



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

September 5, 2019

Thomas P. McCool, Site Vice President
Comanche Peak Nuclear Power Plant
Vistra Operations Company, LLC
P.O. Box 1002
Glen Rose, TX 76043

SUBJECT: COMANCHE PEAK NUCLEAR POWER PLANT, UNITS 1 AND 2 – RESPONSE
TO REQUEST TO CONSIDER REVISION TO CROSS-CUTTING ASPECTS
FOR TWO FINDINGS

Dear Mr. McCool:

On May 10, 2019, NRC Inspection Report 05000445/2019001 and 05000446/2019001 (ADAMS Accession Number ML19148A438) was issued with seven findings. By letter, dated June 5, 2019, Vistra Operations Company LLC (hereafter Vistra) provided a response concerning the characterization of the cross-cutting aspects assigned for two of the findings (ML19165A020). The purpose of this letter is to provide the NRC response to the Vistra letter.

Non-Cited Violation 05000445; 05000446/2019001-04

The inspectors identified a Green, non-cited violation of 10 CFR 50.65(a)4 for failure to implement risk-mitigating actions during diesel generator maintenance. Specifically, this maintenance necessitated running a hose through a normally shut door intended to protect against flooding, fire, and medium energy line break effects. To mitigate the risk of allowing the door to be open, a compensatory action was planned to secure the door so that it was open no more than 2 inches. However, workers in the room were concerned about their safety because emergency egress would be impeded with the door secured, so they decided to open the door, but remain available to quickly close the door if needed. After the inspectors identified that the compensatory measure was not implemented as planned, the licensee determined that attempting to close the door after a medium energy line break initiated would not provide adequate protection.

This finding was assigned a cross-cutting aspect of H.14, Conservative Bias, because the inspectors determined that workers assumed that the planned risk management actions were not necessary because they were present and able to quickly shut the door, without stopping work and discussing their plan to alter the actions with their supervisor.

In their letter, Vistra agreed with the characterization of the condition as a Green non-cited violation of 10 CFR 50.65(a)(4), but disagreed with the assignment of H.14 as the cross-cutting aspect. Vistra concluded that H.8, Procedure Adherence, was the most appropriate cross-cutting aspect for this finding because their corrective action program (Condition Report 2019-000672) coded the issue as lack of procedure use and adherence. Vistra pointed

out that this was also the cause determined for a similar violation (NCV 05000445/2017002-04 and 05000446/2017002-04) for failure to evaluate risk management actions when blocking open a door that was credited as a hazard barrier.

Inspection Manual Chapter 0310 provides guidance for assigning cross-cutting aspects. Inspection Manual Chapter 0310 establishes the cross-cutting aspect as being the performance characteristic of a finding that is either the primary cause of the performance deficiency or the most significant contributing cause. The NRC does not expect inspectors to perform formal cause evaluations, but they are expected to assess available information, including cause evaluation results performed by the licensee when assigning a cross-cutting aspect. Inspection Manual Chapter 0310 relies upon additional guidance and examples that are provided in NUREG 2165, "Safety Culture Common Language."

For this finding, the performance deficiency was: "The failure to implement planned risk mitigating actions."

In reviewing Vistra's request, the NRC determined that the licensee did not perform a cause evaluation prior to the issuance of this finding. Therefore, the information on the cause is new information.

The NRC reviewed the details associated with NCV 05000445/2017002-04 and 05000446/2017002-04. This finding did involve blocking open a door credited as a hazard barrier credited as protection from tornado-borne missiles. The shift manager authorized blocking open the door without reviewing or implementing the risk management actions. The performance deficiency was: "The failure to adequately assess the risk and implement required risk management actions for the proposed maintenance activities." Upon review, this earlier finding was different than the one under consideration, in that the decision-making process failed to recognize the risk and therefore failed to recognize the need to implement risk management actions. In contrast, in the finding under consideration, the risk was recognized and the risk management actions were described to the workers, but they decided to modify the actions rather than implement the specified actions.

The NRC's independent reviewer concluded that H.8, Procedure Adherence, would amount to restating the performance deficiency as the cause.

Upon review, the NRC concluded that the most appropriate CCA is H.11, Challenge the Unknown, based on the following:

- The performance deficiency falls within the area of Human Performance and is not associated with either Problem Identification and Resolution or with Safety Conscious Work Environment.
- The work documents correctly identified the risk associated with blocking open the door and provided appropriate risk mitigating actions, so there was not a failure to recognize the need for risk mitigating actions as was the case in the NCV referenced by Vistra's letter.
- The workers recognized that risk mitigating actions were required prior to commencing work, but also recognized that taking those actions created a conflict in that industrial safety was impacted (blocked emergency egress). Faced with uncertainty, workers apparently decided on their own how to resolve the conflict, rather than discussing the competing risks with supervision.

These circumstances most closely align with H.11, Challenge the Unknown, which includes the following description: “Individuals stop when faced with uncertain conditions. Risks are evaluated and managed before proceeding.” NUREG 2165 covers the same topic and has six related examples. Example 5, which is most applicable to this finding, states, “Individuals stop work activities when confronted with an unexpected condition, communicate with supervisors, and resolve the condition prior to continuing work activities. When appropriate, individuals consult system and equipment experts.”

Therefore, the cross-cutting aspect for NCV 05000445/2019002-04 and 05000446/2019002-04 will be revised to be H.11, Challenge the Unknown.

Non-Cited Violation 05000445; 05000446/2019001-05

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” associated with the licensee’s failure to follow the requirements of station Procedure STI-421.01, “Initiation of Issue Reports.” An NRC inspector questioned whether material stored outside near the plant in a temporary laydown area inside the protected area could become missile hazards to safety-related equipment during tornado conditions. In the subsequent licensee response, an evaluation concluded that the material could create a tornado missile hazard and the material needed to be secured to prevent that from happening. However, station personnel failed to notify the shift manager of an issue with material storage in the protected area that could become a tornado-borne missile. This issue required evaluation of operability and compensatory actions for resolution, but this did not occur.

This finding was assigned a cross-cutting aspect of H.14, Conservative Bias, because the inspectors determined that Engineering personnel failed to use decision-making practices that emphasized prudent choices over those that are simply allowable.

Vistra stated that they agree with the NRC’s characterization of the condition as a Green NCV of 10 CFR Part 50, Appendix B, Criterion V, associated with the failure to follow the requirements of station Procedure STI-421.01. However, Vistra stated that they did not agree with the assignment of H.14 as the cross-cutting aspect for this finding. Vistra believes that the cause for the finding was related to teamwork. Specifically, when engineering personnel completed an evaluation and determined there was an adverse condition that required notification of the shift manager, Engineering did not discuss that conclusion with the original issue owner, who was in a different organization (Siemens). Vistra believes that this performance deficiency involved individuals and work groups that did not communicate and coordinate their activities within and across organizational boundaries to ensure that nuclear safety was maintained. Therefore, Vistra requested that the cross-cutting aspect be changed to H.4, Teamwork.

The following performance deficiency was documented for this finding: The licensee’s failure to follow the requirements of Procedure STI-421.01 when a degraded condition was identified.

The NRC’s independent reviewer requested additional information from Vistra to provide the basic sequence of activities that occurred as part of the licensee’s response to the inspectors’ concern. The Regulatory Affairs Manager for Comanche Peak Nuclear Power Plant provided two e-mails (ADAMS Accession No. ML19231A389) in response to this request. The basic sequence reported was as follows:

- On January 31, 2019, the senior resident inspector reported the concern to the control room and an engineering manager. The engineering manager discussed it with a civil

engineer, who assigned a contractor (Siemens engineer), to submit an issue report. An issue report is an initial report used to screen issues and will become a condition report for issues to be addressed in the corrective action program (CAP) or become a tracking report if the issue is non-CAP or administrative.

- The Siemens engineer wrote Issue Report 2019-001119. The issue report was worded as a question, so it was screened as an administrative issue and became Tracking Report 2019-001119.
- An action to perform an evaluation was created to determine if the material in the temporary laydown area in the protected area could potentially affect important structures, systems, or components.
- In parallel, the civil engineer started a discussion with the operations support manager because there was a threat of severe weather in the area at that time. It was agreed that if a tornado was to hit and the evaluation was not finished, the plant would be shutdown per station Procedure STI-904.
- The inspector pointed out that the evaluation necessitated entry of the problem into the CAP, but that action was not performed.
- On February 4, 2019, the civil engineer completed the evaluation and concluded that the material in question needed to be strapped down. Engineering management approved the evaluation on February 6, 2019.
- On February 14, 2019, the inspectors reviewed the draft evaluation and noted that the condition required an operability review to assess the potential impact of the unrestrained material during a tornado. The condition also required compensatory measures to restrain the material. However, this condition was not reported to the shift manager so these actions could be considered.

Upon review, the NRC considered the following:

- The performance deficiency falls with the area of Human Performance. It could be considered within the area of Problem Identification and Resolution. It is clearly not related to Safety Conscious Work Environment.
- The sequence of events indicate that the question was directed to appropriate individuals and work groups and the question was answered appropriately, so Problem Identification and Resolution was ruled out. However, some actions related to notification and documentation did not occur, so Human Performance was further considered.
- The licensee did not perform a cause evaluation for this performance deficiency.
- The cause could reasonably be associated with the following cross-cutting aspects:

- H.4 – Teamwork: Individuals and work groups communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety is maintained.
- H.13 – Consistent Process: Individuals use a consistent, systematic approach to make decisions. Risk insights are incorporated as appropriate.

Since NUREG 2165 did not contain relevant examples that made one of these cross-cutting aspects appear more appropriate than the other choice, the NRC accepted the licensee's recommendation that H.4 – Teamwork should be assigned as the cross-cutting aspect.

Therefore, the cross-cutting aspect for NCV 05000445/2019002-05 and 05000446/2019002-05 will be revised to be H.4 – Teamwork.

Sincerely,

/RA/

Neil F. O'Keefe Chief
Reactor Projects Branch B
Division of Reactor Safety

Docket Nos. 05000445 and 05000446
License Nos. NPF-87 and NPF-89

cc: Electronic Distribution for Comanche Peak

COMANCHE PEAK NUCLEAR POWER PLANT, UNITS 1 AND 2 – RESPONSE TO REQUEST TO CONSIDER REVISION TO CROSS-CUTTING ASPECTS FOR TWO FINDINGS – September 5, 2019

DISTRIBUTION:

SMorris, RA
 MShaffer, DRA
 AVegel, DRP
 MHay, DRP
 RLantz, DRS
 GMiller, DRS
 DCylkowski, RC
 DDodson, RIV/OEDO
 VDricks, ORA
 JWeil, OCA
 NJordan, NRR
 AMoreno, RIV/OCA
 BMaier, RSLO
 HFreeman, IPAT
 NOKeefe, DRP
 BTharakan, DRP
 JMelfi, DRP
 NBrown, DRP
 MChambers, DRP
 NDay, DRP
 LReyna, DRP
 PJayroe, DRP/IPAT
 MHerrera, DRMA
 R4Enforcement
 ROP Reports

DOCUMENT NAME: R:_REACTORS\ CP\2019\word doc\Vistra Contested CCAs for CP 2019001.docx

ADAMS ACCESSION NUMBER: ML19248B828

SUNSI Review ADAMS: Non-Publicly Available Non-Sensitive Keyword:
 By: NO'Keefe Yes No Publicly Available Sensitive NRC 002

OFFICE	BC:PBA	C:CRS/RCB	BC:PBB			
NAME	JJosey	MHaire	NO'Keefe			
SIGNATURE	/RA/	/RA/	/RA/			
DATE	08/22/2019	08/27/2019	09/5/2019			

OFFICIAL RECORD COPY