

Brunswick 2

3Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: N/A Jul 05, 2006

Identified By: NRC

Item Type: FIN Finding

95001 Supplemental Inspection

This supplemental inspection was conducted in accordance with Inspection Procedure 95001, to assess the licensee's evaluation associated with a Unit 2 performance indicator in the initiating events cornerstone. The Unplanned Power Changes per 7000 Critical Hours Performance Indicator crossed the threshold from Green (very-low risk significance) to White (low-to-moderate risk significance) in the fourth quarter of 2005. Specifically, the licensee experienced two unplanned power changes in the second quarter of 2005, one unplanned power change in the third quarter of 2005, and four unplanned power changes in the fourth quarter of 2005. The first unplanned power change, which occurred on April 20, was the result of a downpower initiated to remove the 2B reactor feed pump from service following an impeller failure which occurred on April 19. The second unplanned power change, which occurred on June 25, was the result of a downpower initiated to stabilize condenser vacuum following the trip of the 2B circulating water pump. The third unplanned power change, which occurred on August 5, was the result of placing Unit 2 in cold shutdown due to declaring all site emergency diesel generators (EDGs) inoperable. The fourth, fifth and sixth unplanned power changes, which occurred on November 8, 14, and 25, respectively, were the result of downpowers initiated to effect repairs on condenser tube leaks. The seventh unplanned power change, which occurred on December 13, was the result of a downpower caused by tripping of the 2B recirculation pump.

The licensee's problem identification, root cause and extent-of-condition evaluations, and corrective actions for the seven downpowers were adequate.

Inspection Report# : [2006007\(pdf\)](#)

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Engineering Change Procedure Resulting in Inoperable Reactor Core Isolation Cooling System

An NRC-identified non-cited violation was identified for failure to meet Technical Specification (TS) 5.4.1, Procedures. Specifically, the temporary modification process was not followed when implementing a temporary change to the Unit 2 reactor core isolation cooling keepfill system. As a result, appropriate reviews of the impact on reactor core isolation cooling system operability were not performed. This resulted in the Unit 2 reactor core isolation cooling system being inoperable due to the potential of voiding the reactor core isolation cooling pump discharge piping during certain scenarios.

This finding is more than minor because it is associated with operating equipment lineup and affected the Mitigating System Cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance (Green) because it did not represent an actual loss of safety function for greater than the TS allowed outage time. The inspectors determined that the cause of this finding is a performance aspect of the human performance cross-cutting area, in that the cause was due to personnel failing to follow the temporary modification process (Section 1R04).

Inspection Report# : [2006003\(pdf\)](#)

Significance:  Nov 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedural Controls for RHR System Venting

Green. A Green NRC identified, non-cited violation (NCV) of Technical Specification (TS) 5.4.1.a was identified for failure to establish written procedures to direct venting of the residual heat removal (RHR) system in response to increasing system pressure. Instead, system venting was directed through informal communications, such as e-mails and telephone calls. The licensee entered the deficiency associated with lack of procedural guidance into their Action Request Program for resolution.

This finding is more than minor because it affected the ability of the licensee to properly control the venting of the RHR system and was associated with the Mitigating Systems Cornerstone and the respective attribute of procedure quality. The finding is of very low safety significance because there was no actual loss of safety function. A contributing cause of the finding is related to the cross-cutting element of problem identification and resolution.

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

Barrier Integrity

Emergency Preparedness

Significance:  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Potential Reduction in Effectiveness of Emergency Plan

An NRC-identified non-cited violation of 10 CFR 50.54(q) was identified for the failure to determine if the introduction or the increasing of air into the offgas flowpath for the purpose of reducing steam jet air ejector radiation monitor readings would reduce the effectiveness of the site Emergency Plan. The deficiency associated with this finding is that a 50.54(q) review was not performed to determine if there would be a potential reduction in the effectiveness of the site Emergency Plan because emergency action level classifications for both an Unusual Event and an Alert are based on radiation level readings from the steam jet air ejector radiation monitor. The procedure change which allowed the introduction of air into the offgas flowpath, and the implementation of the procedure on June 1, 2006 did not have associated 50.54(q) reviews.

The finding was greater than minor because it is associated with the Emergency Preparedness Cornerstone and potentially affected the program elements of 10 CFR 50.54(b)(4). The finding was of very low safety significance because the licensee performed an analysis of the potential affects of the range of airflow rates on the radiation monitor readings which demonstrated that the emergency action level values would not have been detrimentally affected.

Inspection Report# : [2006004\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Significance: N/A Dec 16, 2005

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION AND RESOLUTION

The inspectors determined that the licensee was effective in identifying problems and entering them into the Corrective Action Program (CAP). One example was noted where new action requests/nuclear condition reports (ARs/NCRs) were not written for current failures, instead the issue was tracked with an old NCR. Problem evaluation and corrective action implementation were generally effective with deficiencies noted in corrective action timeliness and in the quality and timeliness of investigations. The inspectors noted several examples where significant adverse conditions had recurred, indicating that all root/contributing causes had not been determined or that corrective actions had not provided timely resolution. Significant investigations were ongoing and recent CAP process changes were initiated by management to address these issues. The inspectors did not identify any new CAP problems not already being addressed by the licensee. The inspectors determined that the site staff felt free to raise issues and that management wanted issues placed into the CAP for resolution. Some engineering department staffing and CAP workload distribution concerns were noted in the employee concerns program (ECP). The ECP coordinator and management were already addressing the underlying issues related to these concerns and their potential affect on plant equipment. The inspectors did not identify any reluctance to report safety concerns.

Inspection Report# : [2005011\(pdf\)](#)

Last modified : December 21, 2006