

# Summer

## 4Q/2009 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  Dec 31, 2009

Identified By: NRC

Item Type: FIN Finding

#### **Failure to Follow Procedure and Correct Previously Identified Deficiencies with the Operator Workaround Program**

A Green NRC-identified finding was identified for the failure to adequately implement a procedure and correct previously identified deficiencies with the licensee's operator workaround program. This resulted in operator workarounds and challenges not fully or adequately being assessed, untimely resolution and status reporting of operator workarounds. The licensee initiated Condition Report (CR)-1000079 to address this issue.

This finding is more than minor because it was similar to examples 3.j. and 3.k. in Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues," where significant programmatic deficiencies were identified that could lead to worse errors if left uncorrected. In addition, the finding has the potential to lead to a more significant safety concern in the management and correction of operator workarounds that can have an adverse effect on the functional capability of a mitigating system or that can impact human reliability in responding to initiating events. Using NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 –

Initial Screening and Characterization of Findings," this finding was determined to be of very low safety significance (Green) because the failure to follow procedure and correct previously identified operator workaround program deficiencies, by themselves, did not result in an actual loss of operability or functionality, loss of system safety function, actual loss of safety function of a single train for greater than its Technical Specification (TS) allowed outage time, actual loss of safety function of one or more non-TS trains of equipment designated as risk-significant per 10CFR50.65 for greater than 24 hours, and was not potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program component because operations department personnel failed to take appropriate corrective actions to address previously identified deficiencies with following the operator workaround program procedure (P.1.d).

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

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### Barrier Integrity

**Significance:**  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Follow Procedure Results in Inadvertent Loss of Spent Fuel Pool Inventory**

A Green self-revealing non-cited violation (NCV) was identified for the failure to comply with TS 6.8.1. As a result of the failure to follow a procedure, approximately 8000 gallons of water was inadvertently transferred from the SFP to the refueling cavity. This issue was entered in the licensee's CAP as CR-09-04237.

This finding is more than minor because it is associated with the human performance and configuration control attributes of the Barrier Integrity cornerstone and affects the cornerstone objective to provide reasonable assurance

that physical design barriers, such as maintaining functionality of the spent fuel pool system, protect the public from radionuclide releases caused by accidents or events. Using NRC Inspection Manual Chapter 0609, Attachment 4, “Phase 1 – Initial Screening and Characterization of Findings,” this finding was determined to be of very low safety significance (Green) because it only represents a degradation of the radiological barrier function provided by the spent fuel pool, in that, since water level did not decrease less than 23 feet above the top of the irradiated fuel and pool temperature only increased by two degrees Fahrenheit, adequate radiological shielding and spent fuel pool cooling margins were maintained. This finding has a cross-cutting aspect in the area of human performance associated with the work practices component because operators failed to focus adequate attention to detail on following procedure steps in the proper sequence (H.4.b).

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

**Significance:**  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**

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*)

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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## **Public Radiation Safety**

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# 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.

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## Miscellaneous

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