



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION III
2443 WARRENVILLE ROAD, SUITE 210
LISLE, IL 60532-4352

November 9, 2010

Mr. Mark Bezilla
Site Vice President
FirstEnergy Nuclear Operating Company
Perry Nuclear Power Plant
P. O. Box 97, 10 Center Road, A-PY-A290
Perry, OH 44081-0097

**SUBJECT: ERRATA FOR PERRY NUCLEAR POWER PLANT NRC INTEGRATED
INSPECTION REPORT 05000440/2010004**

Dear Mr. Bezilla:

On October 29, 2010, the U.S. Nuclear Regulatory Commission (NRC) issued Integrated Inspection Report 05000440/2010004 (ML103020254). A cross-cutting aspect associated with a non-cited violation was inadvertently incorrectly characterized in the Integrated Inspection Report Summary of Findings. Please insert the attached errata where appropriate into Integrated Inspection Report 05000440/2010004.

We apologize for any inconvenience to you and your staff.

Sincerely,

/RA/

Jamnes L. Cameron, Chief
Branch 6
Division of Reactor Projects

Docket No. 50-440
License No. NPF-58

Enclosure: Errata for Inspection Report 05000440/2010004

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SUMMARY OF FINDINGS

IR 05000440/2010004; 07/01/2010 – 09/30/2010; Surveillance Testing; Problem Identification and Resolution.

The inspection was conducted by resident and regional inspectors. The inspection report (IR) covers a 3-month period of resident inspection. Two green findings which were NCVs were identified. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using Inspection Manual Chapter (IMC) 0609 "Significance Determination Process" (SDP). Cross-cutting aspects were determined using IMC 0310, "Components Within The Cross-Cutting Areas." Findings for which the SDP 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. Inspector-Identified and Self-Revealed Findings

Cornerstone: Mitigating Systems

- Green. The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion XI, Test Control, for the unacceptable preconditioning of the 'A' residual heat removal (RHR) pump minimum flow valve prior to quarterly in-service testing. Specifically, the licensee performed a surveillance that cycled the valve prior to performing stroke time testing, and had not previously performed an evaluation assessing the sequence for preconditioning. The licensee entered the issue into their corrective action program.

The inspectors determined that unacceptably preconditioning the RHR minimum flow valve was a performance deficiency that affected the Mitigating Systems Cornerstone because it can mask the true as-found condition of a component designed to mitigate accidents. The performance deficiency was determined to be more than minor because, if left uncorrected, it could lead to a more significant safety concern. The finding was of very low safety significance because it was not a design/qualification deficiency, did not represent a loss of system safety function, did not result in a loss of function of a single train for greater than its Technical Specification (TS)-allowable outage time, did not result in a loss of function of nonsafety-related risk-significant equipment and was not risk significant due to external events. This finding has a cross-cutting aspect in the work control planning component of the Human Performance area (per IMC 0310 H.3(a)), because the licensee did not appropriately plan work activities for plant structures, systems, and components. Specifically, the licensee did not schedule the surveillance tests in the proper sequence to prevent unacceptable preconditioning of the valve. (Section 1R22)

- Green. The inspectors identified a finding of very low safety significance and associated NCV for a failure to comply with TS 3.0.2 by not entering TS Limiting Condition for Operation (LCO) 3.3.5.1 Condition A and TS LCO 3.3.6.1 Condition A when required. The inspectors determined that the licensee incorrectly utilized a TS Surveillance Requirement Note that allows a delay in entering the Conditions and Required Actions for the given TS LCO. As a result, the licensee failed to correctly enter the Conditions

and Required Actions when reactor level instruments were declared inoperable to perform testing in support of planned maintenance. The licensee entered the issue associated with the failure to comply with TS into their corrective action program.

This performance deficiency was determined to be more than minor because it impacted the Equipment Performance attribute of the Mitigating Systems 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 (i.e., core damage); and if left uncorrected it could lead to a more significant safety concern. This finding is of very low safety significance because it was not a design/qualification deficiency, did not represent a loss of system safety function, did not result in a loss of function of a single train for greater than its TS-allowable outage time, did not result in a loss of function of nonsafety-related risk-significant equipment and was not risk significant due to external events. This finding has a cross-cutting aspect in the decision making component of Human Performance cross-cutting area (per IMC 0310 H.1(b)), because the licensee did not use conservative assumptions to ensure the proposed action was safe. Specifically, the licensee incorrectly used the TS Surveillance Requirement Note to satisfy maintenance requirements. (Section 4OA2)

B. Licensee-Identified Violations

One violation of very low safety significance was identified by the licensee and has been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This violation and its corrective action tracking number are listed in Section 4OA7 of this report.



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Letter to M. Bezilla from J. Cameron dated November 9, 2010.

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