

Robinson 2

3Q/2007 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Aug 17, 2007

Identified By: NRC

Item Type: FIN Finding

Failure to install Thermal Overload (TOL) protection on the 'D' deep well pump

The team identified a finding having very low safety significance (Green) involving the failure of the licensee to meet a self imposed standard. The licensee committed in modification package EC 59037, "Install 'D' Deep Well Pump," to meet or exceed the requirements in the Electrical Power Distribution System Design Basis Document (DBD), DBD/R87038/SD16. DBD sections 4.3.1.c and 4.5.1.20 specified that overload protection be provided. The vendor technical manual for the 'D' deep well pump motor, which is included in the facility technical manual 762-209-103 for the 'D' deep well pump, specified that Thermal Overload (TOL) protection be provided. The vendor technical manual for the 'D' deep well pump motor was referenced in modification package, EC 59037. Contrary to the above, the licensee failed to install TOL protection for the "D" deep well pump.

This finding was more than minor based on the fact that it is associated with the reactor safety mitigation cornerstone aspect of design control. It impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. In accordance with NRC Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the team conducted a Phase 1 SDP screening and determined the finding was of very low safety significance (Green). Since the 'D' deep well pump is not safety related equipment per Chapter 15 of the UFSAR, this finding does not represent a violation of any NRC requirements. The team did not identify any cross cutting aspects associated with this finding. This issue is documented in the corrective action program as nuclear condition report (NCR) 239915. (Section 1R21.2.9.)

Inspection Report# : [2007006](#) (*pdf*)

Significance:  Dec 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Prevent a Repetitive Failure of a Safety-Related Pump's Motor Controller

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, for failure to identify the cause and take corrective action to prevent recurrence for a significant condition adverse to quality, in that the licensee failed to prevent a repetitive failure of a safety-related pump's motor controller when the effects of temperature which reduced the life expectancy of wiring and insulation were not identified.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to events to prevent undesirable consequences. The failure to identify in 2004 that the effects of temperature had reduced the life expectancy of the coil insulation in the motor controller for a service water booster pump resulted in a repetitive failure in 2006. The inspectors determined that the finding was of very low safety significance (Green) because it was not an actual loss of safety function because the redundant system was available. The finding has a cross-cutting aspect in the area of problem identification and resolution. (Section 1R12)

Inspection Report# : [2006005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Respiratory Protection Equipment for Emergency Response

An NRC-identified non-cited violation of 10 CFR 50.47(b)(10) was identified for the failure to provide adequate respiratory protection equipment for emergency response, compromising the protective actions developed for the plume exposure pathway for emergency workers. An adequate quantity of small and large sized self-contained breathing apparatus (SCBA) respirator masks were not available in the control room for licensed plant operators that were fit-tested for said sizes. This issue was entered into the licensee's corrective action program.

This finding is greater than minor because it is associated with the Emergency Preparedness cornerstone attribute of Response Organization Performance and adversely affects the cornerstone objective of ensuring the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The finding was evaluated using Sheet 1, Failure to Comply, of the Emergency Preparedness SDP. The issue described was a planning standard problem, was not a risk-significant planning standard problem, and did not involve a planning standard function failure. Therefore, the finding is of very low safety significance (Green). This finding has a cross-cutting aspect in the area of human performance because the procedure used for managing SCBA equipment did not contain information regarding the mask sizes required to be staged in the control room based on fit-test results for emergency responders, resulting an inadequate number of large and small sized masks being available. (Section 2OS3)

Inspection Report# : [2007002](#) (*pdf*)

Significance: N/A Dec 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate 10 CFR 50.54(q) Evaluation for Emergency Plan Rev. 33

A Severity Level IV non-cited violation was identified for implementing a change to the emergency plan without appropriate justification, contrary to the requirements of 10 CFR 50.54(q). The finding was evaluated under the NRC's Enforcement Policy using the traditional enforcement process because licensee reductions in the effectiveness of its emergency plan impact the regulatory process. The finding was determined to be a non-cited Severity Level IV violation because it involved licensee failure to meet an emergency planning requirement not directly related to assessment or notification (Section 4OA5).

Inspection Report# : [2006005](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Oct 20, 2006

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

No findings of significance were identified. The licensee was effective at identifying problems at a low threshold and entering them into the Corrective Action Program (CAP). The licensee properly prioritized issues and routinely performed adequate evaluations that were technically accurate and of sufficient depth. 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 trend that was not identified by the licensee. The trend involves equipment failures where the root or contributing cause was identified as vendor-related.

Prioritization and evaluation of problems in the CAP were effective. The technical adequacy and depth of evaluations, proposed corrective actions and timeliness were commensurate with the safety significance of the issue. The inspectors identified only minor deficiencies associated with cause determinations. Overall, this area of the program was considered to be effective.

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.

Operating Experience (OE), from within the Progress nuclear fleet, the industry, and the NRC, was being effectively used in the CAP. OE was evaluated for applicability at the station and was also used in the assessment of issues that occurred at Robinson. However, during the inspection the inspectors identified several instances where the licensee did not comply with the requirements of their procedure to enter issues identified by the OE program into the CAP. These instances had no safety impact and, therefore, were considered to be minor. Furthermore, these issues did not affect the overall assessment of the use of OE.

Self-assessments were effective in identifying issues, and prioritizing and evaluating them in accordance with their risk significance for operability, reportability, common cause, generic concerns, extent of condition, and extent of cause. Resulting corrective actions were generally effective to prevent recurrence.

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 and contract employees and a review of station activities, site personnel felt free to report safety concerns.

Inspection Report# : [2006009](#) (*pdf*)

Last modified : December 07, 2007