

Farley 2

1Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate maintenance instructions results in inoperability of the TDAFW pump

A self-revealing, Green non-cited violation of TS 5.4.1 was identified for inadequate work instructions used to perform corrective maintenance on the Unit 2 TDAFW pump 'A' UPS which resulted in an inoperability of the TDAFW pump. This finding has been entered into the licensee's CAP as condition report (CR) 2009101467.

Failure to provide appropriate work sequence instructions related to the maintenance on the 'A' UPS is a performance deficiency. This finding is more than minor because it is associated with the Procedure Quality attribute of the Mitigating Systems cornerstone and adversely impacted the cornerstone objective because the inadequate work instructions resulted in loss of redundant and diverse control power sources to the TDAFW pump which affected the ability of the pump to respond to initiating events to prevent undesirable consequences. This finding was assessed using the Phase 1 screening worksheet of the SDP and determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for greater than the TS allowed outage time and was not potentially risk-significant due to external events. This finding is assigned a cross-cutting aspect in the Resources component of the Human Performance area (H.2(c)) because the work sequence instructions used to perform the corrective maintenance did not contain complete guidance necessary for proper operation of the UPS breakers. (Section 1R19)

Inspection Report# : [2009002](#) (*pdf*)

Significance:  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:  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)

Significance:  Apr 04, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Areas Where OMAs Are Performed Did Not Have ELUs Installed

The team identified a non-cited violation of Farley Unit 2 Operating License Condition 2.C.(6), for the licensee's failure to fully implement the approved fire protection program, in that emergency lighting units (ELUs) were not installed in all areas where local operator manual actions were required to support post-fire safe shutdown. Specifically, the team determined that there were no ELUs installed to illuminate the front panels of the Reactor Coolant Pump (RCP) switchgear, located in the Train 'A' switchgear room, where post-fire safe shutdown local operator manual actions were required to trip the RCP 4160 Volt alternating current breakers. The finding was entered into the licensee's corrective action program under Condition Reports 2008103335, 336, and 337.

The finding is greater than minor because it is associated with the reactor safety Mitigating Systems cornerstone attribute of protection against external factors (i.e., fire) and it affects the cornerstone attribute of ensuring reliability and capability of systems that respond to initiating events. Specifically, the finding adversely affected the ability to perform local operator manual actions required to achieve and maintain safe shutdown conditions following a fire in the cable spreading room. The inspectors assessed the finding using IMC 0609, Appendix F, Fire Protection Significance Determination Process. The team determined that this finding was of very low safety significance (Green) because the operators had a high likelihood of completing the task using flashlights, which operators are directed to carry with them by procedure while performing local actions.

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

Significance:  Apr 04, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

ELU Test Failures Were Not Documented In CRs As Required By Procedure

The team identified a non-cited violation of Farley Unit 2 Operating License Condition 2.C.(6), for the licensee's failure to fully implement test control requirements incorporated in approved plant procedures associated with the periodic testing of emergency lighting units. As a consequence, condition reports (CRs) were not initiated as required, when battery conductance measurements did not meet acceptance criteria. The finding was entered into the licensee's corrective action program as Condition Report 2008103290.

This issue is a performance deficiency because the licensee did not properly document ELU test failures on CRs for trending and evaluation in accordance with the surveillance test procedures. The finding involved systems or components (i.e., emergency lights) required for post-fire safe shutdown of the reactor. The finding is greater than minor because it is associated with the reactor safety Mitigating Systems cornerstone attribute of protection against external factors (i.e., fire) and it affects the cornerstone attribute of ensuring reliability and capability of systems that respond to initiating events. The team determined that this finding was of very low safety significance (Green) because the operators had a high likelihood of completing the task using flashlights, which operators are directed to carry with them by procedure while performing local actions.

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

Barrier Integrity

Emergency Preparedness

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 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*)

Last modified : May 28, 2009