McGuire 2
3Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to establish adequate ND venting procedures
The inspectors identified a NCV of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures and Drawings, for the failure to establish acceptance criteria to determine operability in surveillance procedures used to vent the decay heat removal (ND) system in Modes 5, 6, and No-Mode in preparation for Mode 6. The issue was entered into the licensee's corrective action program as PIP M-11-04745

The licensee's failure to establish adequate acceptance criteria for ND venting surveillance procedures PT/1/A/4200/036 and PT/2/A/4200/036 was a performance deficiency (PD). The PD was determined to be more than minor because if left uncorrected, the failure to establish acceptance criteria for surveillance tests which establish the basis for the ND system operability in modes 5 and 6 would have the potential to lead to a more significant safety concern in that conditions which could impact system operability could remain undetected. In addition, the finding adversely affected the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using IMC 0609, Appendix G, Shutdown Operations Significance Determination Process, Attachment 1, the finding was determined to be of very low safety significance (Green) because a quantitative assessment was not required based on the criteria in Attachment 1. The finding had a cross-cutting aspect of implementation of operating experience in the Operating Experience component in the area of Problem Identification and Resolution because the licensee failed to implement operating experience from Generic Letter (GL) 2008-01 into station procedures [P.2(b)]. (Section 4OA5.4)

Inspection Report# : 2011004 *(pdf)*

Significance: SL-IV Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to update the UFSAR for GL 91-13
An NRC-identified SL-IV non-cited violation (NCV) of 10 CFR 50.71(e) was identified when the licensee did not update the Updated Final Safety Analysis Report (UFSAR) to reflect their response to Generic Letter (GL) 91-13, Essential Service Water System Failures at Multi-Unit Sites, which described capabilities in existing procedures for cross-connecting nuclear service water (RN) between units. Licensee corrective actions include submitting a license amendment and updating the UFSAR following amendment approval.

This performance deficiency (PD) was considered as traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. This PD was determined to be a SL-IV violation using Section 6.1 of the NRC Enforcement Policy because it did not result in a condition evaluated as having low-to-moderate or greater safety significance (i.e., White, Yellow, or Red). Cross-cutting aspects are not assigned to traditional enforcement violations. (Section 1R11.1)

Inspection Report# : 2011002 *(pdf)*

Significance: SL-IV Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to obtain a license amendment for RN sharing between units
An NRC-identified SL-IV NCV of 10 CFR 50.59 was identified for making changes to the UFSAR, section 9.2, and Abnormal Procedure AP-20, Loss of RN, which required prior NRC approval. The changes allowed donating a train of nuclear service water to the unit experiencing a loss of service water (LOSW) event by opening the unit crossover valves. Licensee corrective actions include removing the steps from AP-20, submitting a license amendment request, and updating the UFSAR following amendment approval.

This PD was considered as traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. This PD was determined to be a SL-IV violation in accordance with Section 6.1 of the NRC Enforcement Policy because it did not result in a condition evaluated as having low-to-moderate or greater safety significance (i.e., White, Yellow, or Red). Cross-cutting aspects are not assigned to traditional enforcement violations. (Section 1R11.2)

Inspection Report# : 2011002 *(pdf)*

Significance: G Mar 31, 2011
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to eliminate fish in the SNSWP
A self-revealing Green NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, was identified for the licensee's failure to correct a condition adverse to quality. The licensee had previously identified that the fish population in the Standby Nuclear Service Water Pond (SNSWP) had significantly increased but failed to perform the annual fish eradication of the SNSWP to prevent macro-fouling of the RN pump suction strainers. This resulted in the licensee declaring both trains of RN inoperable and entry into TS 3.0.3 for both units. Licensee corrective actions included chemically treating the SNSWP to eliminate the macro-fouling source, flushing the RN intake lines, and establishing a periodic chemical treatment of the SNSWP.

This PD was more than minor because it was associated with the equipment performance attribute and adversely impacted the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of the RN system to provide long term decay heat removal because the macro-fouling of the suction strainers rendered the RN pumps inoperable. This finding was evaluated using IMC 0609, Significance Determination Process, with an exposure time of greater than 30 days. A Phase 3 SDP analysis was required to be performed and determined the resultant core damage frequency (CDF) was <1E-6 (Green). This finding was determined to be directly related to the conservative assumptions aspect of the Decision Making component in the Human Performance cross-cutting area because the licensee's decisions to defer the macro-fouling treatment of the SNSWP were non-conservative [H.1(b)]. (Section 4OA3.3)

Inspection Report# : 2011002 *(pdf)*

Significance: G Oct 22, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Correct a Condition Adverse to Quality Associated with Emergency Diesel Generators Fuel Transfer System Niagara Flow Meters
The NRC identified a Non-cited Violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to correct a condition adverse to quality in that a single vulnerability failure of the fuel transfer (FD) system Niagara flow meters identified in 2003 could potentially restrict fuel flow to the EDGs which would impact their safety function. In addition, these flow meters were identified as a Category A risk component which required preventative maintenance (PM) strategy and no PM or inspection for these flow meters was ever performed. This issue was documented in the corrective action program as PIP M-10-6442 and the license intends to replace the flow meters for 1A EDG and 2A EDG in 2011.

The inspectors concluded that the failure to correct a condition adverse to quality for the FD system flow meters identified in 2003 was a performance deficiency (PD). The PD was 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 EDGs to respond to initiating events to prevent undesirable consequences in that the flow meters could potentially restrict fuel flow to the EDGs which would impact their safety function. The finding was determined to have very low safety significance (Green) because there was no loss of safety function of any EDG train. The inspectors determined that the cross-cutting area of Human Performance, component of Work Control, and aspect of Work Planning was applicable because the licensee did not incorporate risk insights in their plan work activities to remove this potential single vulnerability failure of Niagara flow meters in a timely manner. H.3(a) (4OA2)
Inspection Report# : 2010006 *(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: SL-IV Jun 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to notify the NRC of a situation related to public health and safety
• SL-IV. An NRC-identified non-cited violation of 10 CFR 50.72 was identified when the licensee did not notify the NRC that they had reported a non-routine event related to the health and safety of the public to another government agency. The licensee notified the Federal Energy Regulatory Commission (FERC) of leakage in a FERC-licensed intake dike and did not notify NRC within four hours of notifying FERC. The licensee entered this condition into their correction action program (CAP) as Problem Investigation Program (PIP) M-11-3600.

The failure to notify the NRC as required by 10 CFR 50.72 about a notification to FERC of a significant condition related to public health and safety was a performance deficiency (PD). This PD was considered as traditional enforcement because the failure to notify the NRC had the potential for impacting the NRC's ability to perform its regulatory function. This PD was determined to be a SL-IV violation using Section 6.9 of the NRC Enforcement

Policy. Cross-cutting aspects are not assigned to traditional enforcement violations. (Section 4OA3.1)

Inspection Report# : 2011003 *(pdf)*

Significance: SL-IV Jun 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to submit an LER for a valid RPS actuation
An NRC-identified non-cited violation of 10 CFR 50.73, Licensee Event Report (LER) System, was identified for the licensee's failure to submit an LER within 60 days for a valid reactor protection system (RPS) actuation. The reactor was manually tripped when control rod L-13 did not respond as expected during rod control movement testing. The licensee entered this condition into their CAP as PIP M-11-2694.

The inspectors determined that the licensee's failure to submit an LER in accordance with 10 CFR 50.73(a)(2)(iv)(A) was a PD. This PD was dispositioned as traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. This violation was determined to be a SL-IV violation using Section 6.9 of the NRC Enforcement Policy. Cross-cutting aspects are not assigned for traditional enforcement violations.

Inspection Report# : 2011003 *(pdf)*

Significance: N/A Oct 22, 2010
Identified By: NRC
Item Type: FIN Finding
2010 McGuire PI&R
The inspectors concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution, as evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. The licensee effectively used risk in prioritizing the extent to which individual problems would be evaluated and in establishing schedules for implementing corrective actions. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. However, the inspectors identified several examples where issues were not prioritized in accordance with site CAP guidance and two examples of evaluations which lacked appropriate rigor. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner.

The inspectors determined that overall, audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.
Inspection Report# : 2010006 *(pdf)*

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