

# Robinson 2

## 3Q/2008 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to adequately assess risk when assuming availability prior to performing post maintenance testing.**

The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50.65(a)(4) for the failure on August 14 to adequately assess plant risk as Yellow after post-maintenance valve lineups failed to restore service water cooling to the B emergency diesel generator (EDG). As a result, the licensee incorrectly assumed that the B EDG was available to perform its safety function prior to performing a post maintenance test, and thereby performed an inadequate risk assessment which lowered plant risk from Yellow to Green status. As an immediate corrective action, the licensee implemented Operations Night Order 08-10 which required interim measures be performed to ensure that plant risk will not be downgraded until the component being returned to service has been proven to be available by performing a functional verification. The licensee also plans to proceduralize this interim measure into procedure OMM-048, Work Coordination and Risk Assessment. This issue was entered into the licensee's corrective action (CA) program for resolution.

Inspection Report# : [2008004](#) (*pdf*)

**Significance:**  Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to maintain emergency diesel generator service water valve configuration control**

The inspectors identified a Green NCV of Technical Specification 5.4.1 for the failure on August 11 to maintain configuration control of the service water system for the B emergency diesel generator (EDG) when a service-water isolation valve to the EDG was closed outside of an approved process. The failure to maintain equipment configuration control of the closed service water isolation valve is contrary to Regulatory Guide 1.33 which requires the licensee to implement procedures affecting quality, which includes procedures maintaining equipment configuration control. This failure directly led to this valve remaining closed after the licensee electrically aligned the EDG for automatic start and declared it available on August 14. With this valve closed and the EDG aligned for auto-start, the EDG would have started without cooling water, rendering the EDG incapable of meeting its designed safety functions. As immediate corrective actions, the licensee performed a comprehensive valve and switch line-up on the EDG and issued an operations night order which required operators to perform certain interim measures when operating components without procedural guidance or clearance order control, to ensure that a positive means of control has been established. The licensee also plans to revise appropriate operating procedures to clarify requirements for performing valve and switch line-ups after maintenance activities. This issue was entered into the licensee CA program for resolution.

Inspection Report# : [2008004](#) (*pdf*)

**Significance:**  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to manage the increase in plant risk by failing to implement risk-management actions prior to performing switchyard maintenance activities**

The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50.65(a)(4) for the failure to protect the Emergency Diesel Generators (EDGs) and Auxiliary Feedwater (AFW) pumps during maintenance activities involving the operation of bucket trucks in the switchyard. The licensee determined that this activity would increase the Loss of Offsite Power event initiator and resulted in Yellow risk condition. As a result of failing to protect the EDGs and AFW pumps, the licensee failed to implement the appropriate risk-management actions prior to performing maintenance.

The finding is more-than-minor because it is related to a risk-management issue where the licensee failed to implement the risk-management action, which the licensee determined to be a significant compensatory measure. The finding has a cross-cutting aspect in the area of Human Performance because the licensee did not ensure supervisory and management oversight of work activities such that nuclear safety is supported, in that supervisory oversight of work activities did not verify that risk-management actions were completed prior to conducting maintenance activities which increased nuclear risk.

Inspection Report# : [2008003](#) (*pdf*)

**G**

**Significance:** Dec 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Determine the Cause of a Failure of the Steam-Driven Auxiliary Feedwater Pump to Start**

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI for the licensee's failure in 2005 to determine the cause of a failure of the steam-driven auxiliary feedwater pump to start, thereby allowing a subsequent similar failure in 2007.

The performance deficiency was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone. Specifically, the performance deficiency decreased the reliability of the SDAFW pump by increasing the probability that the pump's governor air supply solenoid valve would fail to open on demand. This finding was determined to have very low safety significance because it was not a design or qualification deficiency and did not represent the loss of a system safety function. This finding has a cross-cutting aspect in the area of Human Performance because the licensee did not ensure that personnel, equipment, procedures, and other resources were available and adequate to assure nuclear safety, in that the licensee did not ensure that resources were available and adequate to produce a complete investigation for a significant condition adverse to quality.

Inspection Report# : [2007005](#) (*pdf*)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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**Significance:** Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to barricade and conspicuously post a High Radiation Area during refueling outage 24**

The inspectors identified a Green non-cited violation of Technical Specification (TS) 5.7.1 for the failure to barricade and conspicuously post a High Radiation Area (HRA) during refueling outage 24.

The finding is more-than-minor because the area radiation levels within the boundaries exceeded the levels (greater than 100 mr/hr) such that the area was required to be barricaded and conspicuously posted as a HRA. The finding has a cross-cutting aspect in the area of Problem Identification and Resolution because the licensee did not thoroughly evaluate problems such that the resolutions address causes and extent of conditions, in that the root cause investigations had failed to thoroughly evaluate the recurring nature of these issues and had failed to establish effective corrective actions that addressed the root cause and failed to prevent recurrence of these issues.

Inspection Report# : [2008003](#) (*pdf*)

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## **Public Radiation Safety**

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## **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.

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## Miscellaneous

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**Significance:** Mar 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure of the licensee to assess the increased risk resulting from removing a boric acid injection path from service**

The inspectors identified a Green non-cited violation of 10 CFR 50.65(a)(4) for the failure of the licensee to perform a risk assessment on March 10, 2008, before establishing maintenance boundaries which removed a boric acid injection flow path from service. This finding was more than minor because it is related to a risk assessment and management issue where the licensee failed to consider risk significant systems, structures, or components and support systems that were unavailable during maintenance. The finding has a cross-cutting aspect in the area of Human Performance (H.3(a)) because the operations staff did not appropriately plan the work activity of establishing maintenance boundaries by incorporating risk insights of the site's risk model.

Inspection Report# : [2008002](#) (*pdf*)

Last modified : November 26, 2008