Farley 1
1Q/2010 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to control conbustible material in a no intervening combustible allowed area of the plant
An NRC-identified NCV of License Condition 2.C.(4) was identified for the failure to control combustible material in the Unit 1 Component Cooling Water (CCW) Pump area as required by the licensee's administrative controls program. Workers left combustible material in the area of the 1A CCW pump motor, which is identified as a 10 CFR 50, Appendix R, Section III.G.2.b area. Twenty feet of cable separation exists in the area, but because no fire barrier exists, no intervening combustibles or fire hazards are allowed. Work Order (WO) 1082262401 was generated by licensee personnel to clean the sight-glasses on the inboard and outboard motor bearings of the 1A CCW pump. Part of the preparation and planning process includes a transient fire load analysis, which is included in the maintenance work instructions. In the case of this WO, the instructions utilized the fire load analysis data for the Unit 1 CCW heat exchanger area instead of the CCW pump area, and was included in the written instructions. The inspectors determined these inadequate work instructions contributed to the performance deficiency. The licensee entered their failure to control combustible material into their CAP for resolution (CR 2009114934) for resolution. The licensee's immediate corrective action was removal of the material from the location.

The finding was more than minor because it adversely affected protection against the external factors attribute of the Initiating Events (IE) cornerstone, to limit the likelihood of those events upsetting plant stability and challenging critical safety functions during shutdown, as well as power operations. Specifically, this finding affected plant safety-related equipment required for the safe shutdown of the plant in the event of a plant fire. This finding was assessed using the Phase 1 screening worksheets of Appendix 4 and Appendix F of MC 0609. The inspectors determined the presence of combustible materials was a low degradation finding against the fire protection program, because the identified material had a low likelihood of causing a fire from an existing source of heat or electrical energy. The inspectors determined the finding was of very low safety significance (Green) because of the low degradation rating. This finding was assigned a cross-cutting aspect in the
resources component of the Human Performance area because complete, accurate and up-to-date design documentation, procedures, work packages, and correct labeling of components were not provided (H.2(c)). (Section 1R05)

Inspection Report# : 2010002 *(pdf)*

Significance: G Mar 31, 2010
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to maintain control of combustible material
A self-revealing NCV of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures and Drawings, was identified for the licensee's failure to maintain combustible material a distance of 35 feet or greater from the "hot work" area as required by station procedure FNP-0-AP-38, Use of Open Flame. Unit 1 entered a Notification of Unusual Event (NOUE) emergency action level on December 12, 2009, when a fire occurred in the CCW heat exchanger/pump room. The fire occurred below and to one side of the scaffold near the service water (SW) supply to the 1A CCW heat exchanger isolation valve Q1P16V003A. The cause of the fire was combustible material left in the work area by licensee personnel performing lead abatement on piping supports for a plant modification. Welding personnel had later entered the area, performed welding/grinding activities, then placed work-related material in a concentrated area under the work area. The licensee entered this performance deficiency into their CAP (CR 2009114825) for resolution.

The finding was more than minor because it adversely affected the protection against the external factors attribute of the IE cornerstone to limit the likelihood of those events upsetting plant stability and challenge critical safety functions during shutdown, as well as power operations. Specifically, this finding resulted in upsetting plant stability and potentially affected plant safety-related equipment. This finding was assessed using the Phase 1 screening worksheets of Appendix 4 and Appendix F of MC 0609 SDP, and determined a Phase 2 analysis was required. Fire Damage State (FDS) 0 was assigned to the actual fire and any postulated fires due to the performance deficiency. FDS 0 indicated that no functions failed as a consequence of these fires. In the actual fire there was no functional damage to any target. Also, the peak heat release had happened and passed when the fire was extinguished. Consistent with Inspection Manual Chapter 0609, Appendix F, a maximum heat release rate of 200 KW was selected for the postulated transient combustible fires. No targets were observed in the zone of influence where the combustible material was located. Under step 2.2 of Appendix F performance deficiencies associated with FDS 0 fires were not analyzed in the Fire Protection SDP as a risk contributor. Therefore, the finding was determined to be of very low safety significance (Green). A contributing cause of the finding is the failure of supervisory personnel to ensure the area was free of combustible material as required by FNP-0-AP-38 and the actual open flame permit. Therefore, this finding was assigned a cross-cutting contributing cause related to the Human Performance work-practices component, and its aspect of the licensee ensures supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported (H.4(c)). (Section 4OA3)

Inspection Report# : 2010002 *(pdf)*

Mitigating Systems

Significance: G Mar 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Violatin of technical specification 5.4.1 for failure to maintain procedures for full flow recirculation after a loss of coolant accident
The inspectors identified a Green NCV of TS 5.4.1 for the failure to maintain emergency procedure FNP-1/2-ESP-1.3, Transfer to Cold Leg Recirculation, Rev. 19. ESP-1.3 contained a step to verify containment sump level was sufficient to adequately cover the containment sump screens prior to initiating cold leg recirculation following a loss of coolant accident (LOCA) which led to a full flow recirculation. The containment sump level specified by the procedure was not sufficient to ensure suction vortexing and air ingestion into the emergency core cooling system (ECCS) would have been prevented. This finding was entered into the licensee's corrective action program as condition report (CR) 20101101103. Planned corrective actions included issuing a standing night order to ensure adequate containment sump level is verified prior to transferring to cold leg recirculation and formally changing the value in ESP-1.3.

This finding is more than minor because it affects the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems (containment spray and residual heat removal) that respond to initiating events (LOCAs which lead to full flow recirculation phase) to prevent undesirable consequences (i.e., core damage) and the cornerstone attribute of Procedure Quality, i.e. Operating (Post Event) Procedures (EOPs). The team assessed this finding using the SDP and determined that the finding was of very low safety significance (Green) because the inspectors determined that there was no loss of safety system function. Safety system function was determined to be maintained since the analyzed LOCAs in the accident analysis of the facility updated final safety analysis report (UFSAR) would introduce sufficient water into the containment from ECCS and the reactor coolant system (RCS) to provide sufficient containment sump level to ensure water level above the sump screens to prevent air introduction. This finding was reviewed for cross-cutting aspects and none were identified since the performance deficiency has existed since initial operation and is not indicative of current licensee performance. (Section 1R17)

Inspection Report# : 2010002 *(pdf)*

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation

Failure to Identify A Credible Source of Flooding in the Internal Flooding Evaluation of Record
A self-revealing NCV of 10 CFR 50, Appendix B, Criterion III, Design Control, identified for licensee's failure to identify a credible source of flooding in their internal flooding evaluation of record (performed in 1999). On March 27, 2009, a licensee flushing evolution of the Unit 2 Main FW system resulted in water entering the Lower Equipment Room through the floor drain system. The licensee discovered the flooding evaluation failed to identify a credible source of flooding from the floor drain system. The licensee performed a root cause analysis and determined a FW line break in the MSVR concurrent with this open drain path, would result in a worst case maximum flood level in the lower equipment room of 1 foot and 10 inches above the floor. This level was determined to adversely affect the Turbine Driven Auxiliary Feedwater Pump (TDAFWP) ninterrupted power supply inverter/rectifier and would render the pump inoperable.

The licensee's failure to identify a credible source of flooding in their internal flooding evaluation of record was a performance deficiency. This finding was greater than minor because it adversely affected the equipment reliability attribute of the mitigating systems cornerstone objective to ensure the availability, reliability and capability of systems responding to initiating events to prevent undesirable consequences (i.e., core damage). This finding was assessed using the Phase 1 screening worksheet of the SDP and it was determined a Phase 3 analysis was required. Phase 3 evaluation under the SDP determined that the finding was of very low safety significance (Green). The dominant accident sequence was a Steamline Break with the normal Air Compressors failing due to common cause followed by operators failing to terminate the Safety Injection. The finding was reviewed against the cross-cutting aspects listed in IMC 0305, Operating Reactor Assessment Program, and determined not to have a cross-cutting aspect reflective of current licensee performance.
Inspection Report# : 2009005 *(pdf)*

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Implement Maintenance Inspections of Safety-Related Switchgear
A self-revealing NCV of TS 5.4.1, Procedures, was identified for failure to implement preventative maintenance inspections on the 1-2L 600 volt load center as specified by FNP-0-EMP-1322.10, Maintenance and Cleaning of Westinghouse Switchgear. Failure to perform the specified inspections on the 1-2L 600 volt load center allowed bus fastener torque to degrade so bus bar damage occurred rendering said vlc inoperable. Licensee entered issue into CAP (CR 2008103720) & completed corrective actions to restore operability& schedule specified maintenance inspections on the vlc.

failure to implement preventative maintenance inspections on said vlc specified by FNP-0-EMP-1322.10 was a performance deficiency. This finding was greater than minor because it adversely affected the equipment performance attribute of the MS cornerstone objective to ensure the availability, reliability and capability of systems responding to initiating events to prevent undesirable consequences (i.e., core damage). MS cornerstone column of Phase 1 screening wksheet of SDP used to assess finding. Was determined to require a Phase 3 analysis because finding represented actual LOSF of a single train for greater than its allowed TS outage time. Inspector determined the finding was of very low safety significance (Green). The dominant accident sequence was a failure of ATrain SW thru loss of the 4KV F Bus, failure of the BTrain thru a failure of that train's pump cooling sub-system and inability of the 600 VAC Load Center 1/2L to provide power due to the performance deficiency, leading to total loss of S W to the unit. AFW provided secondary side cooling but, without SW both RCP seal cooling sources, CCW thermal barrier cooling & HHSI/Charging seal injection, failed. A seal LCA happened w/o ability to makeup to the RCS and core damage ensued. This finding is associated with a cross-cutting aspect in the work control component of the human performance area (H.3(b)).
Inspection Report# : 2009005 *(pdf)*

Significance: G Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
1-2R 600 Volt Load Center Operability
NRC-identified NCV of TS 3.8.9 was identified forfailure to meet LCO of maintaining 2 trains of AC vital bus electrical power distribution subsystems operable. Licensee failed to evaluate plant conditions and identify 1-2R 600

vlc was unable to meet surveillance req of correct breaker position/voltage for longer than allowed outage time.

Failure 2 properly eval plant conditions & recognize surveillance req of TS 3.8.9 unmet was perform deficiency. LCO of maintaining 2 trains of AC vital bus elect pwr distribution subsystems available unmet 4 longer than allowd outage time. 8/ 5 through 8/ 9 (85 hours and 6 minutes), Unit 2 pwr supply to vlc was unavail 2 meet Unit 2 portion of TS 3.8.9. Finding greater than minor because adversely affected equip performance attribute of the MS cornerstone objective ensuring availability, reliability& capability of systems responding to IEs to prevent undesirable conseq. 1-2R 600 vlc unable to perform automatic function during dual unit LOSP w/ LOCA on specified unit. Finding determined requiring Phase 2 analysis b/c condition existed longer than allowed outage time for single trn of safety-related equip. Phase 3 eval done under SDP determnd finding was very low safety significance (Green). Although 1 pwr source to R1/2 600 VAC lc was OOS, analysis assumed lc totally OOS. 112 hour exp time also used. Dominant accident seq dual unit LOSP due to severe weather leading to station blackout by combo of EDG failures & perform deficiency. Finding assigned cross-cutting aspect in work practices component of HP area (H.4(b)) b/c licensee failed to execute sequence req by restoration tagout proc. controlling plant config.
Inspection Report# : 2009005 *(pdf)*

Significance: G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Implement Performance Monitoring of SWP Seismic Supports
Self-revealing NCV of 10CFR50.65(a)(1) identified for failure to perform monitoring of SWIS seismic rings resulting in inability of 2A,B,C&E SWP seismic rings to perform their func.b/c of fastener degradation. Licensee entered CR into CAP as 2009109700 and completed corrective actions to restore ring function.

The ring failure is a performance deficiency. Finding greater than minor b/c adversely affected equip reliability attribute of MS cornerstone objective ensuring availability, reliability, capability of systems reponding to IE preventing undesired conseq. Phase 1 Screen Wksht of SDP used to assess finding. SWP determined not degraded. Finding associated w/cross-cutting aspect in CAP component for PI&R area (P.1)(d)).
Inspection Report# : 2009005 *(pdf)*

Significance: G Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Load Sequencer Operability during EDG Surveillance Tests
NRC identified Green NCV of 10CFR50, Appendix B, Criterion III, Design Control, for failure to translate EDG system inoperable during test performance. Licensee entered issue into CAP as CR2008105195 & is taking corrective action to modify the EDG LOSP circuit perf. of EDG surveillance tests.

Failure to translate system design into procedures/instruct for perf EDG surveill tests rending LOSP ELS inoperable was a perf deficiency greater than minor b/c req surveillance test procedure didn't alert operators that perf of tests rendered LOSP load seq inop & tests perf exceeding allowed outage time for inop seq. SDP phase 1 screening determined core decay heat removal affected w/in MS cornerstone when the perf deficiency represented loss of train of a safety function for greater than its TS allowed outage time. Phase 3 SDP req b/c phase 2 wksheets don't provide allowed outage time. Phase 3 analysis was performed. The SDP result was Green, a finding of very low safety significance. No cross-cutting aspect was assigned to this finding.
Inspection Report# : 2009005 *(pdf)*

Significance: G Nov 20, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Procedure for the B Train SSPS System Testing
A seal-reaviling Green NCV of 10 CFR 50 Appendix B, Criterion V was identified for an inadequate procedure for testing the 'B' train SSPS. While Unit 1 was in Mode 5 and N31 source range instrumentation was tagged out and unavailable, the licensee performed step 5.6.1.1B of FNP-1-STP-33.3, resulting in N32 source range instrument being

de-energized. Procedure FNP-1-STP-33.3 inadvertently de-energized the only operable source range instrument for Unit 1. TS 3.31 required a minimum of one source range neutron monitors with the plant in this condition. When the licensee recognized this condition, they immediately restored power to N32 and exited the TS action statement.

The issue was more than minor because it was associated with the procedure quality attribute of the MS cornerstone and adversely affect the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undersirable consequences (i.e. core damage). Specifically, the SSPS procedure resulted in a total loss of source range instrumentation during testing which affected the safety function of the source range neutron flux indication in Mode 5. The finding was assessed using the Phase 1 and 2 Shutdown Operations screening worksheets and determined to required a Phase 3 analysis. Phase 3 analysis determined the finding to be of very low safety significance because the dominant sequence is a boron dilution event and de-energizing the source range for less than a minute would not prevent an operator from taking the necessary actions to address potential boron dilution. No cross-cutting issue was identified.
Inspection Report# : 2009007 *(pdf)*

Significance: G Sep 30, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Implement Surveillance Test Instructions to Prevent Over-Speed of the TDAFW Pump
Green. A self-revealing NCV of Technical Specification (TS) 5.4.1, Procedures, was identified for failure to implement surveillance test procedure instructions for starting the Unit 1 TDAFW pump. The failure resulted in an over-speed trip and inoperability of the pump. This finding has been entered into the licensee's CAP as condition report (CR) 2009110308.

The failure to implement surveillance test procedure instructions for starting the Unit 1 TDAFW pump was a performance deficiency. This finding was greater than minor because it adversely affected the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability and capability of systems responding to initiating events to prevent undesirable consequences (i.e., core damage).
This finding was assessed using the Phase 1 screening worksheet of the SDP and determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for greater than the TS allowed outage time, and was not potentially risk-significant due to external events. The inspectors identified a cross-cutting aspect in the human performance area of work practices (H.4(b)). The licensee established procedure instructions requiring both steam supplies to the TDAFW pump be opened simultaneously to prevent over-speeding the pump, however, personnel did not follow those procedures. (Section 1R22)

Inspection Report# : 2009004 *(pdf)*

Significance: G Sep 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Degraded Emergency Air System Conditions
Green. A self revealing NCV of 10 CFR 50.65(a)(1), Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants, was identified for failure to monitor and maintain the emergency air system's capability to operate the steam generator atmospheric relief valves (ARVs) and turbine driven auxiliary feedwater (TDAFW) pump steam admission valves since 1995.

This finding was greater than minor because it was associated with the equipment performance attribute and affected the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to preclude undesirable consequences (i.e. core damage). The degradation of the reliability and capability of the emergency air system was attributed to the lack of adequate monitoring and maintenance. This finding was assessed using the Phase 1 screening worksheet of the SDP and determined a Phase 3 analysis was required. Phase 3 results characterized the performance deficiency as very low safety significance (Green) based on risk. The inspectors identified a cross-cutting aspect in the problem identification and resolution area of corrective action program P(1)(c).

Inspection Report# : 2009004 *(pdf)*

Significance: G Sep 30, 2009
Identified By: NRC
Item Type: FIN Finding
Failure to Implement Procedures Used to Prevent Seismic Interaction with Safety-Related Equipment
Green. A self-revealing finding was identified for a failure to implement procedures to ensure that temporary equipment carts were immobilized in order to prevent inadvertent contact with safety related equipment. Specifically, the Unit 1 'H' bus protective relay cabinet resulting in inoperability of the 1C Emergency Diesel Generator (EDG). This finding was entered into the licensee's CAP as CR 2009101710.

Failure to implement a procedure to ensure temporary equipment carts were immobilized to prevent inadvertent contact with the Unit 1 'H' bus protective relay cabinet was a performance deficiency. This finding was greater than minor because it adversely affected the equipment reliability attribute of the mitigating systems cornerstone objective to ensure the availability, reliability and capability of systems responding to initiating events to prevent undesirable consequences (i.e., core damage). This finding was assessed using the Phase 1 screening worksheet of the SDP and determined to be of very low safety significance (Green) because it did not result in an actual loss of safety function of a single train for greater than the TS allowed outage time. The finding did not involve a total loss of any safety function, as identified by the licensee through a Probabilistic Risk Assessment (PRA), Individual Plan Examination of External Events (IPEEE), or similar analysis, contributing to external event-initiated core damage accident sequences (i.e., initiated by a seismic, flooding, or severe weather event). The inspectors identified a cross-cutting aspect in the human performance area of work practices component (H.4(b)). The licensee had established a procedure requiring all wheeled items left in safety-related areas be made incapable of rolling and personnel did not follow the procedure. The procedure the licensee failed to implement was not safety related, therefore, the performance deficiency did not result in a violation of regulatory requirements.

Inspection Report# : 2009004 *(pdf)*

Significance: G Jun 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Test Procedures for SG Blowdown Isolation Valves
Green. An NRC identified NCV of 10 CFR 50, Appendix B, Criterion XI, Test Control, was identified for failure to establish adequate procedures to verify automatic closure of the Unit 1 and Unit 2 Steam Generator blowdown (SGBD) isolation valves. This finding has been entered into the licensee's CAP as condition report (CR) 2009107127.

The failure to establish and implement adequate test procedures including acceptance criteria necessary to verify safety-related equipment is capable of performing its design function is a performance deficiency. This finding is more than minor because if left uncorrected, the condition could result in the failure to recognize safety function testing acceptance criteria specified by plant design had not been met, and would be a more significant safety concern. This finding was assessed using the Phase 1 screening worksheet of the SDP and determined to be of very low safety significance (Green), because it did not result in an actual loss of safety function of a single train for greater than the Technical Specification (TS) allowed outage time, and was not potentially risk-significant due to external events. This finding was assigned a cross-cutting aspect in the Problem Identification and Resolution (PI&R) area (P.1(d)) because the licensee had identified the need for additional testing of contacts related to SGBD isolation in March 2006, but no corrective actions were taken to address this issue in a timely matter commensurate with safety significance and complexity. (Section 1R19)
Inspection Report# : 2009003 *(pdf)*

Significance: G Jun 30, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Test Procedures for Verification of Steam Dump Arming From Reactor Trip (P-4) Signal and P-4

Contact Verification
Green. A self-revealing NCV of TS 5.4.1.a. for failure to implement FNP-1-STP- 33.8, Verification of Steam Dump Arming from Reactor Trip (P-4) Signal and P-4 Contact Verification, was identified when licensee personnel took actions not directed by the procedure. During performance of FNP-1-STP- 33.8, licensee personnel changed the established initial conditions by placing the Solid State Protection System (SSPS) into a different operating mode. This finding has been entered into the licensee's CAP as CR 2009104718.

The failure to follow FNP-1-STP- 33.8 is a performance deficiency. This finding is more than minor because it was associated with the Mitigating Systems cornerstone attribute of Configuration Control and adversely affected a cornerstone objective in that failure to follow the procedure resulted in changing the initial conditions previously established. This finding was determined to be of very low safety significance because the procedure was successfully preformed prior to entering a mode that required the SSPS to be operable. This finding has a cross-cutting aspect of Work Control in the area of Human Performance (H.3(b)) in that the licensee did not keep personnel apprised that the SG LO-LO level reactor trip signal in SSPS would not be blocked using the "Normal Method." (Section 1R22)
Inspection Report# : 2009003 *(pdf)*

Significance: G Jun 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Include Water Tight Doors in the Scope of the Maintenance Rule
Green. An NRC identified NCV of 10 CFR 50.65 (b) was identified for failure to include the Auxiliary Building water-tight doors within the scope of the maintenance rule (MR) monitoring program. During routine plant inspections, the inspectors noticed degraded door seals (excessive hardening of the rubber seal with small chunks missing) and worn hinges on water tight doors located in the Auxiliary Building. The inspectors discovered one Unit 2 door in which the seal area had cracks completely across. The inspectors determined the sealing function assumed in the licensee internal flooding analysis for these doors was challenged. This finding has been entered into the licensee's CAP as CR 2009106669.

The licensee's failure to include the water-tight doors within the scope of their MR program and the subsequent degraded condition of these doors is a performance deficiency. The performance deficiency is more than minor because it adversely affected the equipment performance attribute of the Mitigating System Cornerstone objective to ensure the availability, reliability, and capability of systems responding to initiating events to prevent undesirable consequences (i.e. core damage). This finding was assessed using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined the finding was of very low safety significance (Green) because although it did involve degradation of equipment or function specifically designed to mitigate a flooding event (i.e. flooding barriers), it did not result in a loss of safety function. No cross cutting aspects were identified. (Section 4OA2)
Inspection Report# : 2009003 *(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: W May 02, 2009
Identified By: NRC
Item Type: VIO Violation
Failure to Establish Effective Means of Providing Early Notification (Inaccurate Tone Alert Radios Addresses)
An AV of 10 CFR 50.47(b)(5) was identified for a failure to maintain the means to provide alert and notification and clear instruction to all of the population within the plume exposure pathway emergency planning zone (EPZ). Specifically, in February 2008 the licensee

determined that they had not provided tone alert radios (TARs) to approximately 171 addresses requiring radios, and failed to ensure the State of Georgia had established the capability for compensatory alerting measures. The licensee's failure to maintain the public alert and notification system to meet the design requirements of the Federal Emergency Management Agency (FEMA) approved Alert and Notification system (ANS) design report and supporting FEMA approval letter resulted in a degradation of a risk significant planning standard.
The licensee's failure to provide the means for notification and instruction to the populace within the plume exposure pathway EPZ in the event of a radiological emergency as required by 10 CFR 50.47(b)(5) is a performance deficiency. The licensee's failure to remain in compliance with the FEMA approved ANS design report and supporting FEMA approval letter contributed to the performance deficiency. This finding is more than minor because it is associated with the emergency preparedness cornerstone attribute of facilities and equipment, and affected the cornerstone objective of ensuring that 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 significance of this finding was determined using Manual Chapter 0609 Appendix B, Emergency Preparedness Significance Determination Process (sheet 1) – Failure To Comply.
The NRC preliminarily determined this finding to have low to moderate safety significance (White) in that it resulted in the degradation of a Risk Significant Planning Standard (RSPS) function (10 CFR 50.47(b)(5)).
This finding had a cross cutting aspect of Human Performance because the licensee did not adequately ensure supervisory and management oversight of work activities, including the electrical utilities providing connect and disconnect information regarding addresses within the emergency planning zone, such that nuclear safety was supported (H.4.c).

Update:
NOTICE OF VIOLATION
Southern Nuclear Operating Company, Inc. Docket Nos. 50-348, 50-364
Joseph M. Farley Nuclear Plant License Nos. NPF-2, NPF-8
Units 1 and 2 EA-09-103
During an inspection completed by the NRC on May 18, 2009, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is set forth below:
10 CFR 50.54(q) states, in part, that a licensee authorized to possess and operate a nuclear power reactor shall follow and maintain in effect emergency plans which meet standards in 10 CFR 50.47(b).
10 CFR 50.47(b)(5) requires, in part, that the licensee establish a means to provide early notification and clear instruction to the populace within the plume exposure pathway Emergency Planning Zone (EPZ).
The Farley emergency plan identifies both tone alert radios (TARs) and sirens as the means by which it provides alert and notification to the populace within the plume exposure pathway.
Contrary to the above, the licensee failed to maintain an effective means of providing early notification and clear instruction to the populace within the plume exposure pathway EPZ. Specifically, in January 2008, the licensee identified that approximately 109 TARs had not been provided to residences that were outside the limits of the sirens but within the 10 mile EPZ of Farley Nuclear Plant. The licensee's subsequent review identified additional residences within the 10 mile EPZ which were required to have TARs in accordance with the Farley emergency plan, but were not provided TARs.
This violation is associated with a White Significance Determination Finding.
Inspection Report# : 2009502 *(pdf)*
Inspection Report# : 2009503 *(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

Significance: N/A Nov 20, 2009
Identified By: NRC
Item Type: FIN Finding
PI&R Identification and Resolution of Problems
The team concluded that, in gerneral, problems were properly identified, evaluated, prioritized, and corrected. Generally, the threshold for initiating condition reports was appropriately low, as evidenced by the types of problems identified and the large number of condition reports entered annually into the CAP. Employees were encouraged by management to initiate condition reports. However, the team did identify some examples where plant issues were not appropriately entered into the CAP.

Generally, prioritization and evaluation of issues were consistent with the licensee's CAP guidance, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally timely, effective, and commensurated with the safety significance of the issues. However, the team did identify some examples where plant issues were not appropriately evaluated consistent with the licensee's CAP guidance.

The team determined that, overall, audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. The licensee's operating experience usage was found to be generally acceptable and integrated into the licensee's process for performing and managing work, and plant operations.

Based on discussion and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.
Inspection Report# : 2009007 *(pdf)*

Significance: N/A Aug 24, 2007
Identified By: NRC
Item Type: FIN Finding
Biennial Identification and Resolution of Problems Inspection Results
One finding of very low safety significance (Green) was identified. The licensee was generally effective in identifying problems at a low threshold and entering them into the corrective action program. The licensee properly prioritized issues entered into the corrective action program (CAP) and routinely performed evaluations that were technically accurate and of sufficient depth to address the issue documented in the condition reports (CRs). Overall, corrective actions were effective; however, minor examples of inadequate condition report broadness reviews and documentation issues related to the closure of action items were identified. In general, operating experience was found to be used both proactively and reactively by personnel involved in the corrective action program; however, an example of industry operating experience was identified in which the licensee did not completely develop interim compensatory measures for a condition to which Farley was vulnerable. The licensee’s programmatic self-assessments and audits were generally effective in identifying weaknesses in the corrective action program; however, a missed opportunity in the trending of issues which could result in adverse effects on safety-related plant components was identified. The inspectors also concluded that the workers at Farley felt free to report safety concerns.

Inspection Report# : 2007006 *(pdf)*

Last modified : May 26, 2010