

McGuire 2

1Q/2012 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Operable Fire Assembly in Unit 2 Auxiliary Feedwater Pump Room

An NRC-identified Green non-cited violation (NCV) of Technical Specification (TS) 5.4.1.d was identified for failure to maintain an operable fire assembly resulting in an unsealed pipe penetration through a 3-hour rated fire barrier wall separating the Unit 2 Train A/B motor driven auxiliary feedwater pump room from the Unit 2 mechanical penetration equipment room. The licensee reinstalled pipe caps on each end of the unsealed pipe.

The performance deficiency (PD) was more than minor because it was associated with the protection against external events attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective in that the unsealed opening adversely impacted the ability of the fire barrier to perform its intended safety function. The finding was of very low safety significance because the fire barrier deficiency represented a low fire degradation rating. The finding was directly related to the cross-cutting area of Human Performance under the Procedural Compliance aspect of the Work Practices component because station personnel failed to follow fire protection impairment procedures for breaching a fire assembly. [H.4(b)]

Inspection Report# : [2012002](#) (*pdf*)

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: FIN Finding

Failure to Enter Condition Adverse to Quality into the CAP

A NRC-identified Green finding was identified for the failure to follow the site's corrective action program (CAP) procedure which required the initiation of a PIP for a degraded 2B emergency diesel generator (EDG) Bellofram seal. The degraded Bellofram seal contributed to the improper setup of the 2B EDG governor actuator which resulted in the 2B EDG not achieving the required 105 percent full power output.

The performance deficiency was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely impacted the cornerstone objective in that the capability of the EDG to provide continuous and adequate load margin was affected. The finding was of very low safety significance because it did not represent an actual loss of safety function of the system or train. The finding was directly related to the cross-cutting aspect of implements the CAP with a low threshold in the Corrective Action Program component in the area of the Problem Identification and Resolution because the licensee did not enter the condition into the CAP.

[P.1(a)]

Inspection Report# : [2012002](#) (*pdf*)

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*)

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 40A3.1)

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*)

Last modified : May 29, 2012