

Comanche Peak 1

1Q/2012 Plant Inspection Findings

Initiating Events

Significance:  Sep 17, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Supervision Causes Inadvertent Engineered Safety Features Actuation

The inspectors reviewed a self-revealing noncited violation of Technical Specification 5.4.1.a for the failure of the unit supervisor to adequately maintain responsibility for the operation of Unit 1 and the supervision of operations personnel during preparations for a reactor startup. As a result, when an operator performed a trip of the main feedwater pump, the motor driven auxiliary feedwater pumps received an engineered safety features actuation and initiated full auxiliary feedwater flow to the steam generators. Operators throttled feedwater flow to prevent overflow of the steam generators and excessive cool down of the reactor coolant system. The licensee entered the finding into the corrective action program as Condition Report CR-2011-008052.

The failure of the unit supervisor to maintain responsibility for the operation of Unit 1 and the supervision of operations personnel during preparations for a reactor startup was a performance deficiency and resulted in an unplanned engineered safety features actuation of the auxiliary feedwater pumps. The finding was more than minor because it was associated with the configuration control attribute of the initiating events cornerstone and affected the cornerstone objective, in that, it increased the likelihood of those events that upset plant stability. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment would not be available. This finding has a human performance crosscutting aspect associated with decision making, in that, the unit supervisor failed to communicate the decision to install the auxiliary feedwater pump auto start fuses to all control room personnel.

Inspection Report# : [2011004](#) (*pdf*)

Significance:  Jun 18, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate External Flooding Instructions

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" for the failure to have adequate external flooding instructions. The licensee's technical requirements manual included circulating water system stop gates as a flood protection measure. This statement was not accurate for a reservoir level greater than 778 feet. As a result, the licensee failed to provide specific instructions for flood protection during circulating water system maintenance with wood barriers in place. In addition, during service water travelling screen replacement, the licensee failed to provide adequate guidance to mitigate debris from entering the service water pump suction if water level were to increase above 778 feet. As a result, the service water system was susceptible to fouling during a flooding event. The licensee entered the finding into the corrective action program as Condition Report CR-2011-004062.

The licensee's failure to have adequate external flooding instructions that resulted in safety related equipment being vulnerable to external flooding was a performance deficiency. The performance deficiency was more than minor 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 that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to involve equipment designed to mitigate an external flood and could result in a plant trip or affect more than one train of safety equipment and required a Phase 3 analysis. A senior reactor analyst determined that the finding was of very low safety significance because the calculated bounding delta core damage frequency was 1.9E-8. The finding has a human

performance crosscutting aspect associated with decision-making because the licensee failed to demonstrate that nuclear safety is an overriding priority when faced with unexpected plant conditions.

Inspection Report# : [2011003](#) (pdf)

Significance:  Jun 18, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Properly Install Insulation Results in Frozen Feedwater Flow Sensing Lines

The inspectors reviewed a self-revealing finding for the failure of the licensee to provide adequate instructions to maintenance personnel when installing insulation on feedwater flow sensing lines. As a result, three sensing lines froze and caused a feedwater perturbation that required operators to take control of the system to stabilize the plant. This finding does not involve enforcement action because no regulatory requirement violation was identified. The licensee entered the finding into the corrective action program as Condition Report CR-2011-001224.

The licensee's failure to provide adequate instructions for the installation of insulation on feedwater flow sensing lines was a performance deficiency. The finding was more than minor because it was associated with the equipment performance attribute of the initiating events cornerstone and adversely affected the cornerstone objective, in that, it increased the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment would not be available. The finding did not have a crosscutting aspect because it was not representative of current licensee performance.

Inspection Report# : [2011003](#) (pdf)

Significance:  Jun 18, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Correct a Degraded Charging System Valve

The inspectors reviewed a self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the licensee's failure to correct a deficiency with a charging header vent valve. As a result, the valve failed open after an operator attempted to close the valve resulting in a 40 gpm charging system leak. The licensee entered the finding into the corrective action program as Condition Report CR-2011-001876.

The licensee's failure to correct a leaking vent valve was a performance deficiency. The finding was more than minor because it was associated with the equipment performance attribute of the initiating events cornerstone and adversely affected the cornerstone objective, in that, it increased the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment would not be available. The finding did not have a crosscutting aspect because it was not representative of current licensee performance.

Inspection Report# : [2011003](#) (pdf)

Mitigating Systems

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Remove Materials and Debris from Containment

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a for the failure to follow procedure

and remove items from containment. As a result, maintenance personnel failed to remove materials that could be transported to the containment emergency core cooling sumps during an accident. The inspectors informed the licensee of the debris inside containment and the licensee corrected the condition. The licensee entered the finding into the corrective action program as Condition Report CR 2011 013343.

The failure of the maintenance personnel to follow procedure and remove materials from containment was a performance deficiency which resulted in debris remaining in containment. The finding was more than minor 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 the emergency core cooling sumps. Using NRC Manual Chapter 0609, "Significance Determination Process," Appendix G, "Shutdown Operations Significance Determination Process," Attachment 1, Checklist 2, the finding was determined to be of very low safety significance because the licensee maintained adequate mitigation capability for the current plant state and the finding was not characterized as a loss of control event. The finding has a human performance crosscutting aspect associated with resources because the licensee failed to ensure that personnel performing the maintenance activity were adequately trained on the procedure requirement to remove the materials when leaving containment.

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correctly Reassemble a Motor Operated Valve

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a for the failure to follow procedure and correctly restore motor operated valves. As a result, the licensee inverted the Unit 1 power operated relief valve block valves' limit switch covers and placed the drain on the top. The licensee entered the finding into the corrective action program as Condition Report CR 2011 011871.

The failure to follow procedure and correctly restore motor operated valves, which resulted in inverted limit switch covers with the drain on the top, was a performance deficiency. The finding was more than minor because if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern in that other valves may have been incorrectly restored. The inspectors determined that the finding was associated with the mitigating systems cornerstone and affected the unit during a refueling outage. Using NRC Manual Chapter 0609, "Significance Determination Process," Appendix G, "Shutdown Operations Significance Determination Process," Attachment 1, Checklist 2, the finding was determined to be of very low safety significance because the licensee maintained adequate mitigation capability for the current plant state and the finding was not characterized as a loss of control event. The finding has a human performance crosscutting aspect associated with work practices because the licensee failed to use appropriate self and peer checking.

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify Inadequate Auxiliary Feedwater Pump Bearing Oil Levels

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure of the licensee to promptly identify and correct adverse auxiliary feedwater pump oil levels. As a result, the inspectors identified seven instances where the oil level was outside of the prescribed sight glass indication. The licensee entered the finding into the corrective action program as Condition Report CR-2011- 12430.

The licensee's failure to promptly identify and correct the improper auxiliary feedwater pump bearing oil level was a performance deficiency. The finding was more than minor 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 the auxiliary feedwater pumps. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not result in an actual loss of safety function of an auxiliary feedwater

pump. The finding has a problem identification and resolution crosscutting aspect associated with corrective action program, in that, licensee personnel failed to trend and assess the abnormal oil level condition reports in the aggregate to identify common cause problems.

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Sep 17, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Operator Licensing Examination Integrity

The inspectors identified a noncited violation of 10 CFR Part 55.49, “Integrity of Examinations and Tests,” for the failure of the licensee to ensure the integrity of annual operating exams. During the 2009 annual operating exam, 17 licensed operators received three of five job performance measures, and 17 additional licensed operators received four of five job performance measures for their operating tests that had been administered to other licensed operators in previous weeks. In addition, five licensed operators received two of three crew simulator scenarios as part of their operating test that had been administered to other licensed operators in previous weeks. Allowing more than 50 percent of an operating test section to be comprised of exam material previously administered on any other test in the same examination cycle is considered an exam integrity compromise. However, evaluation of the 2009 exam results for the affected population showed that the compromise did not have an actual effect on the equitable and consistent administration of the examination. The licensee entered the finding into the corrective action program as Condition Report

CR-2010-010851.

The failure of the licensee’s training staff to maintain the integrity of examinations administered to licensed operations personnel was a performance deficiency. The finding was more than minor because it adversely impacted the human performance attribute of the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, if left uncorrected, the performance deficiency could have become more significant in that allowing licensed operators to return to the control room without valid demonstration of appropriate knowledge on the annual operating examinations could be a precursor to a more significant event. Using NRC Manual Chapter 0609, “Significance Determination Process,” Phase 1 worksheets, and the corresponding Appendix I, “Licensed Operator Requalification Significance Determination Process,” the finding was determined to have very low safety significance because, although the 2009 finding resulted in a compromise of the integrity of operating test job performance measures and simulator scenarios with no compensatory actions immediately taken when the compromise should have been discovered in 2009. The equitable and consistent administration of the test was not actually impacted by this compromise. This finding has a crosscutting aspect in the area of resources associated with ensuring that procedures are accurately translated from industry standards, such that the 50 percent maximum overlap criteria was not exceeded.

Inspection Report# : [2011004](#) (*pdf*)

Significance:  Sep 17, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure All License Conditions Are Met for Licensed Operators

The inspectors identified a noncited violation of 10 CFR 55.53, “Conditions of License,” for the failure of the licensee to ensure that licensed operators met all the conditions of their licenses in order to be considered an active watch stander. Specifically, the licensee failed to ensure that three licensed operators met the complete plant tour requirement specified in 10 CFR 55.53(f) prior to license reactivation and subsequent performance of licensed operator duties. The licensee entered the finding into the corrective action program as Condition Report CR-2011-004990.

The failure of the licensee to ensure that all individuals authorized by a license to operate the controls of the facility met the conditions of their licenses as defined in 10 CFR Part 55.53 was a performance deficiency. This finding was more than minor because it was associated with the human performance attribute of the mitigating system cornerstone and affects the cornerstone’s objective of ensuring the availability, reliability, and capability of systems that respond

to initiating events to prevent undesirable consequences. Using NRC Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheets, and the corresponding Appendix I, "Licensed Operator Requalification Significance Determination Process," the finding was determined to have very low safety significance because more than 20 percent of the license reactivation records reviewed contained these deficiencies. This finding has a crosscutting aspect in the area of resources that support human performance in that the licensee failed to ensure that procedures are complete and accurate to ensure licensed operators maintain all conditions of their licenses in accordance with 10 CFR 55.53.

Inspection Report# : [2011004](#) (pdf)

Significance: SL-IV Jul 28, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Conclude a Change from the UFSAR Required Prior NRC Review and Approval

The inspectors identified a Severity Level IV Non-Cited Violation of 10 CFR 50.59, "Changes, Tests, and Experiments," associated with the failure to conclude that a change from the UFSAR required prior NRC review and approval prior to implementation. Specifically, the licensee made changes to the acceptance criteria for allowable diesel generator jacket water leakage in the UFSAR that resulted in more than a minimal increase in the likelihood of occurrence of a malfunction of a structure, system, or component important to safety. The licensee captured this finding in their corrective action program as Condition Report CR 2011-008509.

This finding was more than minor because there was a reasonable likelihood that the change would require a prior NRC approval. Violations of 10 CFR 50.59 are violations that potentially impede or impact the regulatory process and are processed through Traditional Enforcement. As required by Section 6.1 of the Enforcement Policy, the inspectors performed a Phase 1 screening in accordance with Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," to determine the significance of the finding. The inspectors determined that the finding is of very low safety significance (Green) because the finding: (1) was not a design or qualification issue confirmed not to result in a loss of operability or functionality; (2) did not represent an actual loss of safety function of the system or train; (3) did not result in the loss of one or more trains of nontechnical specification equipment; and (4) did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. Since violations of Title 10 CFR 50.59 may result in conditions evaluated as having very low safety significance by the Significance Determination Process, the inspectors categorized the finding as Severity Level IV in accordance with the Enforcement Manual. The finding was a violation determined to be of very low safety significance, was not repetitive or willful, and was entered into the corrective action program. Therefore, this violation is being treated as a noncited violation consistent with the NRC Enforcement Policy. The inspectors did not identify a crosscutting aspect with this finding since this performance issue occurred in 2004 and is not reflective of current performance.

Inspection Report# : [2011006](#) (pdf)

Significance:  Jul 28, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Diesel Generator Jacket Water Instructions

The inspectors identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion V, for the licensee's failure to have documented instructions for an activity affecting quality. Specifically, the licensee did not have documented instructions for filling the diesel generator jacket water system when the normal fill method would not be available during a loss of offsite power. Specifically, prior to July 27, 2011, the licensee failed to have adequate instructions for filling the diesel generator jacket water system, an activity affecting quality, during a loss of offsite power. This issue was entered into the licensee's corrective action program as Condition Report CR-2011-008510.

This performance deficiency was determined more than minor because it was associated with the procedure quality 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 to prevent undesirable consequences. Using IMC 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding is determined to be of very low safety significance because the finding did not result in an actual loss safety related equipment for greater than its technical specification allowed outage time and did not represent a loss of equipment designated as risk-significant in the maintenance rule. The finding did not have a crosscutting aspect because it was not representative of current licensee performance.

Significance:  Jul 28, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Operability Determination Process for a Degraded Condition Related to Emergency Diesel Generator

The inspectors identified a Green noncited violation of Title 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure of the licensee to follow the operability determination Procedure ODA-309, “Operability Determination and Functionality Assessment Program.” Specifically, the licensee did not appropriately evaluate a long-standing degraded condition such that the emergency diesel generators would remain operable for their mission time duration as required by ODA-309. As a result, adequate compensatory measures were not established to ensure operability. This issue was entered into the licensee’s corrective action program as Condition Report CR 2011-008508.

The performance deficiency was determined to be more than minor because it was associated with the equipment performance attribute of the Mitigating System cornerstone and affects the cornerstone objective to ensure the availability and reliability of emergency diesel generators that respond to initiating events to prevent undesirable consequences in that the emergency diesel generators supply power to vital and safety related loads. Because Manual Chapter 0609, Attachment 4, “Phase 1-Initial Screening and Characterization of Findings,” was not well suited for this finding a Phase 3 Risk Significance Estimation was required. A Region IV senior reactor analyst performed a bounding Phase 3 significance determination and found that the finding was of very low safety significance. The bounding change to core damage frequency was $6.7E-7$ /year. The simplified plant analysis risk (SPAR) model does not include the contribution of the recently installed alternate power generators, which would considerably lower the risk significance of an emergency diesel generator failure for the station blackout sequences, which comprise most of the risk of this finding. The inspectors determined that there was a crosscutting aspect in the area of human performance decision-making because the licensee failed to use conservative assumptions in decision making in the assessment of operability.

Inspection Report# : [2011006](#) (pdf)

Significance:  Jul 28, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Repeated Diesel Generator Cam Cover Bolt Failures

The inspectors identified a Green noncited violation of Title 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” in that the licensee did not correct a condition adverse to quality regarding the safety related emergency diesel generators. Specifically, as of July 12, 2011, the licensee failed to assure that the identified broken cam cover bolts on the emergency diesel generators were adequately corrected. This issue was entered into the licensee’s corrective action program as Condition Report CR 2011-008505.

The performance deficiency was determined to be more than minor because it was associated with the equipment performance attribute of the Mitigating System cornerstone and affects the cornerstone objective to ensure the availability and reliability of emergency diesel generators that respond to initiating events to prevent undesirable consequences in that the emergency diesel generators supply power to vital and safety related loads. Because Manual Chapter 0609, Attachment 4, “Phase 1-Initial Screening and Characterization of Findings,” was not well suited for this finding a Phase 3 Risk Significance Estimation was required. A Region IV senior reactor analyst performed a bounding Phase 3 significance determination and found that the finding was of very low safety significance. The bounding change to core damage frequency was $6.7E-7$ /year. The simplified plant analysis risk (SPAR) model does not include the contribution of the recently installed alternate power generators, which would considerably lower the risk significance of emergency diesel generator failure for the station blackout sequences, which comprise most of the risk of this finding. The inspectors determined that there was a crosscutting aspect in the area of problem identification and resolution because the licensee failed to thoroughly evaluate problems such that the resolutions address causes and extent of conditions, as necessary.

Inspection Report# : [2011006](#) (pdf)

Significance: G Jun 18, 2011

Identified By: NRC

Item Type: FIN Finding

Inadequate Alternate Power Generator Procedure

The inspectors identified a finding for the failure of the licensee to provide adequate procedure instructions for refueling the alternate power generators. As a result, during a station blackout event, the alternate power generators could have ran out of fuel since the fuel tank was sized for approximately 2.6 hours of operation at full load and instructions for obtaining additional fuel did not exist. This finding does not involve enforcement action because no regulatory requirement violation was identified. The licensee entered the finding into the corrective action program as Condition Report CR 2011 005399.

The licensee's failure to provide adequate instructions for replenishing the alternate power generators fuel tank was a performance deficiency. The finding was more than minor because it was associated with the procedure quality attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective, in that, the inadequate instructions did not ensure the availability, reliability, and capability of the alternate power generators to electrical power to the units during a station blackout event. Using NRC Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance because the finding did not result in an actual loss safety related equipment for greater than its technical specification allowed outage time and did not represent a loss of equipment designated as risk-significant in the maintenance rule. The finding has a human performance crosscutting aspect associated with resources, in that, the licensee failed to ensure that adequate procedures and equipment were available.

Inspection Report# : [2011003](#) (*pdf*)

Significance: G May 03, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Effective Corrective Actions for a Condition Adverse to Fire Protection

The team identified a noncited violation of License Condition 2.G for the failure to implement and maintain in effect all provisions of the approved fire protection program. Specifically, the team identified two examples where the licensee failed to implement effective corrective actions to ensure that time-critical manual actions would be accomplished within analyzed times for alternative shutdown scenarios. The first example involved the failure to close a spuriously opened pressurizer power-operated relief valve within the time allowed by the postfire safe shutdown analysis. The second example involved the failure to restore station service water cooling before damage could occur to the credited emergency diesel generator in the event of a control room fire with a loss of offsite power. The licensee entered this issue into their corrective action program as Condition Reports CR-2011-001647, CR-2011-001742 and CR-2011-001836. In response to this issue, the licensee re-ordered the procedure steps to isolate the power-operated relief valves and ensure the standby service water pump was running sooner. The licensee planned to perform a validation of the revised procedures.

Failure to implement effective corrective actions to ensure that time-critical manual actions would be accomplished within analyzed times for alternative shutdown scenarios is a performance deficiency. This performance deficiency was more than minor because it was associated with the protection against external events (fire) attribute of the Mitigating Systems cornerstone and it adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The significance of this finding could not be evaluated using Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," because the performance deficiency involved a control room fire that led to control room abandonment. A senior reactor analyst performed a Phase 3 evaluation bounding analysis that concluded this finding had very low safety significance (Green) because the number of electrical cabinets in the control room and cable spreading room that contained circuits that could have a fire that could affect the power-operated relief valves or station service water system was a small fraction of the total. This performance deficiency had a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because the licensee did not take appropriate corrective actions to address safety issues in a timely manner, commensurate with their safety significance.

Inspection Report# : [2011007](#) (*pdf*)

Significance: **G** May 03, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Mitigate or Correct Potential Single Spurious Fire Damage Scenario

The team identified a noncited violation of License Condition 2.G for failure to implement and maintain in effect all provisions of the approved fire protection program. Specifically, the licensee failed to recognize that electrical cables for the pressurizer power-operated relief valves and associated block valves were installed in many of the same cable trays, leaving the plant susceptible to fire damage that could spuriously open the power-operated relief valve and prevent the ability to shut the block valve. This scenario could challenge operators by creating a loss of coolant during a plant fire. The licensee entered this issue into their corrective action program as Condition Reports CR-011-001319, CR-2011-001807, CR-2011-001808 and CR-2011-002430. As a compensatory measure, the licensee revised attachment 17 to Procedure ABN-901, "Fire Protection System Alarms or Malfunctions," Revision 9, to close the affected pressurizer block valves in the event of a fire in the Auxiliary or Safeguards buildings in order to mitigate potential circuit interactions that could spuriously open a power-operated relief valve.

Failure to identify and mitigate or correct an existing plant configuration that was susceptible to single spurious failures while performing expert panel reviews of fire damage scenarios that could prevent safely shutting down the plant in the event of a fire is a performance deficiency. This performance deficiency was more than minor because it is associated with the protection against external events (fire) attribute of the Mitigating Systems cornerstone and it adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team used Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," because the performance deficiency affected fire protection defense-in-depth strategies involving post-fire safe shutdown. Because the Phase 1 screening criteria were not met, the analysis continued to Phase 2. Because the finding did not screen as Green during the Phase 2 analysis, a senior reactor analyst performed a Phase 3 analysis. Using information from the Phase 2 worksheets and discussions with the licensee PRA staff, the senior reactor analyst's Phase 3 analysis calculated the total change in core damage frequency to be $3.2E-7/\text{yr}$ (Green), based on the proximity of fire sources available to damage these circuits. This finding had a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program component because the licensee did not identify the issues completely, accurately, and in a timely manner commensurate with their safety significance while conducting expert panel reviews of this and other scenarios in 2009. After review of the additional information provided by licensee, the inspectors determined that no cross-cutting aspect applied. The NRC documented this in letter dated July 8, 2011 (ADAMS Accession No. ML11192A046).
Inspection Report# : [2011007](#) (pdf)

Significance: **G** May 03, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure Emergency Lights in Safe Shutdown Areas had an 8-Hour Capacity

The team identified a noncited violation of License Condition 2.G for failure to implement and maintain in effect all provisions of the approved fire protection program. Specifically, the licensee failed to establish a maintenance and/or test program that demonstrated that emergency lighting had an 8-hour capacity in areas required for safe shutdown. When inspectors questioned the licensee's practice of replacing the emergency light batteries without ever testing to confirm that the replacement interval was appropriate to ensure an 8-hour capacity, the licensee conducted tests that showed that 22 percent of the batteries on a 3-year replacement interval failed in less than 8 hours. The licensee entered this issue into their corrective action program as Condition Report CR-2011-001821. The licensee created action items to CR-2011-001821 for additional testing on a broader sample of emergency lights to aid in determining the correct replacement interval to ensure operability, and shortened the 3-year replacement interval for lights which failed to meet operability requirements as a result of testing to a more conservative 2-year replacement interval which had no demonstrated testing failures.

The failure to establish a maintenance and/or test program that demonstrated operability for 8-hour emergency lighting required for operator manual actions at safe shutdown equipment is a performance deficiency. The performance deficiency was more than minor because it is associated with the protection against external events (fire) attribute of the Mitigating Systems cornerstone and it adversely 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 the emergency lights to last 8 hours could adversely affect the ability of operators to perform the manual actions required to support safe shutdown in the event of a fire. The significance of this finding was evaluated using Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," because the performance deficiency affected fire protection defense-in-depth strategies involving post-fire safe shutdown systems. Using Appendix F, Attachment 2, "Degradation Rating Guidance Specific to Various Fire Protection Program Elements," the finding was assigned a low degradation rating because the finding minimally impacted the performance and reliability of the fire protection program element. The team also noted that operators were required to obtain and carry flashlights. Therefore, the finding screened as having very low safety significance (Green). This finding did not have a crosscutting aspect because it was not indicative of current licensee performance, in that the replacement program had been used for longer than 3 years.

Inspection Report# : [2011007](#) (pdf)

Barrier Integrity

Significance:  Jun 18, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Develop Adequate Guidance for Extreme Damage Mitigation Procedures

The inspectors identified a noncited violation of 10 CFR 50.54(hh)(2) for the licensee's failure to develop adequate guidance to restore core and spent fuel cooling capabilities for a postulated loss of large areas of the plant.

Specifically, the licensee failed to ensure suction hose size derived from an engineering report was translated into procedures, failed to provide adequate procedure guidance for use of a fire truck to draw water from the reservoir, and failed to stage hoses in the location specified by procedure. The licensee entered the finding into the corrective action program as Condition Report CR 2011 005830.

The licensee's failure to develop adequate guidance to restore core and spent fuel cooling capabilities for a postulated loss of large areas of the plant was a performance deficiency. The finding was more than minor because it was associated with the procedure quality attribute of the barrier integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding and containment) protect the public from radionuclide releases caused by accidents or events. Using NRC Manual Chapter 0609, Appendix L, "B.5.b Significance Determination Process," the finding was determined to be of very low safety significance because the finding did not affect both the recoverability and availability of an individual mitigating strategy. The finding has a human performance crosscutting aspect associated with resources, in that, the licensee failed to ensure adequate facilities, equipment, and trained personnel were available to ensure nuclear safety is maintained.

Inspection Report# : [2011003](#) (pdf)

Emergency Preparedness

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Guidelines for Protective Action Recommendations Outside the Emergency Planning Zone

The inspectors identified a non-cited violation of 10 CFR 50.47(b)(10) for failure of the licensee to have guidelines developed and in place for the choice of protective actions during an emergency. Specifically, Procedure EPP 304, "Protective Action Recommendations," Revision 20, did not provide direction for the development of protective action recommendations outside the emergency planning zone. The licensee entered the finding into the corrective action program as Condition Report CR-2011 009218.

The failure to develop and implement guidelines for the choice of protective actions during an emergency is a performance deficiency. This finding is more than minor because it has the potential to affect safety, and affects the emergency preparedness cornerstone attributes of emergency response organization performance and procedure quality. The finding is of very low safety significance because it was a failure to comply with NRC requirements, was associated with a risk-significant planning standard, and was not a functional failure of the planning standard or degraded planning standard function. The finding has a problem identification and resolution crosscutting aspect associated operating experience because the licensee did not use operating experience to maintain and update the protective action procedure.

Inspection Report# : [2011005](#) (*pdf*)

Significance:  Jun 18, 2011

Identified By: NRC

Item Type: FIN Finding

Failure to Update Severe Accident Management Guidelines

The inspectors identified a finding for the licensee's failure to follow procedure guidance and update the severe accident management guidelines. As a result, as of May 16, 2011, the severe accident management guidelines did not incorporate the latest owners' group guidance, plant hardware changes, and incorporation of extreme damage mitigation guideline actions. This finding does not involve enforcement action because no regulatory requirement violation was identified. The licensee entered the finding into the corrective action program as Condition Report CR 2011-005982.

The licensee's failure to follow procedure guidance and update the severe accident management guidelines was a performance deficiency. The finding was more than minor because if left uncorrected, the finding would have a potential to lead to a more significant safety concern. Using NRC Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," the finding was determined to be of very low safety significance because the finding was not associated with an emergency preparedness planning standard. The finding has a human performance crosscutting aspect associated with resources, in that, personnel failed to follow expectations regarding procedural compliance and closed a condition report without addressing the deficiencies identified in the condition report.

Inspection Report# : [2011003](#) (*pdf*)

Occupational Radiation Safety

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Perform Adequate Radiation Surveys

The inspectors reviewed a self-revealing non-cited violation of 10 CFR 20.1501(a) because radiation protection staff failed to perform an adequate survey to evaluate and determine the radiological hazards in the floor drain tank room. The licensee entered the finding into the corrective action program as Condition Report CR 2011 010174 and immediately posted the room as a locked high radiation area.

The failure to perform a radiation survey to determine radiological hazards was a performance deficiency. The finding was greater than minor because it was associated with the occupational radiation safety cornerstone attribute of program and process and affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation during routine operations. Using NRC Manual Chapter 0609, "Significance Determination Process," Appendix C, "Occupational Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance because: (1) it was not associated with as low as is reasonably achievable (ALARA) planning (2) there was no overexposure, (3) there was no substantial potential for an overexposure, and (4) the ability to assess dose was not compromised. The finding has a human performance

crosscutting aspect associated with work control because the licensee failed to ensure interdepartmental communication and coordination prior to commencing work activities and assuring accurate radiation safety information was provided to workers.

Inspection Report# : [2011005](#) (pdf)

Significance:  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Radiological Work Permit Requirements

The inspectors reviewed a self-revealing non-cited violation of Technical Specification 5.4.1.a for the failure of a worker to follow radiological work permit requirements. Specifically, a chemistry technician received a dose rate alarm greater than 120 millirem per hour and failed to immediately exit the area and contact radiation protection. The licensee entered the finding into the corrective action program as Condition Report CR 2011- 010774.

The failure to follow the instructions on a radiation work permit by not immediately contacting radiation protection when a dose rate alarm was received was a performance deficiency. The finding was greater than minor because it was associated with the occupational radiation safety cornerstone attribute of program and process and affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation during routine operations. Using NRC Manual Chapter 0609, "Significance Determination Process," Appendix C, "Occupational Radiation Safety Significance Determination Process," the finding was determined to be of very low safety significance because: (1) it was not associated with as low as is reasonably achievable (ALARA) planning or work controls, (2) there was no overexposure, (3) there was no substantial potential for an overexposure, and (4) the ability to assess dose was not compromised. The finding has a human performance crosscutting aspect associated with work practices because the licensee failed to effectively communicate expectations regarding procedural compliance to the worker.

Inspection Report# : [2011005](#) (pdf)

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 : May 29, 2012