Seabrook 1
4Q/2010 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G May 20, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Test ECCS (RHR-SI) Valve Interlocks
Green. The team identified a finding of very low safety significance involving a non-cited violation of 10 CFR 50, Appendix B, Criterion XI, "Test Control," in that, NextEra did not assure that all testing required to demonstrate that structures, systems, and components will perform satisfactorily in service were identified and performed in accordance with written test procedures. Specifically, the team determined that interlocks between emergency core cooling system valves were not properly tested to demonstrate that the associated valves will perform satisfactorily in service. In response, NextEra entered the issue into the corrective action program and implemented acceptable interim actions to ensure operability.

The finding is more than minor because it is associated with the design control 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. The team determined the finding was of very low safety significance (Green) because it was not a design or qualification deficiency, did not represent a loss of system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding did not have a cross-cutting aspect because the most significant contributor of the performance deficiency was not reflective of current licensee performance.
Inspection Report# : 2010006 *(pdf)*

Significance: G May 20, 2010
Identified By: NRC
Item Type: FIN Finding
Failure to Take Timely Corrective Action for Battery Sizing Calculations for SBO Loads
The team identified a finding of very low safety significance for NextEra's failure to take effective or timely corrective actions regarding the battery sizing calculation for safety related battery loading under station blackout (SBO) conditions. Specifically, although NextEra identified that the SBO battery sizing calculation had significant errors, no action was taken to either formally revise the calculation or ensure it was not used. The team also identified additional errors in the existing calculation. In response, NextEra entered the issue into the corrective action program, performed analysis, and confirmed there were no existing operability issues.

The finding is more than minor because it is associated with the design control 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. The team determined the finding was of very low safety significance (Green) because it was not a design or qualification deficiency, did not represent a loss of system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action (P.1(d)), because NextEra did not take appropriate corrective actions to address safety issues in a timely manner. Specifically, NextEra did not take action to either formally revise the SBO battery sizing calculation or to ensure that it was not used since identifying deficiencies approximately four years ago.

Inspection Report# : 2010006 *(pdf)*

Significance: G Apr 15, 2010
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate instructions to install test equipment caused the A EDG to be inoperable
A self-revealing non-cited violation of Technical Specification 6.7.1, Procedures and Programs, was identified related to the failure of the A EDG during a maintenance run per EC145293 on April 15, 2010. Specifically, NextEra did not provide adequate work instructions to control temporary test equipment attached to the EDG. This led to the failure of the jacket water cooling system that required operators to shutdown the engine, resulting in unplanned unavailability for the A EDG. The leak was promptly repaired and the EDG restored to a functional status on April 17, 2010. The issue was entered into the corrective action program as condition report 221321.

The finding is more than minor because it is associated with the work control attribute of the Mitigating Systems cornerstone and it adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the inadequate work instructions intended to flow balance the A EDG coolant system during an instrumented run, resulted in unplanned extended unavailability of the A EDG. The inspectors determined the issue was of very low safety significance because the finding was not a design or qualification deficiency, did not result in an actual loss of safety function, and was not potentially risk significant for external events. The finding had a cross-cutting aspect in the area of human performance - resources [H.2.c] because the work instructions were not adequate to assure temporary test equipment was properly installed.

Inspection Report# : 2010003 *(pdf)*

Barrier Integrity

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

Significance: N/A Oct 01, 2010
Identified By: NRC
Item Type: FIN Finding
Seabrook Biennial PI&R Inspection Summary
The inspectors concluded that problems were, in general, properly identified, evaluated, and resolved within the corrective action program (CAP). NextEra personnel identified problems at a low threshold and entered them into the CAP. The inspectors determined that NextEra personnel screened issues appropriately for operability and reportability, and prioritized issues commensurate with the safety significance of the problems. Root and apparent cause analyses appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors determined that corrective actions addressed the identified causes and were typically implemented in a timely manner. However, the inspectors also identified a number of minor performance deficiencies that involved a lack of adherence to the procedures used to perform root cause analyses.

NextEra's audits and self-assessments reviewed by the inspectors were adequate to determine programmatic weaknesses and deficiencies. Additionally, the inspectors concluded that NextEra, in general, identified, reviewed, and applied relevant industry operating experience (OE) to the Seabrook Station. However, the inspectors also identified minor performance deficiencies that involved lack of adherence to the procedures that implemented the self assessment on OE programs. Based on interviews, observations of plant activities, and reviews of the CAP and the Employees Concerns Program (ECP), the inspectors did not identify any concerns with site personnel willingness to raise safety issues, nor did the inspectors identify conditions that could have had a negative impact on the site's safety conscious work environment (SCWE).
Inspection Report# : 2010008 *(pdf)*

Last modified : March 03, 2011