River Bend 1
4Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Control Scaffold Construction
The inspectors identified a Green noncited violation of Technical Specification 5.4.1.a for the failure of maintenance personnel to control scaffold erection per procedure. This failure resulted in the licensee installing 31 scaffolds in safety related areas that required either rework or an engineering evaluation to resolve as built deviations from the minimum seismic separation requirements. As a result, the design function of the safety related equipment was potentially adversely affected. The licensee entered this issue into their corrective action program as Condition Report CR-RBS-2009-3963.

The failure to erect scaffolds in accordance with procedures is a performance deficiency. This finding is more than minor because it is similar to Inspection Manual Chapter 0612, Appendix E, “Examples of Minor Issues,” Section 4, Example a, because Entergy had routinely failed to perform the requisite engineering evaluation and because it was associated with the protection against external events attribute of the mitigating systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events in order to prevent undesirable consequences. The finding was determined to be of very low risk significance (Green) because no actual loss of safety function occurred and the finding did not screen as potentially risk significant due to external events. This finding has a crosscutting aspect in the area of human performance, work practices, because the licensee failed to ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported [H.4(c)].
Inspection Report# : 2009004 *(pdf)*

Significance: G Sep 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain Reactor Core Isolation Cooling System Seismic Design
The inspectors identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for failure to implement measures to ensure that the seismic design basis for the reactor core isolation cooling turbine governor hydraulic system was correctly translated into the specifications, drawings, procedures, or instructions. This resulted in work to reroute the piping and an engineering evaluation to resolve seismic concerns. The licensee entered this issue into their corrective action program as Condition Report CR RBS 2009 3747.

The failure to implement design control features for the seismic design of the reactor core isolation cooling system is a performance deficiency. This finding was more than minor because it is similar to Inspection Manual Chapter 0612, Appendix E, “Examples of Minor Issues,” Section 5, Example a, in that the reactor core isolation cooling turbine was returned to service without the seismic spacing required by the original design or completion of an evaluation for the as left condition. This resulted in rework and additional engineering analysis to correctly resolve the seismic qualification concerns. The performance deficiency also affected the mitigating systems cornerstone attribute of external events and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events in order to prevent undesirable consequences. The inspectors evaluated the finding using Inspection Manual Chapter 0609, Attachment A, “Phase 1 – Initial Screening and Characterization of Findings,”

for the mitigating systems cornerstone. After answering “no” to all five questions in the mitigating systems cornerstone column of Table 4a, “Characterization Worksheet for Initiating Events, Mitigating Systems, and Barrier Integrity Cornerstones,” the inspectors concluded that the finding was of very low safety significance. This finding does not have a crosscutting aspect because the performance deficiency occurred in 1989 and is not reflective of current plant performance.
Inspection Report# : 2009004 *(pdf)*

Significance: G Sep 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Ensure Standby Liquid Control System Test Tank Remained Drained
The inspectors identified a Green noncited violation of Technical Specification 5.4.1.a for the failure of operations personnel to provide adequate procedural guidance to preclude water intrusion into the nonseismically qualified standby liquid control system test tank which resulted in the degradation of both trains of the standby liquid control system. The licensee entered this issue into their corrective action program as Condition Report CR RBS 2009 3862.

The failure to provide appropriate procedures to keep the standby liquid control test tank drained is a performance deficiency. The finding is more than minor because it affects the protection against external events attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems responding to initiating events to prevent undesirable consequences. The inspectors determined that the finding was of very low safety significance because the finding was not a design or qualification deficiency, did not represent a loss of a system/train safety function, and did not screen as potentially risk significant due to external events. This finding has a crosscutting aspect in the area of problem identification and resolution’s corrective action program because the licensee failed to take appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity. Specifically, the licensee failed to address the cause of inadvertent water intrusion into the standby liquid control test tank in a timely manner to prevent the common mode failure of both trains of standby liquid control [P.1(d)].
Inspection Report# : 2009004 *(pdf)*

Significance: G May 15, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Operability Determinations for a Degraded Diesel Exhaust Pipe
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures and Drawings” for twice failing to perform an adequate operability evaluation on the Division II diesel generator after the number 8 cylinder exhaust pipe cracked and later when two of four exhaust flange bolts failed.

The finding is more than minor because it affects the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems responding to initiating events to prevent undesirable consequences. The team determined that a Phase 3 significance determination was required because the finding screened as potentially risk significant due to potential loss of safety function of a single train. Region IV senior risk analysts performed a Phase 3 significance determination and determined that the issue represents a finding of very low safety significance (Green). This violation has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because the licensee did not thoroughly evaluate problems such that the resolutions address causes and extent of conditions, as necessary. Specifically the licensee failed to properly prioritize and evaluate for operability a degraded Division II diesel generator Number 8 cylinder exhaust pipe and flange [P.1 (c)].
Inspection Report# : 2009008 *(pdf)*

Significance: G Mar 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Risk Assessment While the Control Building Chilled Water System was Removed from Service
The inspectors identified a Green noncited violation of 10 CFR 50.65(a)(4) involving the failure of operators to

perform an adequate risk assessment while the Division 1 control building chilled water was unavailable. Specifically, the inspectors identified that licensee personnel non-conservatively evaluated the on-line risk as Green instead of Yellow. This resulted in an unrecognized increase in the level of risk as determined by Entergy's probabilistic safety analysis evaluation. The licensee entered this issue into their corrective action program as Condition Report CR-RBS-2009-0862.

Using Inspection Manual Chapter 0612, Appendix E, Section 3, Item 7(e), the finding is more than minor because the licensee's risk assessment had errors and incorrect assumptions regarding the unavailability of mitigating systems that put the plant in a higher risk category. Using Inspection Manual Chapter 0609, "Significance Determination Process," Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," the finding is determined to have very low safety significance because the incremental core damage probability deficit for the affected time period is less than 1.0E-6. This finding has a crosscutting aspect in the area of human performance component for work practices because Entergy personnel did not effectively follow procedures [H.4(b)].
Inspection Report# : 2009002 *(pdf)*

Barrier Integrity

Significance: G Sep 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Containment Closure Procedure
The inspectors identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of operations personnel to fully implement a station procedure to control obstructions in primary containment openings in Modes 4 and 5. The failure to follow procedure challenged the licensee's ability to establish containment closure. The licensee entered this issue into their corrective action program as Condition Report CR-RBS-2009-4296.

The failure to implement the containment closure procedure is a performance deficiency. This finding is more than minor because it affected the configuration control attribute of the barrier integrity objective to provide reasonable assurance that the physical design barriers (containment) will protect the public from radionuclide releases. Using Inspection Manual Chapter 0609, Appendix H, "Containment Integrity Significance Determination Process," the finding was assessed as a Type B finding because it is related to a degraded condition that has potentially important implications for the integrity of the containment without affecting the likelihood of core damage and was of very low significance because the licensee did not lose the capability to close containment when planned. The finding has a crosscutting aspect in the area of human performance, work control, because the licensee failed to appropriately coordinate work activities (identifying cables, quick disconnects, removing unidentified cables) to address the operational impact of those work activities on containment operability [H.3(b)].
Inspection Report# : 2009004 *(pdf)*

Significance: G Mar 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to promptly correct a condition adverse to quality
The team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to implement required actions to ensure that conditions were promptly corrected. Specifically, on February 10, 2009, during a review of corrective action documents, the inspectors noted that corrective actions for condition report CR-RBS-2007-03034 were inadequate to correct a condition in which an instrument was not treated as measuring and test equipment. The team noted that corrective action was proposed, but not implemented, and the condition report was closed. The condition which prompted the condition report still existed at the time of the inspection. The licensee entered this issue into corrective action program as condition report CR-RBS-2009-00747.

The failure to implement timely corrective action is a performance deficiency. The finding is greater than minor because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety

concern, such as an improperly calibrated main steam line monitor. The performance deficiency affected the barrier integrity cornerstone in that the proper calibration of the main steam line monitors is necessary to ensure proper isolation of containment in the event of fuel damage. Using Phase 1 worksheet from Manual Chapter 0609, "Significance Determination Process," this finding was determined to have very low safety significance because it did not represent a degradation of the radiological barrier function provided for the control room, auxiliary building, spent fuel pool, or standby gas treatment system; did not represent an actual open pathway in the physical integrity of the reactor containment and heat removal components, and did not involve an actual reduction in function of hydrogen ignitors in the reactor containment. This finding has a crosscutting aspect in the area of human performance associated with the decision making component because the licensee did not use conservative assumptions to demonstrate that the decision to close the condition report with no further action was appropriate (H1.b).
Inspection Report# : 2009006 *(pdf)*

Emergency Preparedness

Significance: G Jun 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Identify and Formally Critique an Emergency Plan Weakness
The inspectors identified a violation of 10 CFR 50.47(b)(14) for failure to identify and critique a nonrisk significant planning standard weakness demonstrated during a site emergency preparedness drill. Specifically, the licensee demonstrated a weakness in controlling radiological exposures for emergency workers during an emergency, without key emergency response organization decision maker consideration or input, when simulated emergency workers were left in containment during changing radiological conditions. The licensee entered this issue into their corrective action program as Condition Report CR-RBS-2009-02458.

This finding is more than minor because it is associated with the emergency response organization performance attribute of the Emergency Preparedness Cornerstone which ensures the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The inspectors evaluated the significance of this finding using Sheet 1, "Failure to Comply," of Inspection Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," and determined it to be of very low safety significance (Green) because the finding was a failure to comply with the requirements of 10 CFR 50.47(b)(14), the finding was associated with an emergency preparedness planning standard, the associated planning standard was not risk significant as defined by Manual Chapter 0609, Appendix B, and the finding was not a functional failure of the planning standard function. The inspectors determined that the finding has a crosscutting aspect in the area of problem identification and resolution because the licensee did not identify issues completely, accurately, and in a timely manner commensurate with their safety significance [P.1(a)].
Inspection Report# : 2009003 *(pdf)*

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

Last modified : March 01, 2010