Summer
2Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 10, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Motor Starting Analysis
Green. The inspectors identified a NCV of 10 CFR 50, Appendix B, Criterion III, Design Control. Specifically, the licensee failed to verify the adequacy of the degraded voltage relay voltage setpoints by performing motor starting analyses based on voltage afforded by the relays. The failure resulted in several safety related motors having less margin than originally calculated. The licensee assessed the calculations to ensure the motors would start and entered the issue into their corrective action program to address this concern.

This finding is more than minor because it affects the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and operability of the safety related motors to perform their intended safety function during a design basis event and the cornerstone attribute of Design Control, i.e. initial design. The inspectors determined that the finding was of very low safety significance because the deficiency did not result in any motor being inoperable, after additional licensee analysis showed that the motors would have adequate voltage to start based on actual field setpoints. This finding was reviewed for cross-cutting aspects and none were identified since the performance deficiency is not indicative of current licensee performance.
Inspection Report# : 2008007 *(pdf)*

Significance: G Dec 10, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
EDG Exceeded Technical Specification Allowable Outage Time
This finding is more than minor because exceeding a Technical Specification Limiting Condition of Operation affects the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and operability of the EDGs to perform their intended safety function during a design basis event, and the cornerstone attribute of Equipment Performance:, i.e. availability. Following a Phase 3 analysis under the Significance Determination Process (SDP) the finding was determined to be of very low safety significance. The cause of this finding was related to the cross-cutting area of problem identification and resolution, specifically with respect to corrective action, because the licensee did not thoroughly evaluate the anomalous operation of the Parr generator voltage regulators and the reverse power relay in November 2006, such that the resolution adequately addressed causes and extent of condition. (P.1.c)
Inspection Report# : 2008007 *(pdf)*

Significance: G Dec 10, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Procedure for Analyzing the Impact of Updated Vendor Technical Manual
This finding is more than minor because it affects the Mitigating Systems Cornerstone objective to ensure the reliability, availability, and capability of systems that respond to initiating events and is associated with the attribute of procedure quality, in that inconsistencies were identified in Procedure EMP-135.004, Reactor Trip Breaker Testing,

Revision 2, where the licensee routinely failed to evaluate differences between vendor recommendations and the procedure. The finding was determined to be of very low safety significance, because there was no loss of the reactor trip breaker safety function to open on a reactor trip signal. The cause of this finding was related to the cross-cutting area of operating experience, specifically with respect to including vendor recommendations in procedures to support plant safety. (P.2.b)
Inspection Report# : 2008007 *(pdf)*

Significance: G Dec 10, 2008
Identified By: NRC
Item Type: FIN Finding
Failure to Maintain a Vendor Interface Program
This finding is more than minor because it affects the Mitigating Systems Cornerstone objective to ensure the reliability, availability, and capability of systems that respond to initiating events and is associated with the attribute of equipment performance, in that the data in the vendor technical information files necessary to ensure reliable equipment operation was obsolete.

The finding was determined to be of very low safety significance because there was no loss of the reactor trip breaker safety function to open on a reactor trip signal. There was no cross-cutting aspect identified with this finding.

Inspection Report# : 2008007 *(pdf)*

Significance: G Sep 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform ECG Tests During the Biennial Medical Exam for Licensed Operators
On August 11, 2008, while reviewing licensed operator medical records, the inspectors identified two operators who had not received an ECG test as part of their biennial medical exam. The inspectors then reviewed additional licensed operator medical records and identified a third operator who had not received an ECG test. When the inspectors notified the licensee about the missing ECG tests, the licensee conducted an extent of condition review and verified that licensed operators for the oncoming shift had received a complete biennial medical exam. Additionally, the licensee scheduled the operators who had not received the full physical examination an appointment to receive the ECG test by the contract physician.
Inspection Report# : 2008004 *(pdf)*

Barrier Integrity

Significance: G Mar 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Effectively Monitor the Performance of the Control Room Normal and Emergency Air Handling System per the Maintenance Rule
• Green. The inspectors identified an NCV of 10 CFR 50.65 (Maintenance Rule) with two examples for failing to demonstrate that the performance of the control room normal and emergency air handling (control room ventilation) system was being effectively controlled through the performance of appropriate preventive maintenance. Specifically, the licensee failed to: 1) properly categorize a control room ventilation system pressure boundary breach due to maintenance activities as a maintenance preventable function failure (MPFF) against the 'B' train, and 2) properly consider the unavailability time incurred by the functional failure against the 'A' train. These failures to adequately assess the Maintenance Rule (MR) implications of a control room ventilation system functional failure resulted in the system not being placed under the goal setting monitoring requirements of 10 CFR 50.65(a)(1). The licensee entered these issues into their corrective action program as CR-08-00944, CR-09-00107, and CR-09-01056, and placed the control room ventilation system in MR (a)(1) goal setting status.

This finding is more than minor because it is similar to the non-minor maintenance rule example 7.b. provided in Manual Chapter 0612, Appendix E, “Examples of Minor Issues,” which states that violations of Paragraph 10 CFR 50.65(a)(2), failure to demonstrate effective control of performance or condition and not putting the affected structures, systems, and components (SSCs) in (a)(1), are not minor because they necessarily involve degraded SSC performance or condition. This finding was determined to be of very low safety significance (Green) because the incorrect functional failure and unavailability hour assessments did not, by themselves, result in an actual degradation of the barrier function provided for the control room or additional operability or functionality concerns. The finding directly involved the cross-cutting area of Human Performance, component of Resources, and aspect of Personnel Training and Qualifications, in that, the licensee engineering staff did not fully understand MR evaluation requirements for systems with common components or the counting of unavailability hours for systems that are out of service for reasons other than a formal tag-out program (H.2.b).
Inspection Report# : 2009002 *(pdf)*

Significance: G Sep 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain the Control Room Pressure Boundary Operable and Complete the Required TS Actions
A Green non-cited violation of Technical Specification (TS) Limiting Condition for Operation (LCO) 3.7.6, “Control Room Normal and Emergency Air Handling System,” was identified by the inspectors for failure to maintain the control room boundary intact and operable, and complete the required TS actions. Specifically, the control room pressure boundary (CRPB) was discovered to be inoperable for approximately 17 days due to a breach in non-safety related air handler ductwork that defined a portion of the Control Room (CR) envelope. The licensee completed repairs to the non-safety related air handler ductwork, restored compliance with the TS, and documented this issue in their corrective action program as CR-08-00944 and CR-08-00972
Inspection Report# : 2008004 *(pdf)*

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

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