

# Farley 1

## 1Q/2009 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:** **G** Feb 27, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Verification of SW Capability to Concurrently Provide System Design Basis Cooling Requirements and the AFW Alternate Water Source.**

Green: The team identified a finding of very low safety significance involving a non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion III, Design Control. Specifically, the licensee failed to establish measures to verify the design capability of the service water (SW) system to provide water as a suction source for the auxiliary feedwater (AFW) pumps while maintaining adequate SW flow to other safety-related components. The Technical Specification's (TS) action statement for Condensate Storage Tank (CST) Operability, 3.7.6.a, and the corresponding TS bases credit SW as a water source for AFW pumps upon a loss of normal feedwater supply from the CST.

The finding is more than minor because it is associated with the design control attribute of the Mitigating System Cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Due to the lack of appropriate analysis or testing, the SW design basis accident capability was not assured. The team assessed the finding using the SDP and determined that the finding was of very low safety significance (Green) since it was a design deficiency determined not to have resulted in the loss of safety function. Specifically, the licensee had not operated in a condition for which the design deficiency in question was relied upon for operation. The finding was entered into the licensee's corrective action program. There is no cross cutting aspect to this finding because it does not reflect recent performance in that the original SW system analyses were performed in 1990 and 1999 and the inspectors identified no subsequent opportunity for the licensee to identify this deficiency. (Sections 1R21.2.1)

Inspection Report# : [2009006](#) (*pdf*)

**Significance:** **W** Aug 01, 2008

Identified By: NRC

Item Type: AV Apparent Violation

#### **Inadequate Work Instructions Cause 1B EDG Exhaust Header Failure.**

A self-revealing finding and Apparent Violation of Technical Specification 5.4.1 was identified for inadequate work instructions which resulted in the 1B Emergency Diesel Generator (EDG) exhaust header not being installed in accordance with the vendor's instructions. Subsequently, the 1B EDG exhaust header failed during a surveillance test. No immediate safety concern exists because the exhaust header has been repaired and the 1B EDG was returned to service. In addition, the exhaust header replacement had not been implemented on the remaining EDGs.

The failure to provide adequate work instructions for installing the 1B EDG exhaust header is a performance deficiency. This finding is more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone objective of ensuring availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In addition the 1B EDG exhaust header failure potentially affected the ability of the 1B EDG to meet its mission time. This finding was assessed using the applicable SDP and determined to White because there was a calculated risk increase over the base case between 1E-5 and 1E-6. The

dominant accident sequence is a series of failures which results in a reactor coolant pump seal loss-of-coolant accident that cannot be mitigated leading to core damage. The exposure time assumed in the attached SDP analysis was one-half the period from February 10 to March 13 plus approximately 60 hours repair time for the exhaust header.

Inspection Report# : [2008011](#) (*pdf*)

Inspection Report# : [2008012](#) (*pdf*)

Inspection Report# : [2008013](#) (*pdf*)

**Significance:**  Apr 04, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

### **Fire Procedure Credits Unreliable Indication**

The team identified a non-cited violation of Technical Specification 5.4.1, Procedures, in that Units 1 and 2 post-fire safe shutdown abnormal operating procedures AOP 28.1, Fire or Inadvertent Fire Protection System Actuation in the Cable Spreading Room, and AOP 28.2, Fire in the Control Room, credited diagnostic instrumentation that would have been potentially unreliable due to fire damage from a postulated fire in the control room or cable spreading room. The finding was entered into the licensee's corrective action program as Condition Report 2005103665.

This issue is a performance deficiency because the safe shutdown procedure relies on an indication which was not protected from fire damage. The finding is more than minor because it is associated with the procedure quality attribute of the Mitigating Systems cornerstone and it affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors assessed the finding using Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process." The finding was assigned a low degradation rating because it was determined to be a minor procedural deficiency that is compensated by operator experience or familiarity. Because the finding was assigned a low degradation rating, the team determined that this finding was of very low safety significance (Green).

Inspection Report# : [2008006](#) (*pdf*)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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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

**Significance:** N/A Dec 19, 2008

Identified By: NRC

Item Type: FIN Finding

### PI&R Summary

The inspectors identified that the licensee was effective at identifying problems and putting them into the corrective action program (CAP). The licensee's effectiveness at problem identification was evidenced by a CR generation rate of approximately 1000 per month. However, the inspectors identified two examples of delayed identification. The licensee effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. However, the inspectors identified two examples where errors were made in risk evaluation. Licensee assessments were found to be effective. Assessment results adequately identified problems.

Operating experience usage was found to be effective. Operating experience had been integrated into the licensee's processes for managing work and plant operations. However, the licensee had not been periodically reviewing the Part 21 Notices provided on the NRC public web site. On the basis of interviews conducted during the inspection, workers at the site felt free to input safety findings into the CAP.

The corrective actions implemented and planned, to address the issues identified during the 2008 supplemental IP 95002 and IP 95001 inspections were appropriately targeted. The licensee's response to pipe wall thinning and valve replacement in the Service Water System has been commensurate with safety significance.

Inspection Report# : [2008007](#) (*pdf*)

**Significance:** N/A Aug 24, 2007

Identified By: NRC

Item Type: FIN Finding

### Biennial Identification and Resolution of Problems Inspection Results

One finding of very low safety significance (Green) was identified. The licensee was generally effective in identifying problems at a low threshold and entering them into the corrective action program. The licensee properly prioritized issues entered into the corrective action program (CAP) and routinely performed evaluations that were technically accurate and of sufficient depth to address the issue documented in the condition reports (CRs). Overall, corrective actions were effective; however, minor examples of inadequate condition report broadness reviews and documentation issues related to the closure of action items were identified. In general, operating experience was found to be used both proactively and reactively by personnel involved in the corrective action program; however, an example of industry operating experience was identified in which the licensee did not completely develop interim compensatory measures for a condition to which Farley was vulnerable. The licensee's programmatic self-assessments and audits were generally effective in identifying weaknesses in the corrective action program; however, a missed opportunity in the trending of issues which could result in adverse effects on safety-related plant components was identified. The inspectors also concluded that the workers at Farley felt free to report safety concerns.

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

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