

Oconee 2

4Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Implementation of Risk Management Actions Associated With Modification Work Activities on the BWSTs for all Three Oconee Units

An NRC-identified Green NCV of 10 CFR 50.65(a)(4) was identified for the licensee's failure to effectively implement the risk mitigation actions contained in the approved complex activity plans associated with modifications on all three Borated Water Storage Tanks (BWST). This violation has been entered into the licensee's CAP as Problem Investigation Process report (PIP) O-10-0171.

The failure to properly implement the risk management actions of the complex activity plan was a performance deficiency. The finding was more than minor because the modification work on the BWSTs was performed in a manner that had the potential to adversely affect the Emergency Core Cooling Systems primary water source for all three units if left uncorrected by damaging level transmitters and associated cables supporting ECCS suction swap-over. The inspectors completed a Phase 1 screening using Inspection Manual Chapter 0609, "Maintenance Risk Assessment and Risk Significance Determination Process," Appendix K, and determined that the finding was of very low safety significance (Green) based on the Incremental Core Damage Probability resulting from the work activities being less than 1E-6. The finding directly involved the cross-cutting area of Human Performance under the "Work Activity Coordination" aspect of the "Work Control" component in that the licensee failed to appropriately coordinate work activities to ensure the increased risk was minimized in accordance with the approved Complex Activity Plan [H.3(b)]. (Section 1R13)

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inappropriate Removal of Workers Associated With Modification Work Activities on the BWST's from Work Hour Controls

An NRC-identified Green NCV of 10 CFR 26.205 was identified when the licensee excluded individuals working on BWST modifications from work hour controls. This violation has been entered into the licensee's corrective action program as PIP O-09-6989.

The exemption of workers involved in work on a safety-related system from work hours controls was a performance deficiency. The performance deficiency was more than minor because if left uncorrected, the exclusion of workers from work hour controls could have led to a more significant safety concern due to personnel exceeding work hour limits while performing modification work on the BWSTs that could have adversely affected the primary water supply to the emergency core cooling systems. In addition, more than 60 workers were improperly excluded from work hour controls over the 2.5-month period encompassed by the licensee's exclusion. This finding was determined to be of very low safety significance (Green) based on no deficiencies occurring due to worker fatigue which affected risk significant structures, systems, or components. This finding has a cross-cutting aspect of the licensee formally

defining the authority and roles for decisions affecting nuclear safety and communicating these roles to applicable personnel as described in the Decision-Making component of the Human Performance cross-cutting area [H.1(a)]. The licensee failed to ensure that the roles of personnel involved in processing requests exempting workers from work hour restrictions were adequately defined and communicated to ensure implementation of the work hour limits. (Section 4OA5.2)

Inspection Report# : [2009005](#) (pdf)

Significance:  Oct 15, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate assessment and management of risk during SSF ASW inoperability (Section 1R13)

An NRC-identified non-cited violation of 10 CFR 50.65(a)(4) was identified for the licensee's failure to provide adequate guidance to perform an appropriate risk assessment associated with the repair of a through-wall leak on the Unit 2 Standby Shutdown Facility (SSF) auxiliary service water (ASW) pump discharge line which rendered the Unit 2 SSF ASW system unavailable. The licensee initiated Problem Investigative Process reports (PIPs) O-09-6393 and O-09-6003 to evaluate this issue.

The inspectors determined the licensee's failure to provide adequate guidance to subsequently perform an appropriate risk assessment was a performance deficiency. The failure to provide guidance to adequately assess and manage risk was determined to be greater than minor because, if left uncorrected, it had the potential to lead to a more significant safety concern in that risk management actions to protect risk-significant equipment would not have been timely implemented. The inspectors assessed the finding using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," and determined that the finding was of very low safety significance (Green) based on the calculated incremental core damage probability being less than 1×10^{-6} and the additional risk management actions that were implemented. This finding also involved the cross-cutting aspect of failing to appropriately plan work activities by not fully incorporating risk insights as described under the Work Control component of the Human Performance cross-cutting area [H.3(a)]. (1R13)

Inspection Report# : [2009004](#) (pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Comply with Radiological Postings and the Requirements for Entering a Posted High Radiation Area

A self-revealing Green NCV of Technical Specification 5.4.1, Procedures, was identified for the failure to read and comply with all radiological postings and, prior to entering a high radiation area, attend a documented radiation protection briefing, know the radiological conditions in the area, and log onto a Radiation Work Permit that allows entry into a high radiation area, as required by procedure Nuclear Site Directive (NSD) 507, Radiation Protection (RP). The licensee has entered this violation into the corrective action program as PIP O-09-5609.

The failure to follow the requirements of NSD 507 with respect to radiological postings and entry into high radiation areas was a performance deficiency. This finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of Program and Process (Exposure Control) and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The finding was evaluated using the Occupational Radiation Safety Significance Determination Process and determined to be of very low safety significance (Green) because it was not related to As Low As Reasonably Achievable (ALARA) planning, did not involve an overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. The cause of this finding was directly related to the cross-cutting aspect of human performance and error prevention under the work practices component in the area of Human Performance, because the security personnel failed to use self-checking prior to passing through the Unit 1/Unit 2 fuel receiving bay door into the posted high radiation area [H.4(a)]. (Section 2OS1)

Inspection Report# : [2009005](#) (*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

Last modified : March 01, 2010