

Robinson 2

1Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: FIN Finding

Inadequate procedures produced conditions which caused a reactor trip

Green. A self-revealing finding was documented for the licensee's failure to provide adequate procedures for maintenance and installation of the main generator and exciter. As a result, work activities using those procedures produced conditions which led to high turbine vibration, which on November 17, 2008, prompted control-room operators to manually initiate a reactor trip. This failure was a performance deficiency with respect to a self-imposed licensee policy which requires Managers and Supervisors to ensure that procedures are adequate to assure nuclear safety. This finding is addressed in the licensee's corrective action program within Action Request 306903. In that Action Request, one corrective action is to correct the affected procedures.

This finding is more-than-minor because it affected the Equipment Performance attribute of the Initiating Events cornerstone, and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability during power operations. When evaluated per Attachment 4 of Manual Chapter 0609, this finding screened to very low safety significance (Green) because it did not contribute to both an initiating event and the likelihood of a loss of mitigating equipment or functions. This finding has a cross-cutting aspect of supervisory and management oversight, as described in the Work Practices component of the Human Performance cross cutting area because the licensee failed to provide adequate oversight to the work activities associated with turbine-generator reassembly (H.4(c)).

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

Mitigating Systems

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to meet the required actions of TS 3.8.1 for condition B

Green. The inspectors identified a Green non-cited violation of Technical Specification 3.8.1, for the licensee's failure to meet the required actions of TS 3.8.1 for one inoperable emergency diesel generator (EDG), which are, in part, that within 24 hours of discovering the inoperable EDG, the licensee must either verify that the other EDG starts from standby conditions and achieves acceptable steady-state conditions, or determine that the other EDG is not inoperable due to a common cause. The licensee has entered this finding into their corrective action program as Action Request 327363, and plans to insert into the appropriate procedure criteria to describe the required attributes of an adequate determination that an EDG is not inoperable due to a common cause.

This finding is more-than-minor because if left uncorrected, this finding would become a more significant safety and regulatory concern, in that following a common-cause inoperability of both EDGs and the discovery of the inoperability of one EDG, if left uncorrected this violation could result in the licensee correcting the discovered inoperability of one EDG without correcting the undiscovered inoperability of the other EDG, such that the other EDG could remain inoperable for longer than its allowed outage time. Using Appendix A of IMC 0609, the significance of this violation was determined to be of very low safety significance (GREEN), because although the violation could degrade the Emergency AC power function in the Mitigating Systems cornerstone, the violation was

not a design or qualification deficiency confirmed not to result in loss of operability or functionality, did not represent a loss of system safety function, did not represent actual loss of safety function of a single train, did not represent an actual loss of safety function of one or more non-TS Trains of equipment designated as risk-significant, and did not screen as potentially risk significant due to a seismic, flooding, or severe-weather initiating event. 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 (H.2(c)).

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

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*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

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*)

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

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