

Brunswick 2

2Q/2010 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Plant Procedure Caused Loss of E2 Bus

A self-revealing Green non-cited violation of Technical Specification (TS) 5.4.1, Procedures, was identified when the licensee failed to follow procedure 0PICCNV023, Calibration of Westinghouse & Scientific Columbus Teleductors. During the performance of the calibration, procedural steps were not performed correctly and the E2 electrical bus was inadvertently deenergized, requiring the emergency diesel generator #2 to auto-start and reenergize the bus. Emergency diesel generator #2 auto-started and the E2 bus transferred from off-site power. After the event, the licensee halted the maintenance on the E2 bus instruments and restored off-site power to the E2 bus. The event was entered into the licensee's corrective action program as NCR #344300. The finding was determined to be more than minor because the finding was associated with the Initiating Events Cornerstone attribute of configuration control and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations.

The finding affected configuration control because correct test switch alignment was not maintained. The finding also affected the cornerstone objective because loss of the E2 bus represented an upset to plant stability. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of findings," Table 4a for the Initiating Events Cornerstone. The finding was determined to be of very low safety significance (Green) because the finding was a transient initiator that did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. The finding has a cross-cutting aspect in the Human Performance cross cutting area, Work Practices component, because the licensee failed to implement adequate error prevention techniques while performing plant procedure 0PIC-CNV023, Calibration of Westinghouse & Scientific Columbus Teleductors. Specifically, technicians did not utilize adequate error prevention techniques to prevent them from operating the wrong test switch when calibrating instrument 1-E2-AG6-VTR (H.4(a))

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

Mitigating Systems

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Identify and Correct Degraded Fire Protection Sprinklers

The inspectors identified a Green non-cited violation of Brunswick Steam Electric Plant (BSEP) Unit 1 Updated Facility Operating License DPR-71, and the Unit 2 Updated Facility Operating License DPR-62, Condition 2.B.(6), for the licensee's failure to identify and correct degraded fire suppression system sprinklers per the licensee's fire protection program procedures. Procedure, OPT-34.6.4.1, "Sprinkler And Spray System Visual Inspection: RX1, RX2, SW, RW, WT, and DG Buildings," directs the licensee to verify the physical integrity of the spray and sprinkler piping and the absence of sprinkler obstruction or damage for the Unit 1 Reactor Building, Unit 2 Reactor Building, Service Water Building, Radwaste Building, Water Treatment Building, and Diesel Generator Building. After NRC inspectors identified the degraded sprinklers, the licensee re-performed the procedure and identified 40 spray shields to be noncompliant with the procedure's acceptance criteria. Once identified, the licensee initiated compensatory fire

watches. Corrective actions also included replacing or repairing the defective spray shields. This finding was entered into the licensee's corrective action program as NCR #357183.

Failure to follow procedure OPT-34.6.4.1, "Sprinkler And Spray System Visual Inspection: RX1, RX2, SW, RW, WT, and DG Buildings" was a performance deficiency. The finding was determined to be more than minor because it affected the Mitigating Systems cornerstone objective of availability, reliability, and capability of the fixed fire suppression systems and was associated with the protection against external factors (fire) attribute. Specifically, this failure could affect the ability of the water sprinkler system to respond to a fire because the affected sprinklers' spray patterns are reduced and less effective. The issue was determined to be of very low safety significance (Green) using Manual Chapter (MC) 0609, Appendix F, Attachment 1, because the category of fixed fire suppression was evaluated as having low degradation. The system had low degradation because the sprinkler system is expected to display nearly the same level of effectiveness and reliability as it would, had the degradation not been present. The finding has a procedural compliance cross-cutting aspect in the Work Practices component of the Human Performance cross cutting area, because the licensee failed to ensure procedural instructions (procedure OPT-34.6.4.1) were implemented correctly. H.4(b)

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

Significance: G Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Adequately Implement Design Control Measures For The Fire Protection Program

The inspectors identified a Green non-cited violation of BSEP Unit 1 Updated Facility Operating License DPR-71, and the Unit 2 Updated Facility Operating License DPR-62, Condition 2.B.(6), for the licensee's failure to implement adequate design control measures for the fire protection program. Plant drawings which specify the configuration of fire suppression sprinklers are inconsistent and inadequate in that they do not provide complete details for sprinkler spray shields. Dimensions for spray shields on some drawings are incomplete because they don't list all of the necessary critical dimensions. Therefore, some ceiling-level spray shields were incorrectly installed and extended below the sprinklers' fusible links. This would have delayed sprinkler response in a fire. After the identification of this design control issue, the licensee implemented corrective actions which included repairing or replacing the degraded sprinklers. This finding was entered into the licensee's corrective action program as NCR #367339.

The licensee's failure to adequately implement design control measures for the fire protection program as required by the operating license (condition 2.B(6)) was a performance deficiency. The finding was determined to be more than minor because it affected the Mitigating Systems cornerstone objective of availability, reliability, and capability of the fixed fire suppression systems and was associated with the design control and protection against external factors (fire) attribute. Specifically, this failure could affect the ability of the water sprinkler system to respond to a fire because the incorrectly installed spray shields delay the ceiling-level sprinklers' response times. The issue was determined to be of very low safety significance (Green) using MC 0609, Appendix F, Attachment 1, because the category of fixed fire suppression was evaluated as having low degradation. The system had low degradation because the sprinkler system is expected to display nearly the same level of effectiveness and reliability as it would, had the degradation not been present. This finding has no cross-cutting aspect because the design drawing deficiency occurred when the plants were licensed and it is not indicative of current licensee performance.

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

Significance: G Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequately Monitored Maintenance Rule MOV

The inspectors identified a Green NCV of 10 CFR 50.65(a)(1), Requirements for monitoring the effectiveness of maintenance at nuclear power plants, for the licensee's failure to monitor the performance or condition of motor-operated valve (MOV) MS-V28 in a manner sufficient to provide reasonable assurance that it was capable of fulfilling its intended functions. As a result, the licensee did not recognize that the valve was incapable of opening against design differential pressure and failed to take appropriate corrective actions to ensure that the valve could fulfill its emergency operating procedure (EOP) function. After the issue was identified, the licensee altered its operating procedures to compensate for the valve not opening against design differential pressure and entered it into their corrective action program (AR #356800).

The failure to adequately monitor the performance or condition of MOV MS-V28 in a manner to provide reasonable assurance that the valve was capable of fulfilling its intended function is a performance deficiency. The performance deficiency was more than minor because it is associated with the Mitigating Systems cornerstone attribute of equipment performance, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the performance deficiency affected the reliability of the MOV MS-V-28 and its use in EOPs to restore feed to the reactor. Inspectors evaluated the finding using NRC IMC 0609, Significance Determination Process, Appendix A. Since the finding represents an actual loss of a function of non-Technical Specifications equipment designated as risk-significant for greater than 24 hours, the finding required a phase two significance analysis. The Brunswick phase 2 SDP spreadsheet indicated that the finding was greater than green but did not detail to the cases requiring MS-V28 operation therefore a phase 3 SDP analysis was completed by a regional SRA.

The phase 3 SDP analysis was performed in accordance with NRC Inspection Manual Chapter 0609 appendix A utilizing the NRC SPAR model and output from the licensee's full scope PRA model. The result was a risk increase for the finding of $<1E-6$ for core damage frequency (cdf) and $<1E-7$ for large early release frequency (LERF). The dominant sequences were transient initiators with spurious level instrument generated main steam isolation valve (MSIV) closure and the inability to restore main feedwater due to the performance deficiency coupled with failure to achieve successful depressurization and use of low pressure makeup systems leading to core damage. The risk was mitigated by the low initiating event frequency for transient conditions which would allow MSIV reopening and recovery of main feedwater. The availability of low pressure injection systems was also a factor reducing the risk. The result of the phase 3 analysis was that the finding was characterized as having very low safety significance, a Green finding. The cause of this finding was directly related to the problem evaluation cross-cutting aspect in the corrective action program component of the Problem Identification and Resolution cross-cutting area because the licensee failed to adequately evaluate the failure of MS-V28 in November 2008. (P.1(c)).

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

Significance:  Oct 20, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Maintenance Instructions for Maintaining Cleanliness During Emergency Diesel Generator Governor Maintenance

Green. The inspectors identified a Green NCV of Technical Specification (TS) 5.4.1, Procedures, for inadequate cleanliness and flushing procedures for maintaining cleanliness during maintenance on the emergency diesel generator (EDG) governors. This procedural inadequacy resulted in a failure of the emergency diesel generator #4 governor on September 19, 2009. The licensee entered the issue into their corrective action program and replaced the failed governor.

The finding was determined to be more than minor because it is associated with equipment performance and procedure quality attributes of the Mitigating Systems Cornerstone. It also adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the reliability of EDG #4 was reduced because it was susceptible to fouling due to the foreign material in the governor. The finding was evaluated for significance using NRC Manual Chapter 0609, Appendix A, Determining the Significance of Reactor Inspection Findings for At-Power Situations. Using Table 4a of Appendix A to MC 0609, the finding was determined to be of very low safety significance (Green) because the failure of EDG #4 did not represent a loss of safety function, did not represent a loss of EDG #4 operability for greater than its technical specification allowed outage time, and does not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding affects the cross-cutting area of human performance, resources component, complete and accurate documentation aspect because the licensee did not incorporate adequate guidance for maintaining cleanliness of the EDG governor in their maintenance procedures. (H.2(c))

Inspection Report# : [2009011](#) (pdf)

Significance:  Sep 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Annunciator Response Procedure for HPCI Vacuum Tank High Level

A self-revealing Green non-cited violation of TS 5.4.1, Procedures, was identified for an inadequate annunciator response procedure to respond to a high level in the high pressure coolant injection (HPCI) vacuum tank when the barometric condensate pump is not operating. As a result, on January 27, 2009, the Unit 2 HPCI vacuum tank was not drained prior to the HPCI turbine exhaust drain pot filling to the point that operators could not ensure that water was not in the HPCI turbine casing. Without this assurance, the Unit 2 HPCI system was rendered inoperable because starting the HPCI pump with water in the casing could result in damage to the turbine. To correct this condition, operators later identified another valve, valve E-41-F5003, that was used to successfully lower water level in the HPCI exhaust line to below the HPCI exhaust line drain pot. Water level was above the exhaust line drain pot high level alarm, and therefore potentially in the HPCI turbine casing, for approximately two hours. Maintenance personnel later corrected the malfunction for the barometric condensate pump and restored the system to normal. This finding was entered into the licensee's corrective action program as NCR #316695. The finding was determined to be more than minor because it is associated with procedure quality attribute of the Mitigating Systems Cornerstone. It also adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the incorrect HPCI annunciator response procedure led to an unplanned period of unavailability of the Unit 2 HPCI pump. Using NRC Inspection Manual Chapter 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations," the inspectors determined that the finding required a phase two evaluation because the finding represents a loss of system safety function. Using the significance determination phase two pre-solved worksheet, loss of HPCI function for less than three days, the increase in core damage frequency was determined to be less than 1E-6. Therefore, the finding is of very low safety significance (Green). The finding affects the cross-cutting area of human performance, resources component, complete and accurate documentation aspect because the licensee did not incorporate adequate guidance for draining the HPCI vacuum tank when the HPCI pump is in standby and the barometric condensate pump is unavailable in plant procedures (H.2(c)).

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

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish Adequate Installation Instructions for Emergency Diesel Generator Service Water Expansion Joint Control Units

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to specify an appropriate quality standard for the installation of the control units on the emergency diesel generator jacket water heat exchanger inlet and outlet expansion joints. As a result, threaded fasteners on emergency diesel generators #1 and #4 loosened, creating a potential vulnerability to expansion joint failure. The licensee tightened the control unit bolts on all the emergency diesel generator service water expansion joints and initiated an engineering change to prevent the fasteners from loosening. This finding was entered into the licensee's corrective action program as NCR #346113.

The finding was determined to be more than minor because the finding, if left uncorrected, would have the potential to lead to a more significant safety concern. Specifically, over time, the hex nuts on the expansion joint control units could loosen to the point of expansion joint failure, leading to a loss of service water to the emergency diesel generators and failure of the emergency diesel generators. The inspectors evaluated the finding in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of findings," Table 4a for the Mitigating Systems Cornerstone. The finding was determined to be of very low safety significance (Green) because the finding was a design or qualification deficiency confirmed not to result in loss of operability or functionality. This finding has no cross-cutting aspect because the design deficiency occurred in 2005 and is not indicative of current licensee performance.

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

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Include Risk Significant Maintenance in the Site Risk Profile

The inspectors identified a Green non-cited violation of 10 CFR Part 50.65 (a)(4), when the licensee removed the severe accident mitigation guideline (SAMG) diesel generators from service without considering the change in the online plant risk. Online plant risk is modeled and communicated to licensee plant personnel via the equipment out of service (EOOS) profile. The change in online risk was not reflected in the EOOS profile when the SAMG diesel generators were out of service from July 6, 2009 to July 8, 2009. Once the deficiency was identified on July 8, 2009, the EOOS profile was updated by the licensee and reflected the SAMG diesel out of service condition. This finding was entered into the licensee's corrective action program as NCR #351002.

The finding was determined to be more than minor because the finding related to maintenance risk assessment and risk management issues. Specifically, the licensee's risk assessment failed to consider risk significant structures, systems, or components that were unavailable during maintenance. The inspectors evaluated the finding in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of findings," Table 3a for the Mitigating Systems Cornerstone. The finding was determined to degrade the licensee's assessment and management of risk associated with performing maintenance activities under all plant operation or shutdown conditions. In accordance with Baseline Inspection Procedure (IP) 71111.13, "Maintenance Risk Assessment and Emergent Work Control," and IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," the finding was determined to be a maintenance risk assessment issue. Flowchart 1, "Assessment of Risk Deficit," requires the inspectors to determine the risk deficit associated with this issue. The finding was determined to be of very low safety significance because the incremental core damage probability deficit was less than 1×10^{-6} . The regional senior reactor analyst reviewed the information and confirmed that the system was a maintenance rule safety significant system. This finding has a cross-cutting aspect in the area of human performance, work control component, because the licensee did not plan and coordinate work activities consistent with nuclear safety. Specifically, the licensee failed to include risk significant maintenance in the EOOS profile when the SAMG diesel generators were out of service from July 6, 2009 until July 8, 2009 (H.3(a))

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

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Capability of Emergency Diesel Generator Ventilation System to Meet Design and Licensing Requirements

The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion III, Design Control, for failure to translate a key analytical assumption related to operation of the emergency diesel building back draft and check dampers into specifications and ultimately into the installed hardware. This issue was entered into the licensee's corrective action program as NCR 00259088 with actions to evaluate the ability of the EDGs actual installed equipment to satisfy the intended safety function during and following the design basis tornado event. Compensatory measures were established to eliminate the concern pending the licensee's determination of the systems capability to mitigate the effects of a tornado event.

This finding was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of Design Control, i.e. initial design. It impacted the cornerstone objective of ensuring the availability, reliability, and capability of the emergency diesel building ventilation to protect the EDG building structure during a design basis tornado event. Due to the deficiencies between the installed hardware and the assumptions in the calculation, the calculation did not ensure the capability of emergency diesel building ventilation system to perform the safety function. This was determined to be a failure to ensure the availability, reliability, and capability of a safety system that responds to an initiating event to prevent undesirable consequences. The licensee subsequently determined from analysis through modeling and testing that the emergency diesel building ventilation system could perform the safety function during a design basis tornado event with the existing hardware installed. The NRC reviewed this analysis and the results that determined that the existing condition did not result in the loss of the system safety function. The inspectors assessed the finding using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of findings," Table 4a for the Mitigating Systems Cornerstone. The finding was determined to be of very low safety significance (Green) because there was not an actual loss of safety system function based upon the inspector's verification of the Progress Energy analysis of the emergency diesel building ventilation system. The cause of the finding is not related to a cross-cutting aspect because the occurrence was greater

than three years ago and is not indicative of current licensee performance.

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

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure Representative Sampling of Particulate Effluents Released from the Reactor Building Roof Vent

The inspectors identified a Green NCV of 10 CFR 20.1302(a) for failure to ensure surveys of particulate radioactive materials in effluents released to unrestricted areas from the reactor building roof vent were adequate to demonstrate compliance with dose limits for individual members of the public. This issue was initially identified as an unresolved item following an inspection in June 2008. The licensee entered the issue into its corrective action program (AR #292216 and AR #393340). The licensee is currently investigating this issue to identify applicable corrective actions.

The failure to ensure that the reactor building roof vent effluents were adequately monitored is a performance deficiency. This finding is more than minor because it is associated with the Public Radiation Safety cornerstone attribute of Plant Facilities/Equipment and Instrumentation (Process Radiation Monitors) and adversely affects the cornerstone objective. Specifically, the cornerstone objective of providing assurance that adequate protection of public health and safety from exposure to radioactive materials released into the public domain as a result of routine civilian reactor operation was affected because the licensee did not ensure that reactor building effluents were accurately monitored. The finding was evaluated using the Public Radiation Safety SDP and determined to be of very low safety significance (Green). The finding, which involved the effluent release program, was determined to be of very low safety significance (Green) because it was not a failure to implement the effluent program and did not result in public dose exceeding the 10 CFR 50 Appendix I criterion or 10 CFR 20.1301 (e). This finding does not have a cross-cutting aspect because the failure to evaluate the effect of line losses on particulate sampling is a historical issue.

Inspection Report# : [2010002](#) (*pdf*)

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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