

# Browns Ferry 2

## 3Q/2010 Plant Inspection Findings

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### Initiating Events

**Significance:**  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to adequately test molded case circuit breakers**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," for failure to establish a preventive maintenance (PM) test program for safety-related molded case circuit breakers (MCCBs) to demonstrate these breakers would perform satisfactorily upon demand. Since initial startup of all three units, the inspectors found that the licensee had not included 612 critical MCCBs, many of them safety-related, in their PM program which resulted in the MCCBs receiving no planned maintenance or testing. The licensee entered this issue into the corrective action program as problem evaluation report (PER) 209095. The licensee's corrective actions included: identifying all critical MCCBs that required preventive maintenance, developing test procedures for these MCCBs, performing testing for all affected MCCBs, and conducting an extent-of-condition review of all safety-related components potentially excluded from the PM program.

This finding was determined to be of greater than minor significance because it was associated with the Protection Against External Factors attribute of the Initiating Events Cornerstone and adversely affected the cornerstone objective to limit the likelihood of those events, such as fire, that challenge critical safety functions during shutdown as well as power operations. Specifically, the lack of a PM program for safety-related MCCBs resulted in no periodic planned maintenance or testing being performed since original installation, which in most cases was over thirty years. Based on operating experience, this could result in a breaker being slow to trip or sticking in the "on" position after an over-current condition. In accordance with IMC 0609, Significance Determination Process (SDP), Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," this finding was determined to require a Phase 3 analysis since the finding represented an increase in the likelihood of a fire caused by an electrical fault at the MCCB compartment with the breaker not opening. A regional Senior Reactor Analyst conducted a Phase 3 SDP analysis, which concluded that the finding was of very low safety significance (Green).

The cause of this finding was directly related to the cross cutting aspect of Appropriate Corrective Actions in the Corrective Action Program component of the Problem Identification and Resolution area, because the licensee did not adequately implement corrective actions to resolve the deficiencies previously identified by PER 131875 regarding certain Westinghouse MCCBs that were not in the PM program [P.1(d)]. (Section 4OA5.4)

Inspection Report# : [2010004](#) (*pdf*)

**Significance:**  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Inadequate Operating Procedures Cause Partial Loss of Reactor Feedwater Which Results In Unit 2 Manual Reactor Scram**

A Green self-revealing noncited violation of Technical Specifications 5.4.1.a was identified for failure to adequately maintain the accuracy of critical operating procedures for Power Maneuvering, and Reactor Feedwater (RFW) and Condensate System operation, which subsequently resulted in a partial loss of RFW and a Unit 2 manual reactor scram. These procedures were subsequently revised to more accurately reflect integrated plant response and establish appropriate operating limitations for the RFW and Condensate systems. This event was entered into the licensee's corrective action program as PER 203538.

This finding was determined to be of greater than minor significance because it was associated with the Initiating Events cornerstone attribute of Procedure Quality, and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during at-power operations.

Specifically, the licensee's inappropriate revision of critical operating procedures directly contributed to an unintended partial loss of RFW flow resulting in a manual reactor scram. RFW was available throughout the event. The finding was evaluated using Phase 1 of the At-Power Significance Determination Process, and was determined to be of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment or functions were not available. The cause of this finding was directly related to the cross-cutting aspect of complete, accurate and up-to-date procedures in the area of Human Performance because the licensee improperly revised several critical operating procedures [H.2(c)].

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

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## Mitigating Systems

**Significance:**  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to adequately assess online risk associated with maintenance activities on risk significant SSCs**

The inspectors identified a non-cited violation of 10 CFR Part 50.65 (a)(4), for inadequate risk assessments of on-line risk associated with ongoing maintenance activities. Specifically, on July 21 and then again on September 16, 2010, the inspectors found that the licensee failed to perform a probabilistic risk analysis (PRA) evaluation of the multiple risk significant equipment that had been taken out of service for planned on-line maintenance. The licensee entered this issue into the corrective action program as problem evaluation reports (PERs) 241885 and 254000. In both instances the licensee subsequently performed the required PRA evaluations which determined the on-line risk to be Green.

This finding affected the Mitigating Systems cornerstone and was determined to be greater than minor according to Inspection Manual Chapter (IMC) 0612, Appendix B, Issue Screening, because minor violations of 10 CFR 50.65(a) (4) have occurred repeatedly on five occasions and if continued to be left uncorrected would have the potential to lead to a more significant safety concern. The significance of this finding was evaluated using IMC 0609, Appendix K, Maintenance Risk Assessment and Risk Management Significance Determination Process. Based on Appendix K, the inspectors determined that this finding was of very low safety significance (Green) because the licensee's PRA evaluation concluded the actual risk deficit was less than 1E-6 for the incremental core damage probability deficit (ICDPD) and less than 1E-7 for the incremental large early release probability deficit (ILERPD). The cause of this finding was directly related to the cross cutting aspect of Procedural Compliance in the Work Practices component of the Human Performance area, because the licensee failed to follow the instructions in 0-TI-367 which required a PRA evaluation to be performed in accordance with SPP-9.1 [H.4(b)]. (Section 1R13)

Inspection Report# : [2010004](#) (pdf)

**Significance:**  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to perform functional evaluations for gas identified during venting**

An NRC-identified Green non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for the licensee's failure to perform functional evaluations in accordance with procedure NEDP-22, Functional Evaluations, when gas was identified in the High Pressure Coolant Injection (HPCI) System during the Technical Specification required surveillance. The licensee has subsequently performed functional evaluations of the occurrences and entered the issue into their corrective action program as problem evaluation report (PER) 223067.

This finding was considered more than minor because it adversely affected the Mitigating Systems Cornerstone objective of ensuring the availability and reliability of safety systems, and is related to the attribute of Procedure Quality (i.e.- Maintenance and Testing Procedures). Specifically, the failure to perform a functional evaluation or provide adequate justification for not performing one upon identification of gas during venting of the system could

affect the operability, availability, and reliability of the HPCI system or could result in missing an opportunity to identify the source of voiding to preclude future inoperability. This deficiency also paralleled Inspection Manual Chapter 0612, Appendix E, Example 4.a, as the licensee routinely did not perform the required functional evaluations. The team assessed this finding using Inspection Manual Chapter 0609, Significance Determination Process, and determined that the finding was of very low safety significance (Green) because subsequent functional evaluations showed that the gas voids did not impact the operability of the HPCI system.

The cause of this finding was directly related to the cross cutting aspect of Evaluation of Identified Problems in the Corrective Action Program component of the Problem Identification and Resolution area, in that the licensee failed to thoroughly evaluate gas voids such that the resolution addressed causes and extent of conditions, as necessary, and included the failure to thoroughly evaluate for operability and reportability conditions adverse to quality. [P.1(c)] (Section 40A5)

Inspection Report# : [2010004](#) (pdf)

**Significance:**  Sep 24, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure To Correct The EECW Valves Throttled Below Analyzed Condition**

Green: The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to adequately evaluate and take prompt corrective actions to address a condition adverse to quality related to two Emergency Equipment Cooling Water (EECW) system flow control valves determined to have been throttled below the analyzed 0.125 inch gap for a period of approximately three months. This condition restricted the flow to the cooler due to flow blockage which could have resulted in inoperability of the downstream safety-related Core Spray (CS) pump room heat exchangers. This finding was entered into the licensee's corrective action program as PER 257029.

The inspectors determined that the licensee's failure to promptly address an identified deficiency associated with safety related equipment was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective to ensure the availability, reliability, and capability of the Core Spray system to respond to initiating events to prevent undesirable consequences; (i.e., core damage) , since it resulted in 2 valves in the core spray system remaining throttled below their analyzed seat to disc clearance for several months after the licensee became aware of this condition, thus subjecting these valves to an increased likelihood of clogging with debris and affecting the reliability of the system.

The inspectors determined that the finding was of very low safety significance because the finding was not a design deficiency, did not result in an actual loss of system or single train function, and was not potentially risk significant due to external events. The inspectors determined that this finding directly involved the cross-cutting area of Problem Identification and Resolution, component of the Corrective Action Program and aspect of Through Evaluation of Identified Problems because the licensee did not perform a thorough evaluation of identified problems such that the resolutions address causes and extent of conditions. [P.1(c)] (Section 40A2.a.3.1)

Inspection Report# : [2010006](#) (pdf)

**Significance:**  Sep 24, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Correct a Condition Adverse to Quality Associated with the 2D Residual Heat Removal (RHR) Room Cooler (Section 40A2.a.3.3)**

Green: The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to correct a condition adverse to quality by failing to implement adequate corrective actions

to address degradation in the performance of the 2D RHR room cooler. On July 17, 2009, the 2D RHR room cooler thermal overload failed due to high mechanical vibrations, which the licensee failed to identify and correct prior to a subsequent failure on August 19, 2009. This finding was entered into the licensee's corrective action program as PER 261728.

The inspectors determined that the licensee's failure to implement adequate corrective actions after the 2D RHR motor trip on July 17, 2009 was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone in that it adversely affected the reliability of the 2D RHR room cooler to respond to initiating events. The inspectors determined that the finding was of very low safety significance because it did not result in inoperability of a safety function for greater than the allowed technical specification outage time. The inspectors determined that this finding directly involved the cross-cutting area of Problem Identification and Resolution, component of the Corrective Action Program and aspect of Appropriate and Timely Corrective Actions because the licensee did not implement appropriate and timely corrective actions to resolve a condition adverse to quality. Specifically, the problem with the 2D RHR room cooler was not adequately addressed after the motor trip on July 17, 2009. [P.1 (d)] (Section 40A2.a.3.3)  
Inspection Report# : [2010006](#) (pdf)

**Significance:**  Sep 24, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to maintain an Adequate Surveillance Procedure to Prevent an Unplanned HPCI Isolation (Section 40A2.a.3.5)**

Green: The inspectors identified a self-revealing non-cited violation of Technical Specifications 5.4.1.a, Procedures, for an inadequate surveillance procedure used to test High Pressure Coolant Injection (HPCI) pressure switches that led to an unplanned HPCI system isolation and HPCI system being declared inoperable. This finding was entered into the licensee's corrective action program as PER 239313.

The inspectors determined the failure to establish an adequate procedure used for connecting and disconnecting VOMs during testing of pressure switches on the HPCI system was a performance deficiency. The performance deficiency was more than minor because it affected the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective in that the licensee did not ensure reliability and availability of the HPCI system to respond to initiating events to prevent undesirable consequences. The inspectors determined the finding was of very low safety significance because HPCI was out of service for a total of about 12 hours and did not exceed its TS allowed outage time per TS 3.5.1.c. The inspectors determined that this finding directly involved the cross-cutting area of Human Performance, component of Resources and aspect of Complete Documentation because the licensee failed to provide an adequate procedure to perform the HPCI surveillance test. [H.2(c)] (Section 40A2.a.3.5)  
Inspection Report# : [2010006](#) (pdf)

**Significance:**  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to effectively maintain performance of the A3 EECW pump as required by 10 CFR**

The inspectors identified a noncited violation of 10 CFR 50.65(a)(2) for failure to demonstrate that the performance of the A3 Emergency Equipment Cooling Water (EECW) pump was effectively controlled by preventive maintenance (PM) such that the pump remained capable of performing its intended function. Also due to inadequate evaluations performed after the A3 EECW pump exceeded its Maintenance Rule a(2) performance criteria, goal setting and monitoring were not established as required by paragraph a(1) of the Maintenance Rule. The licensee subsequently declared the EECW system in (a)(1) status and was in the process of developing the required goals and monitoring plan. This issue was entered into the licensee's corrective action program as problem evaluation report 223404.

The finding was determined to be of greater than minor significance because it was associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone objective of ensuring availability and reliability of systems designed to respond to initiating events to prevent undesirable

consequences. More specifically, the licensee failed to demonstrate effective control of EECW system availability through appropriate PM. According to NRC Inspection Manual Chapter 0609.04, Phase I - Initial Screening and Characterization of Findings, this finding was determined to be of very low safety significance because it did not lead to an actual loss of a system safety function or screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The cause of this finding was directly related to the cross cutting aspect of Thorough Evaluation of Identified Problems in the Corrective Action Program component of the Problem Identification and Resolution area, because the licensee did not adequately evaluate the causes of the A3 EECW pump unavailability and thereby failed to correctly determine the impact on the 10 CFR 50.65(a)(2) unavailability performance criteria [P.1 (c)]. (Section 1R12)

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

**Significance:**  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Untimely corrective actions to restore compliance of EECW pump in-service testing with ASME OM code requirements**

The inspectors identified a noncited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for failure to promptly recognize, and then correct in a timely manner, non-conforming conditions involving the in-service testing (IST) requirements of the American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance (OM) of Nuclear Power Plants for the Equipment Cooling Water (EECW) system identified in June 2009. These nonconforming conditions involved the use of flow instrumentation without the proper accuracy, and failure to use the pre-service pump curve when establishing additional IST baseline reference values. The licensee revised the timeliness of their corrective action plans and decided to track this issue as a nonconforming condition. This issue was entered into the licensee's corrective action program as PER 225844.

The finding was determined to be of greater than minor significance because if left uncorrected it could become a more significant safety concern. In-service testing of the EECW system in conformance with the ASME OM Code provides assurance that degraded pump performance would be promptly detected and corrected. Failing to recognize and resolve these and other IST program deficiencies could lead to untimely detection of EECW pump degradation. According to Inspection Manual Chapter 0609.04, Phase I - Initial Screening and Characterization of Findings, this finding was determined to be of very low safety significance because it did not lead to an actual loss of a system safety function or screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The cause of this finding was directly related to the cross-cutting aspect of Appropriate and Timely Corrective Actions in the Corrective Action Program component of the Problem Identification and Resolution area because the licensee failed to take appropriate corrective actions to restore full compliance with the ASME OM Code requirements in a timely manner [P.1(d)]. (Section 40A2.2)

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

**Significance:**  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Unit 2 RCIC System Inoperable Beyond the Technical Specification Allowed Outage Time**

A Green self-revealing non-cited violation of Unit 2 Technical Specifications (TS) Limiting Condition for Operation 3.5.3, Reactor Core Isolation Cooling (RCIC) System, was identified for the licensee's failure to comply with the TS required actions for an inoperable RCIC system. The RCIC system was inoperable for approximately 33 days due to an internal failure of the electric governor - magnetic (EG-M) controller, which exceeded the TS allowed outage time (AOT) of 14 days. This issue was entered into the corrective action program as Problem Evaluation Report 203537. The EG-M was replaced and the RCIC system was restored to an operable condition.

This finding was determined to be of greater than minor significance because it was associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, the unresolved failure of the RCIC EG-M resulted in the RCIC system being unable to perform its intended function for

an extended period of time (i.e., 33 days). In accordance with IMC 0609, Significance Determination Process (SDP), Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," this finding required a Phase 2 analysis since it represented an actual loss of a single train for greater than its TS AOT. The Phase 2 SDP analysis determined that the finding was potentially greater than Green (i.e., greater than very low safety significance). A regional Senior Reactor Analyst then performed a Phase 3 SDP analysis which subsequently concluded the finding was of very low safety significance or Green. The cause of this finding was directly related to the cross-cutting aspect of Prompt Identification of Issues in the Corrective Action Program in the Problem Identification and Resolution area, because the licensee failed to enter the identified problem regarding abnormal EG-M voltage into their corrective action program in order to evaluate and resolve the adverse impact of the abnormal EG-M voltage on RCIC system operability [P.1(a)].

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

**Significance:**  Dec 28, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

**Violation of Technical Specification 5.4.1 for Failure to Develop Adequate Procedures to Ensure Tornado Depressurization Protection of the Emergency Diesel Generators**

The inspectors identified a Green non-cited violation (NCV) of TS 5.4.1 for the failure to have an adequate procedure that would ensure tornado depressurization protection of the emergency diesel generators (EDGs). Abnormal Operating Instruction, 0-AOI-100-7, "Severe Weather," did not provide guidance on how to provide pressure equalization of the EDG building for mitigating atmospheric depressurization associated with tornado conditions that could impact the EDG building ventilation system. The design of the EDG ventilation system intake and exhaust dampers requires the dampers to be manually opened prior to a tornado depressurization event to ensure the EDG building and ventilation system remain intact and operable during and after a tornado. This finding was entered into the licensee's corrective action program as problem evaluation report (PER) 206919. As an immediate corrective action, the licensee added steps to procedure 0-AOI-100-7 to station an operator in the EDG building to perform required manual actions in the event of a tornado warning in the area.

This finding is more than minor because it affects the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and operability of the EDGs to perform the intended safety function during a design basis event and the cornerstone attribute of Procedure Quality, i.e. Operating (Post Event) Procedures (AOPs). The inspectors assessed the finding using a Phase I Significance Determination Process (SDP) screening which determined a Phase III SDP evaluation was required due to the fact that the finding involved the loss or degradation of equipment specifically designed to mitigate a severe weather initiating event (e.g., tornado doors). The loss of this equipment by itself, during the external initiating event it was intended to mitigate, would degrade two or more trains of a multi-train safety system. A Phase III SDP evaluation was performed in accordance with NRC Inspection Manual Chapter 0609 Appendix A by a regional Senior Reactor Analyst using the NRC Standardized Plant Analysis 3

The inspectors determined that the use of operating experience (OE) information was a significant cause of this performance deficiency. Regulatory Information Summary 2006-03, "Post Tornado Operability of Ventilation and Air Conditioning Systems" as well as an internal licensee OE had raised a similar concern. The licensee was unaware of the vulnerability of the EDG ventilation system to tornado depressurization events until it was brought to their attention by the inspectors. The licensee's failure to use available OE is directly related to the OE component of the cross-cutting area of Problem Identification and Resolution and the aspect of implementing OE through changes to procedures (P.2.(b)).

Inspection Report# : [2009008](#) (pdf)

**Significance:**  Dec 28, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

**Violation of 10CFR50, Appendix B, Criterion V for Inadequate Procedure for Emergency Equipment Cooling Water System Flow Balancing**

The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, "Instructions,

Procedures, and Drawings,” for the failure to provide adequate guidance in existing procedures utilized for flow balancing of the emergency equipment cooling water (EECW) system. The EECW system provided the heat sink for station safety-related heat loads including cooling for the residual heat removal (RHR) and core spray (CS) room coolers. The installed strainers on the EECW system are capable of filtering debris greater than 1/8 inch (.125 inches), potentially allowing debris less than 1/8 inch to pass through and clog downstream throttle valves. A clog in the throttle valves would prevent adequate flow from reaching safety-related heat exchangers unless procedural guidance or limitations prevented throttling valves to disk-to-seat clearances of less than 1/8 inch. The existing EECW flow balance procedure was inadequate in that it made no provision in the acceptance criteria to limit or evaluate minimum throttle valve seat/disc clearance, and the subsequent potential for increased flow obstruction, resulting from system flow balancing. This finding was entered into the licensee’s corrective action program as problem evaluation reports (PERs) 208374 and 208636. Planned corrective actions included a revision to EECW flow balancing procedures. The inspectors verified and discussed with the licensee existing indications that are available to alert the operator of potential clogging.

This finding is more than minor because it affects the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and operability of the RHR and CS pump room coolers to perform the intended safety function during a design basis event and the cornerstone attribute of Procedure Quality, i.e. Maintenance and Testing (Pre-event) Procedures. The team assessed this finding using the Significance Determination Process (SDP) and determined that the finding was of very low safety significance (Green) because the inspectors found no documented history of an actual loss of safety system function. This finding was reviewed for cross-cutting aspects and none were identified.

Inspection Report# : [2009008](#) (pdf)

**Significance:**  Oct 09, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Deficiencies with Emergency Lighting Units**

The team identified a Green non-cited violation of Browns Ferry Units 1, 2, and 3 Operating License Conditions 2.C (13), 2.C(14), and 2.C(7), respectively, for the licensee’s failure to maintain in effect all provisions of the NRC-approved fire protection program, as described in the Final Safety Analysis Report. The Fire Protection Report (referenced in the Final Safety Analysis Report) requires that measures be established to ensure that conditions adverse to fire protection, such as failures and deficiencies, are promptly identified and corrected. The licensee had not established measures to identify and correct an excessive number of Appendix R emergency lighting unit failures. Specifically, emergency lighting unit failures were not being entered in the corrective action program as problem evaluation reports in order to evaluate and resolve why many of the emergency lighting failures occurred prior to reaching their 6-year replacement date. Additionally, the Fire Protection Report surveillance requirement to replace the Appendix R emergency lighting unit batteries and lamp heads every six years was not being adequately implemented, in that licensee data revealed that several installed emergency lighting units were beyond their 6-year replacement date. The licensee entered this finding into their corrective action program and initiated corrective actions to address these issues.

The licensee’s failure to meet the Fire Protection Report requirements to establish measures to identify and correct a condition adverse to fire protection (excessive Appendix R emergency lighting unit failures); and, to implement the Appendix R emergency lighting system replacement program, is a performance deficiency. The finding is more than minor because it is associated with the reactor safety, mitigating systems cornerstone attribute of protection against external factors (i.e., fire). The excessive emergency lighting unit failures affected the objective of ensuring the reliability and capability of operator manual actions during response to initiating events, The team determined that this finding was of very low safety significance (Green) because the operators had a high likelihood of completing the tasks using flashlights. The cause of this finding has a cross-cutting aspect in the Work Control component of the Human Performance area, in that it was directly related to the licensee not planning and coordinating work activities to support long-term equipment reliability, and their maintenance scheduling was more reactive than preventive (H.3 (b))

Inspection Report# : [2009009](#) (pdf)

**Significance:** G Oct 09, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Establish Adequate Compensatory measures for an Out-of-Service Hose Station**

The team identified a Green non-cited violation of Browns Ferry Units 1, 2, and 3 Operating License Conditions 2.C (13), 2.C(14), and 2.C(7), respectively, for the licensee's failure to maintain in effect all provisions of the NRC-approved fire protection program as described in the Final Safety Analysis Report. The Fire Protection Report (referenced in the Final Safety Analysis Report) requires the licensee to establish adequate compensatory measures for degraded or inoperable fire protection equipment. The licensee failed to establish adequate compensatory measures for an out-of-service hose station, in that the staged additional lengths of hose connected to the closest in-service hose station, established as a compensatory measure, did not provide equal or better protection than the out-of-service hose station that it was replacing. The licensee entered this finding into their corrective action program and took immediate action to review all existing fire protection impairment permits for similar problems. The licensee removed the compensatory measure and restored the out-of-service hose station to service.

The licensee's failure to provide compensatory measures of equal or better protection for an out-of-service hose station is a performance deficiency because it did not meet the requirements of the approved fire protection program. The finding was more than minor because it affected the protection against external factors attribute of the mitigating systems cornerstone, in that it impacted manual fire suppression (i.e., fire brigade) capability; and, affected the cornerstone objective of ensuring the availability of systems that respond to initiating events. Since Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," does not provide guidance for assigning a degradation rating to manual fire suppression, this determination was made using qualitative methods which received NRC management review as provided for in Inspection Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." This finding was determined to be of very low safety significance (Green) because it represented a low degradation of the manual fire suppression function. Although the fire protection impairment permit had been implemented for an out-of-service hose station, the hose station was still functional at the time this issue was identified, because the water supply to the hose station had not been physically isolated. However, the team concluded the fire brigade would have experienced delays in initiating manual fire suppression for a fire in a fire area covered by the impairment. The cause of this finding has a cross-cutting aspect in the Work Control component of the Human Performance area, in that it was directly related to the licensee not planning and coordinating work activities, consistent with nuclear safety, to ensure that adequate compensatory actions were established for an out-of-service hose station (H.3 (a)).

Inspection Report# : [2009009](#) (*pdf*)

**Significance:** Y Oct 09, 2009

Identified By: NRC

Item Type: VIO Violation

**Failure to Ensure One Train of Cables of Syatems Necessary to Achieve and/or Maintain Post-Fire safe Shutdown is Free of Fire Damage in Accordance With 10 CFR Part 50, Appendix R, Section III.G.**

Title 10 of the Code of Federal Regulations (10 CFR), Part 50.48(b)(1) requires that all nuclear power plants licensed to operate prior to January 1, 1979, must satisfy the applicable requirements of 10 CFR Part 50, Appendix R, Sections III.G, III.J, and III.O.

Section III.G requires fire protection of safe shutdown capability.

Section III.G.1 requires fire protection features shall be provided for structures, systems, and components important to safe shutdown. These features shall be capable of limiting fire damage, such that one train of systems necessary for achieving and maintaining hot shutdown conditions is free of fire damage.

Section III.G.2 requires, in part, that where cables and equipment of redundant trains of systems necessary to achieve and maintain hot shutdown conditions are located in the same fire area outside of primary containment, one of the following means of ensuring that one of the redundant trains is free of fire damage shall be provided:

- a. separation of cables and equipment by a fire barrier having a 3-hour rating; or
- b. separation of cables and equipment by a horizontal distance of more than 20 feet with no intervening combustibles or fire hazards. Fire detection and automatic fire suppression shall be installed in the fire area; or
- c. enclosure of cables and equipment of one redundant train in a fire barrier having a 1-hour fire rating. Fire detection and automatic suppression shall be installed in the fire area.

Contrary to the above, since the restart of each unit (Unit 2-1991, Unit 3-1995, Unit 1-2007) and as of January 20,

2010, the date of the inspection report, the licensee had not met nor has met, as of the date of this NOV, the requirements of 10 CFR Part 50, Appendix R, Section III.G, in that:

(i) fire protection features capable of limiting fire damage were not provided for structures, systems, and components important for safe shutdown. Specifically, the Tennessee Valley Authority (licensee) failed to provide fire protection features capable of limiting the fire damage such that one train of systems necessary to achieve and maintain hot shutdown conditions was free from fire damage in Fire Area 8 along with 19 other fire areas designated in the Browns Ferry Fire Protection Report, as required by 10 CFR Part 50, Appendix R, Section III.G.1.

(ii) where cables and equipment of redundant trains of systems necessary to achieve and maintain hot shutdown conditions are located in the same fire area, the licensee did not ensure that one of the redundant trains was free of fire damage by providing one of the following means: (a) a 3-hour rated fire barrier; (b) 20 feet of spatial separation (free of intervening combustibles and fire hazards) with detection and suppression installed in the fire area; or (c) a 1-hour rated fire barrier with detection and suppression installed in the fire area. Specifically, cables associated with the RHRSW Pump A1, RHR Pump 1A, and LPCI injection valve 1-FCV-74-53 in Fire Area 1/Fire Zone 1-4 are some of the many examples in which the licensee failed to ensure that one train of cables of redundant systems or equipment necessary to achieve and maintain hot shutdown conditions, located in the same fire area, outside of primary containment was free of fire damage by one of the means described in 10 CFR Part 50, Appendix R, Section III.G.2.

Inspection Report# : [2010007](#) (*pdf*)

Inspection Report# : [2009009](#) (*pdf*)

**Significance:** <sup>W</sup> Oct 09, 2009

Identified By: NRC

Item Type: VIO Violation

### **Inadequate Safe Shutdown Instruction Entry Conditions for Appendix R Fire Events**

The team identified an apparent violation of Technical Specification 5.4.1.a., in that, the licensee's revision to the safe shutdown instruction entry conditions in December 2008 resulted in inadequate procedural guidance. Specifically, the revision to Procedure 0-SSI-001, "Safe Shutdown Instructions," added an entry condition based on the operator's ability to restore and maintain reactor water level above +2 inches on the narrow range scale, utilizing available equipment. This revision could have delayed or prevented entry into the safe shutdown instructions if reactor water level stayed at or above +2 inches on the narrow range scale. Furthermore, this entry condition was not consistent with the initial plant conditions assumed in the fire protection program safe shutdown analysis. The licensee entered this finding into the corrective action program and revised the entry conditions for the safe shutdown instructions on February 27, 2009, to eliminate the +2-inch reactor vessel water level entry condition.

Failure to meet Technical Specification requirements due to inadequate procedural guidance is a performance deficiency. This finding is more than minor because it is associated with the procedure quality attribute of the mitigating systems cornerstone and the inadequate procedure affected the cornerstone objective of protection against external events such as fire to prevent undesirable consequences. Given the number of fire areas involved, a significance determination process Phase 2 analysis was not performed. A regional senior reactor analyst determined that there were significant obstacles to quantifying the risk of this finding because the methods and tools are not adequate to determine the significance of this finding within the established timeliness goal of 90 days. Therefore, the safety significance of this finding was determined using the guidance and qualitative techniques contained in NRC Inspection Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." The preliminary significance of this finding was determined to be Greater Than Green, which was reviewed and approved by NRC management. The team determined that this finding did not present an immediate safety concern because the immediate safety hazard no longer existed after the licensee revised the safe shutdown instruction in February 2009. The cause of this finding had a cross-cutting aspect in the Decision Making component of the Human Performance area, in that it was related to the licensee not using conservative assumptions in decision making and not conducting reviews to verify the validity of underlying assumptions and identifying possible unintended consequences (H.1(b)).

Inspection Report# : [2009009](#) (*pdf*)

Inspection Report# : [2010007](#) (*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

**Significance:** SL-IV Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Report an Automatic RPS Actuation While Shutdown Per 10 CFR 50.73**

A Severity Level IV, non-cited violation (NCV) of 10 CFR 50.72(b)(3)(iv)(A) and 10 CFR 50.73(a)(2)(iv)(A) were identified by the inspectors for the licensee's failure to recognize that a valid automatic reactor protection system (RPS) actuation while shutdown was a reportable condition. Consequently, the licensee failed to make an eight hour report as required by 10CFR50.72 and submit a licensee event report (LER) within 60 days as required by 10CFR50.73. This issue was documented in the licensee's corrective action program as Problem Evaluation Reports 172053, 178146, and 206168, and subsequently reported as LER 050-260/2009-006.

This finding was considered as traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. However, because this violation was of very low safety significance, was not repetitive or willful, and was entered into the licensee's corrective action program, the NRC has characterized this violation as a Severity Level IV NCV in accordance with Section IV.A.3 and Supplement I of the NRC Enforcement Policy. The cause of this finding was directly related to the cross-cutting aspect of evaluating and properly prioritizing reportable conditions in the area of Problem Identification and Resolution because the licensee did not adequately prioritize their efforts to meet the LER timeliness requirement of 10CFR50.73 [P.1(c)]. (Section 40A3.1)

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

Last modified : November 29, 2010