to the HPCI flow controller during a board walkdown. The licensee's initial investigation revealed that the HPCI flow controller lost power as a result of an intermittent connection in the flow controller fuse holder. The controller fuse holder was tightened by maintenance and the HPCI controller was declared operable on July 16, 2022, at 12:10 EDT following associated post maintenance testing. The licensee's subsequent investigation revealed that the controller was recently replaced in May 2022. During this replacement, the tightness of controller connection to the fuse holder was not verified as the maintenance procedure did not require this step. The licensee assumed that the vendor had verified all aspects of the controller module were inspected. The licensee's post maintenance testing in May, following the controller replacement, verified the HPCI controller to be operable. However, over the next few months the electrical connections became less robust until the connection began exhibiting intermittent continuity and eventually led to the failure noted on July 15. The inspectors noted that reactor core isolation cooling (RCIC) system and automatic depressurization system remained operable during this event. On September 12, 2022, the licensee issued LER 2022-001-00 (see section 71153 of this report) in accordance with 10 CFR 50.73(a)(2)(v)(D) as a condition that could have prevented fulfillment of the safety function needed to mitigate the consequences of an accident. In the LER, the licensee concluded that the cause of the event was inadequate procedural guidance associated with ensuring tightness of the fuse holder.</p> <p><u>Corrective Actions:</u> In addition to securing the fuse in the fuse holder, the licensee added instructions to the associated maintenance procedure to check the fuse holder tightness prior to returning the HPCI and RCIC flow controllers to service following replacement and calibration.</p> <p><u>Corrective Action References:</u> NCR 02434489</p> <p><u>Performance Assessment:</u></p> <p><u>Performance Deficiency:</u> The inspectors determined that the failure to establish maintenance instructions for the HPCI flow controller to ensure continued availability was a performance deficiency.</p> <p><u>Screening:</u> The inspectors determined the performance deficiency was more than minor because it was associated with the Procedure Quality attribute of the Mitigating Systems</p>			

cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to verify the tightness of the HPCI flow controller fuse connection resulted in the inoperability of HPCI for 24 hours.

Significance: The inspectors assessed the significance of the finding using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process (SDP)," Attachment 4, "Initial Characterization of Findings," and Appendix A, "The Significance Determination Process for Findings At-Power." Specifically, using Attachment 4, the finding was determined to adversely affect the Mitigating Systems cornerstone since the finding was related to an inoperable mitigating system. Using IMC 0609, Appendix A, Exhibit 2, the finding was determined to be of very low safety significance (Green) since the finding represented an inoperable single train TS system that did not exceed the TS 3.5.1 allowed outage time of 14 days. An exposure time of 1 day (2 shifts) was assumed because the main control room control boards are frequently inspected and scanned by the operators.

Cross-Cutting Aspect: H.7 - Documentation: The organization creates and maintains complete, accurate and up-to-date documentation.

Enforcement:

Violation: TS 5.4.1.a, Administrative Control (Procedures), states in part, that written procedures shall be established, implemented, and maintained covering the following activities including the applicable procedures recommended in Regulatory Guide 1.33, Appendix A, November 1972 (Safety Guide 33). Safety Guide 33, Appendix A, Section I.1, states in part, that maintenance that can affect the performance of safety-related equipment should be properly planned and performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances.

Contrary to the requirements of TS 5.4.1.a, on May 3, 2022, the licensee failed to establish instructions during maintenance that affected the performance of safety-related equipment. Specifically, the licensee did not establish steps in WO 20304709 02 and Procedure 1-E41-FIC-R600, "Replace Controller, HPCI Turbine Flow," to prevent the loss of power to the HPCI controller.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

Observation: Semi-Annual Trend Review

71152S

The inspectors performed a trend analysis on the licensee's corrective action program to identify trends that could indicate the existence of a more significant safety issue. The inspectors focused their review on equipment performance trends, but also considered the results of inspector daily condition report screenings, licensee trending efforts, and licensee human performance results. The review nominally considered the 6-month period of July - December 2022, although some examples extended beyond those dates when the scope of the trend warranted. The inspectors compared their results with the licensee's analysis of trends. Additionally, the inspectors reviewed the adequacy of corrective actions associated with a sample of the issues identified in the licensee's trend reports. The inspectors also reviewed corrective action documents that were processed by the licensee to identify potential adverse trends in the condition of structures, systems, and/or components as evidenced by acceptance of long-standing non-conforming or degraded conditions.

During this review, the inspectors noted what appeared to be an excessive number of safety system actuations in the past year. Specifically, since December 2021, through the end of 2022, seven safety system actuations occurred. Of these seven only one was a "valid" actuation while the five of the remaining six were "invalid" actuations. One actuation was considered "non-valid."

The valid actuation (NCR 2408197) was a loss of the E-3 bus caused by a washer that inadvertently contacted the connections associated with the bus under voltage relay. This resulted in a stripping of the bus and ultimately a loss of the E-3 bus since the emergency diesel generator No. 3 was under clearance. The inspectors noted no performance deficiency during this event since the washer was never noted on any design drawings.

The January 4, 2022, actuation occurred during routine testing of the primary containment isolation system (PCIS). During testing, channel 'A2' gave a partial isolation for group 2 and secondary containment isolation. The cause was attributed to dirty contacts on an electromechanical relay. The relay was replaced.

On March 5, 2022, during a refueling outage, the '1D' RHR pump tripped as a result of the RHR suction valve, 1E11-F-08, inadvertently closing due to a momentary group 8 signal. The momentary group 8 signal was attributed to a momentary pressure spike caused by flashing due to operation on a single reactor recirculation pump while in mode 3 with speeds lower than 30%. The licensee has made a procedure change to operate at slightly higher recirculation flows while in mode 3 in addition to the evaluation of a new time delay on the associated relays to eliminate the negative effects of a momentary pressure spike.

On March 7, 2022, Unit 1 experienced a low level 3 actuation due to inadequate maintenance planning that removed two level transmitters from service during a refueling outage. These two transmitters met the emergency core cooling system (ECCS) logic and ultimately resulted in a low level 3 ECCS signal. A green NCV was documented in Brunswick Integrated Inspection Report 05000324/2022001 and 05000325/2022001 (ADAMS Accession No. ML22130A108).

On August 6 and August 12, 2022, Unit 2 RB 'A' radiation monitor, 2D12-RM-K609A, spiked high causing a secondary containment isolation and a PCIS group 6 actuation. The radiation monitor indicated radiation levels as high as 6 millirem per hour (mr/hr) while the 'B' channel indicated normal background levels of 0.12 mr/hr. Based on the licensee's investigation, the 'A' RB radiation monitor was determined to be failed due to a faulty sensor/convertor. The detector had recently been replaced in April 2022.

On November 9, 2022, a degraded jumper in the main stack radiation monitor on Unit 1 caused a fuse to blow and ultimately led to a group 6 PCIS isolation. The radiation monitor was subsequently repaired.

The inspectors performed a detailed review of the above actuations but could not identify a common theme between all seven events. The inspectors discussed this negative trend with the licensee.

NCR #	Date	Event	Type	Event Notification (EN) / LER Number
2408197	12/6/2021	Loss of E-3 Bus	Valid	EN 55627, LER 1-2021-001

2410783	1/4/2022	Group 6 PCIS Actuation	Invalid	EN 55756
2418646	3/5/2022	1D RHR Pump Trip	Not Valid	Not Applicable
2418712	3/7/2022	Low Level 3 Actuation	Invalid	EN 55859
2437011	8/6/2022	Group 6 PCIS Actuation	Invalid	EN 56138
2437874	8/12/2022	Group 6 PCIS Actuation	Invalid	EN 56138
2449077	11/9/2022	Group 6 PCIS Actuation	Invalid	EN 56287

**EXIT MEETINGS AND DEBRIEFS**

The inspectors verified no proprietary information was retained or documented in this report.

- On February 2, 2023, the inspectors presented the integrated inspection results to John A. Krakuszeski and other members of the licensee staff.

**DOCUMENTS REVIEWED**

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152A	Corrective Action Documents	AR 02434489	Loss of Power to Unit 1 High Pressure Coolant Injection System Flow Controller	07/15/2022
	Procedures	0PIC-UC013	Calibration of Yokogawa Manual or Programable Indicating Controller Models SMLD and SLPC	13
71153	Corrective Action Documents	AR 02434489	Loss of Power to Unit 1 High Pressure Coolant Injection Flow Controller	07/15/2022