

Braidwood 2

1Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Nov 09, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROVIDE REQUIRED FUNCTION TO FIRE SUPPRESSION SYSTEM IN 2A DOST ROOM

The inspectors identified a finding of very low safety significance and associated non-cited violation of Braidwood Station Unit 2 Operating License NPF-77, Condition 2.E. This finding was related to the unavailability of the foam-water fire suppression system for the 2A diesel oil storage tank room due to a system blockage. The licensee cleared the blockage and revised applicable procedures to prevent future blockages. The primary cause of this finding was associated with the Problem Identification and Resolution cross-cutting area, in that the licensee failed to take timely corrective action resulting in the foam suppression system for the above room being inoperable for a 5 year period. This finding was considered more than minor because it affected the Mitigating Systems cornerstone objective to ensure that external factors (i.e., fire, flood, etc.) do not impact the availability, reliability and capability of systems that respond to initiating events. The finding was of very low safety significance (Green) in accordance with Phase 2 of the Fire Protection Significance Determination Process because there was no realistic scenario by which a postulated fire could have affected more than just the support equipment to the affected emergency diesel generator. In addition, the inspectors verified that the redundant train of emergency AC power and associated safety-related structures, systems and components would remain free of fire damage and that safe shutdown capability could be achieved even with the total loss of one diesel oil storage tank room.

Inspection Report# : [2005008\(pdf\)](#)

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

LACK OF A BOUNDING VOLTAGE DROP CALCULATION DURING AN SI

A finding of very low safety significance was identified by the inspectors associated with a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," where the licensee had no design basis calculation supporting adequate voltage levels for safety related equipment during a safety injection (SI). Voltage drop during an SI transient can be large and could result in operation of required safety-related equipment outside its design basis. After identification by the team, the licensee was able to demonstrate adequate voltage to support the operation of safety related equipment during this bounding voltage transient scenario. This finding was more than minor because if left uncorrected, the finding would become more significant. Modifications to the electrical distribution system can adversely affect the voltage for safety related equipment. Without a bounding voltage drop analysis to support the reliable operation of safety related equipment during an SI, these effects would go unnoticed causing adverse conditions during an actual SI with off-site power available. This finding was of very low safety significance because it screened out using the Phase 1 worksheet.

Inspection Report# : [2005007\(pdf\)](#)

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

EDG SX CROSS-CONNECT NOT SUPPORTED BY DESIGN BASIS

A finding of very low safety significance associated with a 10 CFR Part 50, Appendix B, Criterion III, "Design Control" was identified by the inspectors. The finding involved the operation of the emergency diesel generator jacket water coolers in a cross-connected configuration that was not supported by the plant's license and design basis. The licensee is evaluating the procedure for possible revision. This finding was more than minor because the licensee's established design and license basis for these coolers required a higher level of flow than that actually observed in the coolers during this cross-connected operation. The licensee had inappropriately relied on a manual operator action to justify operation in this configuration. This condition, if left uncorrected, would become more significant. This finding was of very low safety significance because it screened out using the Phase 1 worksheet.

Inspection Report# : [2005007\(pdf\)](#)

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO LEAK TEST BURIED SX INTAKE HEADER PIPING

The inspectors identified a finding involving a Non-Cited Violation (NCV) violation of 10 CFR Part 50.55a(g)4 having very low safety significance for failure to perform periodic leakage testing required by the American Society of Mechanical Engineers Code on the buried portions of the essential service water (SX) system intake piping. This finding was more than minor because failure to perform periodic leakage testing could have allowed undetected through-wall flaws to remain inservice. These undetected flaws could grow in size until leakage from the buried SX intake pipe degrades system operation or if sufficient general corrosion occurs, a gross rupture or collapse of the SX piping sections could occur. The finding was of very low safety significance because the licensee concluded that the piping systems were currently operable based upon pump surveillance testing which measured adequate SX system flow. The licensee also documented that piping failure was not anticipated due to the external pipe coating, cathodic protection and low system operating pressure.

Inspection Report# : [2005007\(pdf\)](#)**G****Significance:** Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

NON-CONSERVATIVE CST INVENTORY CALCULATION

A finding of very low safety significance was identified by the inspectors associated with a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" where the licensee failed to maintain an accurate design basis for the condensate storage tank (CST) useable inventory. The team identified an additional depletion path of CST water, the makeup valve (1(2)CD0035) from the CST to the condenser hotwell, that was not accounted for in the plant's calculation for useable CST volume. This finding was more than minor because it was associated with and affected the Mitigating Systems Cornerstone. Specifically, the capacity of the water source for the auxiliary feedwater (AFW) system was adversely affected by this additional depletion path. This finding was of very low safety significance because it screened out using the Phase 1 worksheet.

Inspection Report# : [2005007\(pdf\)](#)**G****Significance:** Sep 30, 2005

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROVIDE PROCEDURE FOR RECOVERY OF POLUGGED SX STRAINER

The inspectors identified a finding of very low risk significance for failure to provide operators with equipment, procedures and training to manually operate the essential service water (SX) strainers to recover the loss of automatic backwash capability. Specifically, the loss of automatic strainer backwash function following a seismic event would lead to SX strainer plugging and without adequate recovery procedures, the loss of SX system flow. This finding did not constitute a violation of NRC requirements because the strainers (aside from the pressure boundary) and associated backwash equipment were not considered safety-related. The inspectors determined that this finding was of more than minor significance because it would become a more significant safety concern if left uncorrected. Specifically, the failure to provide equipment, procedures and training for manually backwashing the SX strainers could result in loss of cooling to safety-related equipment cooled by SX following a seismic event. An NRC Regional III Senior Reactor Analyst (SRA) performed a qualitative Phase 3 risk evaluation and determined that the initiating event frequency of a seismic event was low. In performing this evaluation, the SRA considered the lack of data to support how long it would take to plug the strainers with sediment or debris and given that strainer plugging may take days, there was a high likelihood that recovery of the backwash function would occur. Although there were no plant procedures, the licensee had access to vendor documents which provided adequate instructions for the manual backwash operation, and the loss of off-site power operating procedure included actions to restore power to the 480 volt motor control center which supplied power to the SX strainer backwash motors and isolation valves. Based on these facts, the SRA determined that the finding was of very low safety significance. The licensee entered this deficiency into their corrective action program for resolution.

Inspection Report# : [2005007\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Significance: SL-IV Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

DECREASING THE EFFECTIVENESS OF THE EMERGENCY PLAN BY CHANGING EAL RU2 THRESHOLD THAT ADDRESS RADIOLOGICAL EFFLUENTS W/O PRIOR NRC APPROVAL OR ADEQUATE 10 CFR 50.54(q) REVIEW

The inspectors identified that the licensee had changed its standard emergency action level (EAL) scheme by revising one EAL's criteria for an Unusual Event declaration that addressed an unplanned radiological release in excess of effluent radiation monitor readings unless the release

could be determined to be below Offsite Dose Calculation Manual limits within 15 minutes for releases that could not be terminated in 60 minutes or less. The inspectors determined that this EAL change decreased the effectiveness of the emergency plan, and that the licensee did not obtain prior NRC approval for this change, contrary to the requirements of 10 CFR 50.54(q). The licensee is evaluating the options to correct the EAL.

This finding was more than minor because extending the time period required for the appropriate emergency classification of a radiological release could adversely affect the performance of both onsite and offsite emergency actions. Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process as specified in Section IV.A.3 of the Enforcement Policy. According to Supplement VIII of the Enforcement Policy, this finding was determined to be a Severity Level IV because it involved a failure to meet a requirement not directly related to assessment and notification. Further, this problem was isolated to one EAL and was not indicative of a functional problem with the EAL scheme. Additionally, because the violation was a Severity Level IV and the licensee entered this issue into its corrective action program this finding is being treated as a Severity Level IV Non-Cited Violation of 10 CFR 50.54(q).
Inspection Report# : [2005010\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : May 25, 2006