Farley 2
3Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2011
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to properly pre-plan maintenance activities whle conducting tagout operations on the 2C charging pump
A self-revealing NCV of Technical Specification (TS) 5.4.1a was identified for the licensee's failure to implement procedures recommended in Regulatory Guide (RG) 1.33. Specifically, the licensee did not properly pre-plan maintenance tagout activities on the unit 2 charging system. As a result, the licensee inadvertently overpressurized the 2C high head safety injection (HHSI) pump suction piping, adversely affecting the availability of the safety-related pump. Upon discovery of this condition, the licensee immediately depressurized the pump suction piping and initiated condition report (CR) 343336.

Failure to properly pre-plan maintenance activities is a performance deficiency. This performance deficiency is more than minor because it is associated with the human performance attribute of the mitigating systems (MS) cornerstone, and adversely affected the cornerstone objective to ensure system availability of components responding to initiating events preventing undesirable consequences. The human performance attribute of the MS cornerstone was determined to be adversely affected because: 1) the licensee's tagout procedure relied on a check valve as part of the maintenance boundary; 2) the licensee's tagout sequence isolated the pump suction valve prior to isolating the pump discharge valve; resulting in overpressurization of the 2C charging pump suction piping, which rendered the 2C charging pump inoperable from August 11, 2011, to September 9, 2011. The significance of this finding was screened using IMC 0609, Significance Determination Process (SDP), Phase 1 worksheets of Attachment 4. The finding screened as Green, because it did not represent an actual loss of safety function of a single train of emergency core cooling system (ECCS) for greater than its TS allowable outage time. The finding was assigned a cross cutting aspect in the resources component of the human performance area (H.2(c)). Specifically, complete, accurate and up-to-date work packages could have prevented overpressurization of the pump. (Section 1R12)

Inspection Report# : 2011004 *(pdf)*

Significance: G Dec 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Station Guidance on Use of Extension Cords and Placement of Equipment in Safety-Related Cable Trays (Section 1R05)
An NRC identified NCV of Technical Specification (T.S.) 5.4.1 was identified for failure to follow station maintenance procedures related to the use of extension cords, which resulted in an energized smoke eductor and its extension cord located within one inch of a safety-related cable tray. On September 30, 2010, the inspectors discovered an operating smoke eductor sitting atop safety-related cable tray AID15A in the Unit 2 component cooling water (CCW) pump and heat exchanger room. The inspectors also noted safety-related cable tray AHD21A ran parallel with, and approximately 36 inches above, cable tray AID15A. The inspectors evaluated the cables in both safety-related cable trays, and learned Unit 2 train 'A' residual heat removal (RHR) and the hot shutdown panel were likely components that would be negatively affected in the event of a fire from this energized equipment. The inspectors immediately notified control room personnel, who then removed the smoke eductor and wrote condition

report (CR) 2010113318.
The failure to maintain an energized and operating smoke eductor with its extension cord greater than one inch from a safety-related cable tray as required by station procedure, FNP-0-ACP-59, Extension Cord Usage and Temporary Electrical Cable Installation Guidelines, is a performance deficiency. The finding was more than minor because it adversely affected the mitigating systems (MS) cornerstone objective of ensuring the availability, reliability, and capability of systems responding to initiating events to prevent undesirable consequences. Specifically, a fire resulting from this energized equipment would challenge train 'A' RHR pump and valves, and potentially lead to the train being inoperable. The significance of this finding was assessed using the Phase 1 screening worksheets of Attachment 4 and Appendix F, Attachment 1 of Manual Chapter (MC) 0609, SDP. Additionally, Phase 2 worksheets of Appendix F, Attachment 1 were used, and the finding was determined to be of very low safety significance (Green), because the safe shutdown path was deemed independent of fire damage state scenarios for the given fire ignition source. The finding was assigned a cross-cutting aspect in the Work Practices component of the Human Performance cross-cutting area because station personnel failed to follow guidance in station procedures related to the control of cable trays (H.4 (b)).
Inspection Report# : 2010005 *(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 Aug 24, 2007
Identified By: NRC
Item Type: FIN Finding
Biennial Identification and Resolution of Problems Inspection Results
One finding of very low safety significance (Green) was identified. The licensee was generally effective in identifying problems at a low threshold and entering them into the corrective action program. The licensee properly prioritized issues entered into the corrective action program (CAP) and routinely performed evaluations that were technically accurate and of sufficient depth to address the issue documented in the condition reports (CRs). Overall, corrective actions were effective; however, minor examples of inadequate condition report broadness reviews and documentation issues related to the closure of action items were identified. In general, operating experience was found to be used

both proactively and reactively by personnel involved in the corrective action program; however, an example of industry operating experience was identified in which the licensee did not completely develop interim compensatory measures for a condition to which Farley was vulnerable. The licensee's programmatic self-assessments and audits were generally effective in identifying weaknesses in the corrective action program; however, a missed opportunity in the trending of issues which could result in adverse effects on safety-related plant components was identified. The inspectors also concluded that the workers at Farley felt free to report safety concerns.

Inspection Report# : 2007006 *(pdf)*

Last modified : January 04, 2012