

Robinson 2

2Q/2005 Plant Inspection Findings

Initiating Events

Significance:  Dec 17, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ESTABLISH AND MAINTAIN A WRITTEN PROCEDURE APPROPRIATE TO THE CIRCUMSTANCES OF PREPLANNING VALVE REPLACEMENTS

Green. A non-cited violation of Technical Specification (TS) 5.4.1 was identified for failure to maintain a written procedure appropriate to the circumstances, involving the planning of maintenance work orders. An inadequate work order developed from this procedure resulted in the RCS Leakage PI becoming White because of packing leakage from a pressurizer spray bypass valve. This finding contributed to a small reactor coolant system (RCS) leak which did not exceed the TS-identified RCS leakage limit, and did not affect any other mitigating systems equipment.

This finding is more than minor because it affected the equipment performance attribute of the Initiating Events cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions, in that the finding resulted in a small loss of coolant within the capability of the RCS makeup systems. The finding did not contribute to the likelihood of a reactor trip or affect any mitigating system functions and had no impact on external event initiators. Therefore this finding screened as Green in the Initiating Events Cornerstone in the Phase 1 worksheet, a finding of very low risk significance.

Inspection Report# : [2004009\(pdf\)](#)

Mitigating Systems

Significance:  Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY AND CORRECT A SURVEILLANCE PROCEDURE THAT UNACCEPTABLY PRECONDITIONS THE RESIDUAL HEAT REMOVAL PUMPS

Green. The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, for failure to promptly identify and correct a condition adverse to quality, in that a surveillance procedure that directed unacceptable preconditioning of the residual heat removal (RHR) pumps was not identified and corrected from 1997 to 2005.

The finding is greater than minor because it is associated with the procedure quality attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective of ensuring the availability and reliability of systems that respond to events to prevent undesirable consequences. Unacceptable preconditioning of the RHR pump could mask a condition that renders the pump inoperable. The finding is of very low safety significance because it is not a design or qualification deficiency, does not represent an actual loss of safety function for a system or train, and is not risk significant due to a seismic, fire, flooding, or severe weather initiating event.

Inspection Report# : [2005003\(pdf\)](#)

Significance: SL-IV Mar 24, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FULLY EVALUATE A CHANGE TO THE DISCHARGE PATH OF A SAFETY INJECTION SYSTEM RELIEF VALVE WHICH POTENTIALLY INVOLVES AN UNREVIEWED SAFETY QUESTION

The inspectors identified a Severity Level IV (SL IV) non-cited violation (NCV) of 10 CFR 50.59 requirements for the failure to fully evaluate a change to the plant which potentially involved an unreviewed safety question (USQ). Specifically, the licensee implemented a plant change in 1992 which directed the discharge of a safety injection system (SIS) relief valve to an open floor drain in the auxiliary building (contrary to the Updated Final Safety Analysis Report), without evaluating the effects on dose consequences. The potential USQ was related to an increase in the dose consequences, if the relief valve, which is located outside containment, were to lift (and potentially fail to reseal) during post-LOCA recirculation conditions.

This finding was evaluated using traditional enforcement and is more than minor because it was a change to the facility which would require NRC review and approval prior to implementation. This finding affected the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to preclude undesirable consequences. However, the technical

issue was determined to be of very low safety significance, given the low likelihood of a scenario involving a loss of coolant accident and actuation of the relief valve.

Inspection Report# : [2005006\(pdf\)](#)

G

Significance: Mar 24, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY AND TRANSLATE DESIGN INPUTS AND ASSUMPTIONS INTO EMERGENCY PROCEDURES

Green: The inspectors identified a non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion III, for the failure to assure that applicable design requirements were correctly translated into a residual heat removal (RHR) emergency procedure. Specifically, the licensee did not incorporate the postulated failure of an RHR pump to stop on demand as a design input into an engineering service request.

This finding is more than minor because it affected the design control attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to preclude undesirable consequences. This finding was determined to be of very low safety significance because the licensee provided field validation information for the emergency procedure which indicated that, under worst case conditions, margin was available to achieve the switchover to recirculation within the time assumed in the accident analyses. The licensee entered this issue into the corrective action program and initiated a revision to the emergency procedure.

Inspection Report# : [2005006\(pdf\)](#)

G

Significance: Sep 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

UNAPPROVED LOCAL MANUAL OPERATOR ACTIONS INSTEAD OF REQUIRED PHYSICAL PROTECTION OR SEPARATION OF CABLES TO PRECLUDE FIRE DAMAGE

A non-cited violation of 10 CFR 50, Appendix R, Section III.G.2, was identified for relying on unapproved local manual operator actions instead of the required physical protection or separation of cables from fire damage. The operator actions were to be accomplished outside the main control room (MCR) and were relied on for hot safe shutdown from the MCR for a severe fire in the south cable vault or the B emergency diesel generator room. The licensee entered this issue into its corrective action program. The operator actions could reasonably be accomplished and are acceptable as compensatory actions until full compliance with the regulation is restored.

The finding adversely affected the reliability and capability of equipment required to achieve and maintain a safe shutdown condition following a severe fire. The finding degraded the defense-in-depth for fire protection. The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. Because the manual actions could reasonably be accomplished, the finding was determined to have very low safety significance.

Inspection Report# : [2004006\(pdf\)](#)

G

Significance: Sep 03, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INOPERABLE FIRE BARRIER PENETRATION SEAL

A non-cited violation of Operating License Condition E, Fire Protection Program, was identified for failure to identify and correct a through-wall hole in a penetration seal fire barrier. The penetration seal was in a three-hour fire rated wall separating the Unit 2 cable spreading room from the turbine building. Upon discovery, the licensee declared the penetration seal inoperable, entered the issue into the corrective action program, and installed a temporary repair.

The finding adversely affected the reliability and capability of equipment required to achieve and maintain a safe shutdown condition following a severe fire. The finding adversely affected the fire confinement defense-in-depth element of fire protection. The finding is greater than minor because it is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone. Because the hole through the seal was small (less than about 1/8 inch in diameter), the finding was determined to have very low safety significance.

Inspection Report# : [2004006\(pdf\)](#)

Barrier Integrity

Significance: N/A Dec 17, 2004

Identified By: NRC

Item Type: FIN Finding

SUPPLEMENTAL INSPECTION CONCLUSION: WHITE RCS LEAKAGE PERFORMANCE INDICATOR

This supplemental inspection was conducted to assess the licensee's evaluation associated with the Reactor Coolant System (RCS) Leakage

Performance Indicator (PI) crossing the Green/White threshold during the 4th quarter of calendar year 2004. This PI is associated with the barrier integrity cornerstone. The PI became White because of excessive packing leakage from valve a pressurizer spray bypass valve. Although the licensee's problem identification, extent-of-condition evaluation, and corrective actions were adequate, the inspectors identified some weaknesses in the licensee's root-cause evaluation.

Inspection Report# : [2004009\(pdf\)](#)

Emergency Preparedness

Significance: SL-IV Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

IMPLEMENTATION OF A CHANGE TO AN EMERGENCY ACTION LEVEL DECREASING EFFECTIVENESS OF THE EMERGENCY PLAN

No Color. A severity level IV non-cited violation was identified for failure to meet the Emergency Plan change requirements of 10 CFR 50.54 (q). A change involving emergency classification of a seismic event, which decreased the effectiveness of the Emergency Plan, Revision 54, was implemented without prior NRC approval. The finding was evaluated using the NRC's Enforcement Policy because licensee reductions in the effectiveness of its emergency plan impact the regulatory process.

This finding is more than minor because extending the time period required for appropriate emergency classification of a seismic event could adversely affect the performance of both onsite and offsite emergency actions. The finding was determined to be a severity level IV violation because it involved licensee failure to meet an emergency planning requirement not directly related to assessment and notification.

Inspection Report# : [2004005\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Oct 22, 2004

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION AND RESOLUTION CONCLUSION

The licensee was effective at identifying problems at a low threshold and entering them into the Corrective Action Program (CAP). Management's involvement in the review of issues documented in the program was timely and appropriate. Self-assessments and audits of the CAP, and trend reviews were critical, thorough, and effective in identifying program deficiencies. Although not reflective of the general assessment into licensee problem identification, the inspectors identified a case where equipment deficiencies in a plant area were not being appropriately identified. Prioritization and evaluation of problems in the CAP were effective. The technical adequacy and depth of evaluations, proposed corrective actions and timeliness were in a manner commensurate with the safety significance of the issue. The inspectors identified noteworthy deficiencies associated with five cause determinations. Although the inspector-identified discrepancies indicated some problems in the evaluation of issues, overall, this area of the program was considered effective. The licensee had identified the site's evaluation of issues as an area of program focus. The CAP was effective in correcting problems consistent with the importance to safety of the issues. Effective management involvement in the process was evident. Outstanding corrective actions were tracked and delays in the implementation of corrective actions received the appropriate level of management attention. During the course of the inspection, the inspectors identified isolated problems with the implementation of corrective actions. However, these issues did not affect the overall assessment of corrective action implementation. Individuals actively utilized the CAP and employee concerns program (ECP). Issues entered into the ECP received the

appropriate level of management involvement. Management demonstrated sensitivity to organizational attitude toward the CAP and a safety conscious work environment. Based on discussions conducted with licensee employees and a review of station activities, site personnel felt free to report safety concerns.

Inspection Report# : [2004007\(pdf\)](#)

Last modified : August 24, 2005