Braidwood 1
4Q/2010 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2010
Identified By: Self-Revealing
Item Type: FIN Finding
FAILURE TO IDENTIFY AND CORRECT WATER DISCHARGED TO THE TURBINE BUILDING FLOOR DURING CONDENSATE REJECT
A self-revealed finding of very low safety significance (Green) was identified for the failure to correct a condition that resulted in water being discharged to the turbine building floor during the reject of condensate from the condenser hotwell. Specifically, water had been observed to overflow to the turbine building floor in multiple instances in the past during hotwell condensate reject. However, the licensee did not implement corrective actions to correct this condition or evaluate its impact on plant equipment as required by the licensee's corrective action program. The water discharged from the condensate hotwell reject during the Unit 2 trip caused a reactor trip of Unit 1 on August 16, 2010. The licensee entered this issue into its corrective action program and changed the operation of the condensate reject from an automated action to a manual action controlled by the operators.

The finding was determined to be more than minor because it was associated with the Initiating Events Cornerstone attribute of configuration control, and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability. The finding screened as very low safety significance (Green) because a Phase 3 evaluation determined that it resulted in a delta core damage frequency of 5.6E-7/year with Large Early Release Frequency (LERF) not being a risk contributor. No violation of NRC requirements was identified because the deficiencies that contributed to the reactor trip were associated with nonsafety-related components. The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because the licensee did not have a low threshold for identifying issues and did not identify issues completely. [P.1(a)] (Section 4OA5.3)
Inspection Report# : 2010010 *(pdf)*

Significance: G Sep 30, 2010
Identified By: Self-Revealing
Item Type: FIN Finding
EVALUATION OF OPERATING EXPERIENCE CONCERNING REACTOR BUILDING FLASHING
A self-revealed finding of very low safety significance was identified for the inadequate evaluation of operating experience done in accordance with the station procedure. Specifically, the licensee evaluated an event at another plant where building material was dislodged during a steam release resulting in a loss of off-site power and concluded the event was not applicable to Braidwood station. The evaluation did not address a previous event at Braidwood where the reactor building flashing was dislodged during a steam release. It did conclude, however, that off-site power could be adversely affected by debris. During the dual unit trip on August 16, 2010, reactor building flashing was dislodged during a steam release and was found on power lines and in the vicinity of the off-site power supplies. The licensee entered this issue into its corrective action program and structurally restrained the flashing left on the reactor building.

The finding was determined to be more than minor because the finding was associated with the Initiating Events Cornerstone attribute of protection against external factors and affected the cornerstone objective of limiting the likelihood of those events that challenge critical safety functions during shutdown. Specifically, not protecting the off-site power supplies from flashing falling from the reactor building could result in a loss of off-site power and would challenge the emergency diesel generators to supply alternating current power to safety-related equipment during the plant shutdown. The finding screened as very low safety significance (Green) because it was determined not be a loss of cooling accident or External Event initiator and would not contribute to both a plant trip and the likelihood that mitigation equipment or functions would not be available. There is no cross-cutting aspect because the 2007

evaluation completed on the operating experience is not reflective of current performance. (Section 4OA5.4)
Inspection Report# : 2010010 *(pdf)*

Mitigating Systems

Significance: SL-IV Dec 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Submit a Licensee Event Report per 10 CFR 73(a)(2)(v) (Section 4OA3.5)
A Severity Level IV NCV of 10 CFR 50.73(a)(2)(v) was identified by the inspectors when licensee personnel failed to report known conditions that could have prevented the fulfillment of the Residual Heat Removal (RHR) system to perform its designed emergency core cooling safety function while operating in the shutdown cooling mode of operation, within 60 days of discovery. Specifically, upon receipt of Westinghouse Nuclear Safety Advisory Letter (NSAL) 0904, "Presence of Vapor in Emergency Core Cooling System/Residual Heat Removal System in Modes 3 or 4 Loss of Coolant Accident Conditions," the licensee determined that a loss of RHR system safety function occurred when both trains of the RHR system were placed into the shutdown cooling mode of operation above 200 degrees Fahrenheit (°F). The station identified four instances in which both trains of RHR were operated in the shutdown cooling mode of operation above 200°F over the previous 3 year period. The licensee, however, failed to report to the NRC within 60 days that the RHR safety function had been lost. The station entered this issue into the CAP as IR 1155372. Corrective actions included the issuance of Licensee Event Report (LER) 05000456/457/2010-007-00 on January 18, 2010.

The inspectors determined that the failure to report this LER in accordance with NRC regulations was a performance deficiency since this issue had the potential to impact the regulatory process. Therefore, this violation was dispositioned through the traditional enforcement process. The inspectors determined that this issue was a Severity Level IV violation based on a similar example referenced in NRC Enforcement Policy Supplement I, Example D.4. The inspectors evaluated this issue under the Reactor Oversight Process (ROP) and did not identify a performance deficiency that could be assessed under the SDP. (Section 4OA2.2).
Inspection Report# : 2010005 *(pdf)*

Significance: G Sep 30, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW PROCEDURES FOR TEMPORARY SCAFFOLDS
The inspectors identified a Green finding and an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," related to the control of temporary scaffolds. Specifically, the licensee's procedure for the installation, modification, and removal of scaffolds was not followed on a routine basis for temporary scaffolds that remained in the plant for greater than 90 days. The licensee entered this issue into the Corrective Action Program as Issue Report 1095900. Corrective actions for this issue included walk downs of temporary scaffolds that had been in place for greater than 90 days utilizing the permanent scaffold checklist, and an assignment to ensure the procedure was followed in the future.

The inspectors determined that this issue was more than minor in accordance with IMC 0612, Appendix E, "Examples of Minor Issues." Specifically, this issue was similar to the more than minor criteria in Example 4.a, "Insignificant Procedural Errors," in that the licensee failed to perform engineering evaluations on similar issues, or if the later evaluation determined that safety-related equipment was adversely affected. The finding was of very low safety significance because there was not a confirmed loss of operability of any mitigating system component. This finding was associated with the cross-cutting aspect of Decision-Making in the Human Performance cross-cutting area. Specifically, the licensee had not made safety-significant or risk significant decisions by utilizing the systematic scaffolding construction process to ensure adequate quality and therefore adequate safety was maintained (H.1(a)).
Inspection Report# : 2010004 *(pdf)*

Significance: G Sep 30, 2010

Identified By: Self-Revealing
Item Type: NCV NonCited Violation
UNPLANNED COOLING WATER FLOW REDUCTION DURING SX IST SURVEILLANCE TEST
A self-revealed Green finding and an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified after the licensee failed to follow procedures during an essential service water inservice test on August 24, 2010. Specifically, during the section of the procedure utilized to establish testing conditions, the licensee throttled the wrong valve resulting in an unplanned reduction in flow to safety-related structures, systems, and components. This flow reduction resulted in the Train "B" equipment being declared inoperable for approximately 5 minutes. The licensee entered this issue into the CAP as IR 1105448. Corrective actions for this issue included returning the Unit 2 essential service water system to operable status by restoring the required valve lineup and a corrective action assignment to provide additional training to the operating crews on the use of human error prevention techniques.

The inspectors determined that this finding was more than minor, because it was associated with the Human Performance attribute of the Mitigating Systems Cornerstone and impacted the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. This finding was determined to be of very low safety significance based on a Phase 3 Significance Determination Process analysis that conservatively bounded the risk of this event to be less than 1.0E-7/yr. The inspectors concluded that this finding was associated with the cross-cutting aspect of Work Practices in the Human Performance cross-cutting area because adequate human error prevention techniques were not effectively used to ensure that the surveillance activity was performed properly (H.4(a)).
Inspection Report# : 2010004 *(pdf)*

Significance: G Sep 30, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
FOREBAY INSPECT-AND-CLEAN ACTIVITIES DID NOT ENSURE THAT SSCs WILL BE CAPABLE OF ERFORMING THEIR SAFETY FUNCTION
The inspectors identified a Green finding and an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to establish adequate controls to ensure that forebay inspect-and-clean activities provided assurance that systems, structures, and components would be capable of performing their safety function during inspect-and-clean intervals. Specifically, the inspectors noted that during the event on August 16, 2010, the operability margin of one train of the essential service water system decreased to zero under forebay fouling conditions that were less than the pre-established limiting conditions. The licensee entered this issue into its corrective action program (CAP).

The finding was determined to be more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, forebay conditions would have been allowed to degrade between inspect-and-clean intervals and the potential adverse impact to the essential service water system and its supported equipment was not evaluated. The finding screened as very low safety significance because it was a design deficiency that was confirmed not to result in an actual loss of operability or functionality. The inspectors determined that this finding had a cross cutting aspect in the area of human performance, decision-making component, because the licensee did not make safety-significant or risk-significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety was maintained. [H.1(a)] (Section 4OA5.1)
Inspection Report# : 2010010 *(pdf)*

Significance: G Sep 30, 2010
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
FAILURE TO REPLACE LOW MARGIN FUSES IN MCC131X1
A self-revealed finding of very low safety significance and an associated non cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified for the failure to establish measures for the selection and review for suitability of equipment essential to the safety–related function of the component. In 2008, the safety-related 1.5 ampere (amp) control power fuses in motor control center (MCC) 131X1 were specified to be replaced with 3.0 amp fuses due to failures of other similar 1.5 amp fuses. In 2009, these fuses failed and were replaced with

the same sized 1.5 amp fuses, even though the licensee's review for suitability concluded the fuses were adequate, but marginally sized. They were then scheduled to be replaced with 3.0 amp fuses in 2015. During the event on August 16, 2010, these fuses failed again at which time they were replaced with 3.0 amp fuses.

The finding was determined to be more than minor because the finding was 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. Specifically, the failure of these fuses resulted in the loss of function for eight safety injection valves. This caused a train of emergency core cooling and containment isolation for the safety injection system to be inoperable. The inspectors answered "no" to the Mitigating Systems questions and screened the finding as having very low significance (Green). This finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because the licensee did not implement corrective actions to address safety issues in a timely manner, commensurate with their safety significance. Specifically, in 2008 these 1.5 amp fuses were specified to be replaced with 3.0 amp fuses, they failed in 2009 and were replaced with 1.5 amp fuses. They were then scheduled for replacement with the higher amp fuses in 2015. [(P.1(d)] (Section 4OA5.2)
Inspection Report# : 2010010 *(pdf)*

Significance: G Sep 17, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow the Operability Determination Procedure
The inspectors identified a Green finding and an associated NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," when licensee personnel failed to adhere to Operability Determination Procedure OP AA 108-115 after identifying a potential auxiliary feedwater (AFW) system design vulnerability. Specifically, since May 15, 2007, the licensee had questioned the motor-driven AFW system's capability to effectively transfer its water source from the Condensate Storage Tank (CST) to the essential service water system during a hypothetical catastrophic failure of the non-seismic CST. The lack of involvement in bringing this issue to the attention of the operating crew, lack of quality in evaluating the issue, and length of time the questions had been unanswered were not consistent with the Operability Determination process. The licensee entered this issue into their CAP as Issue Report (IR) 1114604. Corrective actions planned included performing an Operability Evaluation and a corrective action assignment to ensure a rigorous evaluation was performed on the motor-driven AFW pump's motor and breaker.

The inspectors determined that this issue was more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," because the issue was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the AFW pump operability was not fully evaluated by the licensee. The finding was of very low safety significance because the issue was not a confirmed loss of operability and did not represent a risk significant issue based on the plant's design backup capability to remove decay heat via the primary feed and bleed method. This finding had a cross-cutting aspect in the area of Human Performance for Decision-Making (H.1(a)). Specifically, the licensee did not make a safety-significant or risk-significant decision using the Operability Evaluation systematic process, especially when faced with uncertain or unexpected plant conditions involving a potential design vulnerability to the plant to ensure safety was maintained. (Section 4OA2.1.b.2.c)
Inspection Report# : 2010006 *(pdf)*

Significance: G Apr 02, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
DDAFW Pump Battery Racks were not restored to their Design Basis Seismic Category I
The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance for the licensee's failure to restore the Diesel Driven Auxiliary Feedwater (DDAFW) battery racks to their design basis qualification, Seismic Category I. Specifically, although the licensee identified the existence of gaps between the wooden spacer blocks, batteries and end of racks in 2004 the licensee failed to provide adequate justification to demonstrate that the existing condition still met the Seismic Category I Design Basis requirements as

specified in their design documents. The gaps between the wooden spacer blocks could affect the reliability of the DDAFW DC safety-related batteries being that this component was outside its design basis for over a period of six years. The licensee subsequently entered the issue into their corrective action program and restored the batteries racks to their design requirements.

The finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of equipment performance, and affected the cornerstone objective of ensuring the availability of DDAFW batteries to perform their safety function in external events to prevent undesirable consequences. Specifically, the licensee did not assure that the wooden spacer blocks including the gap would provide adequate support to ensure that the seismically qualified battery rack will perform its safety function. This finding is of very low safety significance (Green) because the qualification deficiency was confirmed not to result in loss of operability or functionality. The inspectors determined that there was no cross-cutting aspect associated with this finding because the gaps between the wooden spacers and the DDAFW batteries were initially identified in 2004; therefore, the finding was not indicative of the plant's current performance.
Inspection Report# : 2010007 *(pdf)*

Significance: G Apr 02, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Lack of Calculation for the DDAFW Minimum Fuel oil Tank Setpoint Level
The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance related to the licensee's failure to develop a calculation for the DDAFW pump minimum fuel oil tank level setpoint. Specifically, the licensee failed to perform a calculation specific to the DDAFW pump day tank to verify the 74 percent level indication was equivalent to the 420 gallons of usable fuel volume that was required by the Technical Specifications (TS). The licensee subsequently entered the issue into their corrective action program to develop design basis documentations.

This finding is more than minor because it was associated with the Mitigating Systems cornerstones attribute of design control and affected the cornerstone objective of ensuring the capability of the safety-related system to respond to initiating events to prevent undesirable consequences. Specifically, the licensee failure to verify that 74 percent tank level exceeded the TS value did not assure the pump was capable of performing its safety function for the entire seven hours mission time. This finding is of very low safety significance (Green) because subsequent calculation/evaluation determined the volume of the tank at 74 percent level was slightly above the minimum required TS limit. The inspectors determined there was no cross-cutting aspect associated with this finding because the deficiency was a legacy design issue and, therefore, was not indicative of the plant's current performance.

Inspection Report# : 2010007 *(pdf)*

Significance: G Apr 02, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Potential Clogging of Essential Service Water (SX) Throttle Valves for Pump Room Coolers
The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," having very low safety significance for the licensee's failure to include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished. Specifically, the licensee's procedures for flow balancing Essential Service Water (SX) supply to safety-related pump room coolers did not include any precautionary statements to limit the degree to which branch loop throttle valves could be throttled down without introducing concerns about potential clogging from particulate in the service water and resultant flow reduction. The licensee subsequently entered the issue into their corrective action program and performed immediate corrective actions included, engineering evaluation to determine current operability, repositioned all throttle valves to at least ¾ turns open and revised the valve throttling procedure to prevent any valve from being throttled to less than ¾ turns open in the future.

The finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of procedure quality and affected the cornerstone objective of ensuring the capability of the system to respond to

initiating events to prevent undesirable consequences. Specifically, under accident conditions, the position of these throttle valves could have led to a potential degradation of the ability of the room coolers to perform their safety-related function of protecting the emergency core cooling system (ECCS) pumps from elevated environmental temperatures. The finding is of very low safety significance (Green) because the design deficiency did not contribute to the likelihood that mitigating equipment or functions would not be available. The inspectors determined there was no cross-cutting aspect associated with this finding because the deficiency was a legacy procedural issue and, therefore, was not indicative of the plant's current performance.

Inspection Report# : 2010007 *(pdf)*

Significance: G Apr 02, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Adverse Impact of Flood Drain Strainer Design Modification on Flooding Analysis
The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance for the licensee's failure to fully verify the adequacy of a design modification important to safety. Specifically, the licensee failed to recognize that bag-type strainers back fitted into floor drains in the Auxiliary Building for the purpose of preventing debris from blocking the floor drain piping were designed in such a way that they actually increased the potential for blockage, thus negatively impacting the analysis of record for internal flooding. The licensee subsequently entered the issue into their corrective action program, performed preliminary evaluation of the affected areas and demonstrated operability. Additional action was initiated to revise the internal flooding calculation and safe shutdown analysis to address the impact of the floor drain strainers.

The finding was more than minor because it was associated with the Mitigation Systems Cornerstone attribute of protection against external events such as flooding and affected the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the floor drain strainer bags were inadequately designed such that they would have increased the possibility of drain plugging. The finding is of very low safety significance (Green) because the licensee was able to demonstrate that, in the event the drains became plugged in any room, a flood in the affected room would have not affected the alternate shutdown equipment. The inspectors determined there was no cross-cutting aspect associated with this finding because these bag-type strainers were installed in 1996; therefore, the finding was not reflective of current performance.

Inspection Report# : 2010007 *(pdf)*

Significance: G Apr 02, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Non-Conservative Acceptance Criteria for CS Pump Performance Testing
The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," having very low safety significance for the licensee's failure to ensure adequate acceptance limits were incorporated into test procedures. Specifically, the licensee failed to consider instrument loop uncertainties when determining the alert and required action values used in the IST procedure for testing of the containment spray (CS) pumps. Consequently, the acceptance criteria for both the upper and lower limits on total developed head (TDH) were non-conservative. As a result, the licensee subsequently entered the issue into their corrective action program, performed an operability evaluation and concluded equipment were operable. Additional corrective actions were assigned to investigate and correct the cause of the apparent degradation of the 2B CS pump.

The finding was more than minor because it was associated with the Mitigating Systems cornerstones attribute of equipment performance and affected the cornerstone objective of ensuring the capability of the system to respond to initiating events to prevent undesirable consequences. Specifically, the failure to consider instrument uncertainties in the development of IST acceptance criteria resulted in the creation of acceptance criteria values that did not ensure that the CS pump could meet its intended safety function. This finding is of very low safety significance (Green) because the licensee was able to demonstrate pumps operability; therefore, there was no loss of safety function. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Operating Experience, because the licensee failed to implement relevant information relating to failure to appropriately account for instrument

uncertainties identified in Information Notice 2008-02 through changes to station procedures.

Inspection Report# : 2010007 *(pdf)*

Significance: G Apr 02, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
EDGs Fuel Oil Consumption Calculation Failed to Account for Frequency Variations
The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance for the licensee's failure to translate the allowable frequency variations, for the emergency diesel generators (EDGs), into the fuel consumption calculation. Specifically, the fuel oil consumption calculation for the EDGs did not assure that TS minimum required fuel limit of 44,000 gallons was adequate to support the EDGs operating at frequency higher than 60 Hertz (Hz) for the seven days mission time. As a result of the inspectors' questions, the licensee subsequently added an action item to an existing condition report to address frequency variation on fuel consumption.

The finding was more than minor because it was associated with the Mitigating Systems cornerstones attribute of design control and affected the cornerstone objective of ensuring the capability of the system to respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed to ensure that the minimum fuel required by TS of 44,000 gallons was adequate to support the EDGs mission time when operating at higher frequency than 60 Hz. This finding is of very low safety significance (Green) because the licensee was able to demonstrate that adequate fuel oil in the storage tanks would be available to support the EDGs when operating within the frequency variation band established by the administrative limits. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because the licensee did not thoroughly evaluate problems associated with safety nuclear safety.

Inspection Report# : 2010007 *(pdf)*

Barrier Integrity

Significance: G Sep 17, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Untimely Corrective Action for Lack of Water Hammer Analysis on the Recycle Hodup tank.
The inspectors identified a Green finding and an associated NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," when licensee personnel failed to promptly correct a previously identified NCV regarding the lack of analysis for water hammer loads on the Recycle Holdup Tank (RHUT) inlet piping induced by Residual Heat Removal (RHR) system relief valve discharges. Specifically, the licensee failed to complete the necessary piping analysis to address potential water hammer effects since the issue was initially identified in June 2007 and documented as a NCV in February 2009. The licensee entered this issue into the CAP as IR 1117296 and planned to accelerate the completion schedule for the analysis.

The finding was more than minor because it was associated with the design control attribute of the Barrier Integrity Cornerstone and affected the cornerstone objective of maintaining the radiological barrier function of the containment. The finding was of very low safety significance because it did not represent an actual open pathway from containment. This finding has a cross-cutting aspect in the area of Human Performance for Resources (H.2(a)) because the licensee failed to maintain long-term plant safety by completing the necessary piping load calculations in a timely manner. (Section 4OA2.1.b.3.b)
Inspection Report# : 2010006 *(pdf)*

Significance: G Mar 31, 2010
Identified By: Self-Revealing

Item Type: NCV NonCited Violation
PERFORMANCE OF TROUBLESHOOTING LEADS TO AUXILIARY BUILDING VENTILATION FAN FIRE
A finding of very low safety significance and an associated Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, “Procedures,” was self-revealed when, on January 9, 2010, auxiliary building ventilation fan 0VA01CC caught fire, resulting in the declaration of an Unusual Event. Specifically, troubleshooting performed on the inboard fan bearing in Spring 2009 changed the bearing oil level without proper limits established, which led to bearing failure due to lack of lubrication. The licensee’s corrective actions included an evaluation of the oil consumption trends for other auxiliary building ventilation fans, additional training on work package quality, and a revision to other existing work orders that are intended to adjust auxiliary building ventilation fan oil levels.
The finding was more than minor because it impacted the Systems, Structures, and Components and Barrier Performance attribute of the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Because the finding only represented degradation, rather than loss, of the radiological barrier function provided for the auxiliary building it screened as an issue of very low safety significance (Green).
This finding is associated with the cross-cutting area component of resources in the human performance cross-cutting area. Specifically, the work instructions for troubleshooting did not contain adequate guidance to adjust the oil bubbler without causing an adverse equipment impact (H.2(c)).
Inspection Report# : 2010002 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Last modified : March 03, 2011