

Browns Ferry 1 3Q/2015 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to provide Adequate Acceptance Criteria for ECCS Venting Surveillance

Green. An NRC identified non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for the licensee's failure to maintain adequate procedure acceptance criteria and cautions to verify operability of the HPCI system in accordance with Technical Specification Surveillance procedure SR 3.5.1.1. As immediate corrective action the licensee performed a prompt operability determination to verify the system remained operable, and plans to make changes to the TS surveillance procedure using the corrective action program. This violation was entered into the licensee's corrective action program as PER 989728.

The performance deficiency was more than minor because, if left uncorrected, it had the potential to lead to a more significant safety concern. Specifically the operability and availability of the HPCI system could be challenged by having procedural guidance which allows acceptable test results when the limiting void conditions may not be met. The finding was associated with the Mitigating Systems cornerstone. Using NRC Inspection Manual 0609, Appendix A, the finding screened as green because it did not represent an actual loss of function of at least a single train for greater than its technical specification allowed outage time, and did not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule program for greater than 24 hours. This finding has a crosscutting aspect in the area of Human Performance because the licensee did not challenge the unknown when, both, establishing the venting procedure acceptance criteria and when observing significant bubbles during the venting procedure. [H.11]. (1R04.2) Inspection Report# : [2015001](#) (*pdf*)

Significance: G Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to have Simulator Fidelity with D EDG Control Switch

Green. A Self Revealing NCV of 10 CFR 55.46(c)(1), "Simulation Facilities," was identified because the licensee failed to demonstrate simulator fidelity associated with D EDG control switch. The licensee's immediate corrective actions were to replace the switch with one that matched the original design. This violation was entered into the licensee's corrective action program as PER 990793.

The performance deficiency was more than minor because it adversely affected the mitigating systems cornerstone objective of Human Performance. Specifically, the simulator fidelity issue contributed to a Human Error (Pre-Event) resulting in the D EDG being inoperable for 8 days and 9 hours. In accordance with NRC Inspection Manual Chapter 0609, Appendix I, the finding was determined to be of very low safety significance (Green) using the simulator

fidelity flowpath (blocks 13 through 15). Specifically, Manual Chapter 0609, Appendix I, "Operator Requalification Human Performance Significance Determination Process," block 15, established a Green finding because although the deficient simulator fidelity negatively affected operator performance, this did not occur during a reportable event. No cross-cutting aspect was assigned because the issue occurred greater than three years ago and is not indicative of current licensee performance. (1R11.1)

Inspection Report# : [2015001](#) (*pdf*)

Significance:  Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Maintain an Operating Procedure Resulted in the D EDG Exceeding its Technical Specification Allowed Outage Time

Green. A Self Revealing NCV of 10 CFR Part 50 Appendix B, Criterion V "Instructions, Procedures, and Drawings" was identified for the licensee's failure to maintain an adequate operating procedure for the D Emergency Diesel Generator (EDG) that resulted in inoperability that exceeded the allowed outage time. The licensee's immediate corrective actions were to restore the D EDG to operability and to replace the D EDG control switch 4 with one that matched the other seven EDGs. The violation was entered into the licensee's corrective action program as PER 990793.

The performance deficiency was more than minor because it adversely affected the mitigating systems cornerstone objective of equipment performance. This violation required a Phase II analysis because the 0612 Appendix A Mitigating Systems Exhibit question of whether the finding represented an actual loss of a single train's function for greater than its technical specification allowed outage time was answered "yes". The regional Senior Reactor Analyst performed a detailed risk analysis for the performance deficiency using the NRC's risk software, and the Unit 2 model. Assumptions included using a conservative screening value for the operator recovery, and the assumption that a common cause failure was not involved. The dominant risk sequences were the loss of offsite power, failures of suppression pool cooling, failure to recover power within 4 hours, and failure of alternate low pressure injection. The short period the EDG was unavailable, and the lack of a common cause resulted in a Green finding. The performance deficiency was assigned a crosscutting aspect of Resources because the licensee did not properly prioritize procedure upgrade resources to ensure that procedures for the D EDG were adequate (H.1). (1R15.1)

Inspection Report# : [2015001](#) (*pdf*)

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: FIN Finding

Failure to Perform Required Continued Monitoring of a Degraded Condition

. The NRC identified a finding (FIN) associated with the licensee's failure to evaluate continued operation for an established and growing crack in the "A" Residual Heat Removal Service Water (RHRSW) pump room floor. The licensee failed to provide justification why continued monitoring was not required while the floor crack continued to degrade for over five weeks. This was a requirement per licensee procedure NEDP-22 Operability Determinations and Functional Evaluations, Section 3.2.2.G.4.a.(2).

This finding was more than minor because, if left uncorrected, it had the potential to lead to a more significant safety concern. Specifically, without sufficient monitoring, the crack had the potential to propagate until the pumps in the RHRSW pump room became inoperable in a PMF event without the licensee's knowledge. This finding is associated with the mitigating systems cornerstone. The finding was screened using Inspection Manual Chapter (IMC) 0609 Appendix A, Exhibit 2, issued June 19, 2012 and was determined to be green because the functions provided by the floor were maintained. The licensee's immediate corrective action was to commence bi-weekly monitoring of the crack until repairs could be made. The cause of this finding was directly related to the cross cutting aspect of the

Evaluation attribute of the Problem Identification and Resolution area because the licensee action to address the cause and extent of condition of the crack did not address the safety aspect of crack propagation. [P.2]

Inspection Report# : [2014005](#) (*pdf*)

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Demonstrate Satisfactory Performance of the Automatic Depressurization System Air Accumulators

A self revealing non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XI, Test Control, was identified for the licensee's failure to correctly demonstrate that Unit 1 Automatic Depressurization System (ADS) valve 1-PCV-1-19 would perform satisfactorily in service in accordance with written test procedures. On October 30, 2014 operators discovered that valve 1-PCV-1-19 would not open as required. Troubleshooting revealed that the control air line accumulator to 1-PCV-1-19 was misconfigured and aligned instead to, non-ADS, steam relief valve 1-PCV-1-18. The licensee determined that the misalignment of the control air hoses which occurred under WO 02-010199-063 on November 22, 2006 had never been tested without the normal control air available.

The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of Configuration Control, 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 improper installation of ADS valve 1-PCV-1-19 control air line resulted in the inoperability of the valve. Using IMC 0609.04, Initial Characterization of Findings and IMC 0609 Appendix A, Exhibit 2 Mitigating Systems screening questions, the finding screened as very low safety significance (Green). The finding did not represent an actual loss of function of a single train for greater than its technical specification allowed outage time and did not represent an actual loss of function of one or more non-technical specification equipment for greater than 24 hours. This finding does not have a cross-cutting aspect because the lack of proper post maintenance testing to verify the configuration of the ADS air line was made in November 2006 and was not reflective of current performance.

Inspection Report# : [2014005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance:  Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Reflect Changes to Facility and Procedures in Final Safety Analysis Report Periodic Revisions

Severity Level IV. An NRC identified non-cited violation (NCV) of 10 CFR 50.71(e)(4) was identified for the licensee's failure to reflect all changes made in the facility or procedures as described in the Final Safety Analysis Report (FSAR) up to a maximum of six months prior to the date of filing the periodic updates to the FSAR with the NRC. The licensee's immediate corrective action was to enter this issue into their CAP as PER 1008424 to update areas in the FSAR identified by the NRC.

The inspectors determined that traditional enforcement per NRC Enforcement Policy was applicable since this finding reflects an impact on the regulatory process in the form of timely and accurate reports to the NRC. Section 6.1.d.3 of the enforcement policy states, in part, that a failure to update the FSAR as required by 10 CFR 50.71(e) in cases where the information is not used to make an unacceptable change to the facility or procedures is a SL IV violation. The inspectors did not identify any occurrence where the lack of timely updates to the UFSAR resulted in an unacceptable change to the facility or procedures. Crosscutting aspects are not assigned for traditional enforcement violations. (Section 1R18)

Inspection Report# : [2015001](#) (*pdf*)

Last modified : December 15, 2015