

Watts Bar 1

1Q/2012 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Develop and Implement Corrective Actions for Probable Maximum Precipitation Drainage Path Impact on Unit 1

The inspectors identified an NCV of 10 Code of Federal Regulations (CFR) 50 Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to develop and implement corrective actions to address the unauthorized placement of temporary structures supporting Unit 2 construction in the probable maximum precipitation (PMP) drainage path. Problem Evaluation Report (PER) 206105, initiated by the licensee on October 28, 2009, identified that Unit 2 temporary structures had been placed inside the plant protected area surrounding Unit 1 and 2 without verifying impacts to the PMP critical flood elevation of 729 feet. The PER required a corrective action plan (CAP) due date of February 14, 2010. The condition as it then existed was bounded by a functional evaluation which expired February 28, 2010. The inspectors determined that the corrective actions had not been implemented and that the original adverse condition had worsened due to the addition of other temporary structures. Based on this observation, the licensee reentered the issue into the corrective action program as PER 413818 and also initiated PER 417148 to address the continuing plant impact from the addition of more temporary structures.

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

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective action involving the failure of a shutdown board to transfer

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's repeat occurrence of a level A problem evaluation report (PER) 176604 written July 17, 2009.

The licensee's failure to ensure that all corrective actions for A level PER 176604 were complete is a performance deficiency. The inspectors reviewed IMC 0612 and determined that the finding was more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern; specifically, the subject safety-related breaker could have been installed in a more critical application or have been installed for a longer period of time, up to 18 months, in the alternate feeder application. Additionally, the finding was associated with the configuration control attribute of the Initiating Events 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 the Phase I screening worksheet of IMC 0609, the inspectors determined that the finding was of very low safety significance (Green) because it would not contribute to both a reactor trip and the likelihood that mitigation equipment or functions would not be available. The cause of the finding was directly related to the cross-cutting aspect for appropriate corrective actions to address safety issues in a timely manner commensurate with their safety significance and complexity in the Corrective Action Program component of the cross-cutting area of Problem Identification and Resolution, in that the licensee failed to take adequate corrective actions to prevent repetition of the fast transfer switch mal-adjustment. Specifically, effective corrective actions to preclude repetition were not implemented but signed as completed when the 1A shutdown board alternate feeder breaker was placed in service. (P.1(d)) (See Section 40A2)

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

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately control non-conforming or degraded equipment

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XV, Nonconforming Materials, Parts, or Components, for the licensee's failure to ensure that 6.9Kv breaker 0-BKR-569-4605025-S, which had been identified as defective, was not labeled or otherwise segregated to prevent it from being installed into the plant.

The licensee's failure to ensure that defective 6.9Kv breaker 0-BKR-569-4605025-S was not installed into the plant is a performance deficiency. The inspectors reviewed IMC 0612 and determined that the finding was more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern; specifically, the subject safety-related breaker could have been installed in a more critical application or have been installed for a longer period of time, up to 18 months, in the Alternate Feeder application. Additionally, the finding was associated with the configuration control attribute of the Initiating Events 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 the Phase I screening worksheet of IMC 0609, the inspectors determined that the finding was of very low safety significance (Green) because it would not contribute to both a reactor trip and the likelihood that mitigation equipment or functions would not be available. The cause of the finding was directly related to the cross-cutting aspect that the licensee ensure supervisory and management oversight of work activities in the Work Practices component of the cross-cutting area of Human Performance, in that the licensee failed to ensure that a defective component was not installed into the plant. H.4(c) (Section 40A2)

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

Mitigating Systems

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Procedure AOI-30.2 C.36, Fire Safe Shutdown Room 737-A1A, Non-feasible Operator Manual Action.

The inspectors identified an NCV of 10 Code of Federal Regulations (CFR) 50 Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to ensure that an operator manual action for fire safe shutdown (FSSD) could be feasibly performed under the current physical plant configuration. Specifically, post-fire safe shutdown procedure Abnormal Operating Instruction (AOI)-30.2 C.36, Fire Safe Shutdown Room 737-A1A, Revision 3, contained instructions for an operator manual action for FSSD that could not be feasibly performed following implementation of a plant design change. A temporary scaffold which was previously installed as a corrective action compensatory measure was removed without authorization. The licensee entered this issue into the corrective action program as Problem Evaluation Report (PER) 485043.

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

Significance:  Mar 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Comply with Technical Specification 3.4.12 by Allowing a Safety Injection Pump to inject into the RCS in Mode 5.

A Green, self revealing NCV of Technical Specification (TS) 3.4.12 was identified for failure to ensure that no safety injection pump was capable of injecting into the reactor coolant system while in Mode 5. The finding was determined to be greater than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This finding was evaluated using the significance determination Phase 1 screening criteria in accordance with Inspection Manual Chapter (IMC) 0609 "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," and was determined to require review in accordance with IMC 0609 Appendix G, Shutdown Operations Significance Determination Process. This finding was determined to have a cross-cutting aspect in the area of human performance associated with the work practices component. The licensee failed to

adequately implement human error prevention techniques, such as self and peer checking, to ensure that the work activity was being performed on the correct component. [H.4(a)].

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

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Comply with Technical Specification 3.8.4, 3.8.5 and 3.0.3 by failing to recognize Vital Batteries III and IV degradation.

A Green, NRC-identified NCV of TS 3.8.4, DC Sources Operating, was identified. The licensee's failure maintain TS operability by accurately identifying that vital battery III was approaching end-of-life was a performance deficiency. It is more than minor because, if left uncorrected, it could lead to a more serious safety concern, that of loss of functionality. Additionally, the finding was associated with the equipment performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using IMC 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance (Green), because subsequent functional testing by the licensee, witnessed by the inspectors, showed that vital batteries III and IV would meet all design basis analysis requirements.

This finding was determined to have a cross-cutting aspect in the area of human performance associated with the decision-making component. The licensee failed to use conservative assumptions in decision making and to adopt a requirement to demonstrate that the proposed action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action. [H.1(b)].

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

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Store Transient Combustible Materials in a Safety-Related/Critical Area of the Auxiliary Building in Accordance With the Approved Fire Protection Plan

An NCV of the Unit 1 Operating License Condition 2.F was identified for the licensee's failure to store transient combustible materials in a safety-related/critical area of the auxiliary building in accordance with the approved Fire Protection Plan (FPP). Specifically, an excessive amount of combustible trash and laundry was stored on the auxiliary building refueling floor. The stored combustible material was approximately two and a half times the allowable limit, and the amount in excess of that limit was stored without an approved transient combustible evaluation, as required by the FPP. As a result, this was an unapproved increase in fire loading due to an increase in the volume of the combustible material in the area. The licensee took immediate corrective action to issue a transient combustible evaluation and then remove the excess combustibles from the area.

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

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedures for Identifying Accumulated Gas in ECCS Systems

The inspectors identified a Green non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to establish adequate procedures to identify accumulated gas in emergency core cooling systems (ECCS). Specifically, the operations surveillance test procedures could allow accumulated gases inside ECCS to be vented without being quantified and evaluated for potential adverse impacts on system operability. The licensee entered this in their corrective action program as PER 478095.

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

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to fully implement corrective actions for a motor boat necessary for flood mode preparation

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to fully implement corrective actions to address a motor boat necessary for flood mode preparation in accordance with Abnormal Operating Instruction (AOI) 7.01, Maximum Probable Flood. As a result the inspectors found that the boat was not in serviceable condition, and there was no procedure to address preventive maintenance of the boat. The licensee entered the issue into the corrective action program as PER 417920 and developing a long-term maintenance strategy.

The licensee's failure to fully implement corrective actions to address a motor boat necessary for flood mode preparation in accordance with AOI 7.01, was a performance deficiency. The inspectors reviewed IMC 0612 and determined that the finding was more than minor because of the lack of an important piece of equipment (motor boat) necessary for coping with the probable maximum flood (PMF) impact on Unit 1. Using the Phase I screening worksheet of IMC 0609, the inspectors determined that the finding was of very low safety significance (Green) because the licensee would have sufficient warning (27 hours) to obtain a replacement boat before it would be impacted by a PMF event. The cause of the finding had a cross-cutting aspect in the area of Problem Identification and Resolution associated with the Corrective Action Program component. It was directly related to the licensee taking appropriate corrective actions to address a safety issue in a timely manner commensurate with its safety significance and complexity. Specifically, the licensee failed to fully implement corrective actions to address a motor boat necessary for flood mode preparation in accordance with AOI 7.01. (P.1(d)) (See Section 1R01)

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

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to fully implement corrective actions for the unapproved storage of oil in a safety related area

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the licensee's failure to fully implement corrective actions to address the unapproved storage of a large quantity of oil in a safety-related area of the auxiliary building in accordance with the approved Fire Protection Plan (FPP). As a result, a drum containing approximately 38 gallons of new hydrocarbon oil was relocated, but not removed from a safety-related area of the auxiliary building, without addressing the FPP requirement for an approved transient combustible evaluation. The licensee entered the issue into the corrective action program as PER 380910 and PER 388926. The remaining oil was removed from the affected room or identified with an approved transient combustible evaluation.

The licensee's failure to fully implement corrective actions to address the unapproved storage of a large quantity of oil in a safety-related area of the auxiliary building in accordance with the approved FPP is a performance deficiency. The inspectors reviewed IMC 0612 and determined that the finding was more than minor because it affected the Protection Against External Factors attribute (i.e., fire) of the Mitigating Systems cornerstone, in that it affected the objective of ensuring availability, reliability, and capability of systems that respond to initiating events. Because the finding increased the fire loading due to an increase in the volume of the predominant combustible in the area, the inspectors completed a SDP Phase I analysis that indicated that the finding was not a major degradation of fire prevention or administrative controls. Using the Phase I screening worksheet of IMC 0609, the inspectors determined that the finding was of very low safety significance (Green). The cause of the finding had a cross-cutting aspect in the area of human performance associated with the work practices component. It was directly related to the licensee defining and effectively communicating expectations regarding procedural compliance and personnel follow procedures. [H.4(b)] Specifically, the licensee failed to follow the control of transient combustibles procedure by allowing the unapproved storage of a large quantity of oil in a safety-related area of the auxiliary building. (See Section 1R05)

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

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure The Operability of an Emergency Battery Lighting Unit in Accordance with the Approved Fire Protection Plan

The inspectors identified an NCV of the Unit 1 Operating License Condition 2.F for the licensee's failure to maintain the operability of Appendix R emergency lighting in accordance with the approved Fire Protection Plan (FPP). Specifically, both lamps for an Appendix R emergency light in the Unit 2B 480 volt transformer room were not aimed in the direction required by design to accomplish the operator manual action to restore outside air ventilation to the room in the event of a fire, as required by the FPP. The licensee implemented compensatory measures and entered this issue into the corrective action program as Problem Evaluation Report (PER) 341645.

The finding was determined to be more than minor because it affected the protection against external events attribute of the Mitigating Systems cornerstone, in that it affects the objective of ensuring reliability and capability of systems that respond to initiating events. This finding was evaluated using Inspection Manual Chapter (IMC) 0609, Appendix F, Attachment 1, and was determined to be of very low safety significance because it was not a major degradation of FSSD capability. The cause of the finding was directly related to the cross-cutting aspect of Effective Supervisory/Management Oversight in the Work Practices component of the area of Human Performance, in that the licensee did not ensure oversight of work activities that adversely affected the operability of Appendix R emergency lighting (H.4 (c)).

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

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Procedure AOI-30.2 C.36, Fire Safe Shutdown Room 737-A1A, Non-feasible Operator Manual Action

The inspectors identified an NCV of Technical Specification 5.7.1, Procedures, for the licensee's failure to maintain a plant procedure to ensure that an operator manual action for fire safe shutdown (FSSD) could be feasibly performed under the current physical plant configuration. Specifically, post-fire safe shutdown procedure AOI-30.2 C.36, Revision 3, contained instructions for an operator manual action for FSSD that could not be feasibly performed following implementation of a plant design change. The licensee took immediate corrective action to install a temporary scaffold as a compensatory measure. The licensee entered this issue into the corrective action program as PER 356563

The finding was determined to be more than minor because it affected the protection against external events attribute of the Mitigating Systems cornerstone, in that it affects the objective of ensuring reliability and capability of systems that respond to initiating events. This finding was evaluated using IMC 0609, Appendix F, Attachment 1, and was determined to be of very low safety significance because the procedure step in question was not a time-critical step. The cause of the finding was directly related to the cross-cutting aspect of Work Activity Coordination in the Work Control component of the area of Human Performance, in that the licensee failed to appropriately coordinate work activities, consistent with nuclear safety, to ensure that changes to the physical plant configuration would not adversely affect the feasibility of operator manual actions (H.3 (b)).

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

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a Transient Combustible Evaluation for Storage of Oil in a Safety Related Area in Accordance with the Approved Fire Protection Plan

The inspectors identified an NCV of the Unit 1 Operating License Condition 2.F for the licensee's failure to store transient combustible materials in a safety-related/critical area of the auxiliary building in accordance with the approved FPP. Specifically, approximately 38 gallons of hydrocarbon oil was stored inside the entrance labyrinth of the 1B charging pump room without an approved transient combustible evaluation, as required by the FPP. As a result, this was an unapproved increase in fire loading due to an increase in the volume of the predominant combustible material in the area. The licensee took immediate corrective action to remove the drum of oil from the area. The licensee entered this issue into the corrective action program as PER 371383 and PER 380910.

The finding was determined to be more than minor because it affected the protection against external events attribute

of the Mitigating Systems cornerstone, in that it affects the objective of ensuring reliability and capability of systems that respond to initiating events. This finding was evaluated using IMC 0609, Appendix F, Attachment 1, and was determined to be of very low safety significance because it represents a low degradation of fire prevention and administrative controls. The cause of the finding was directly related to the cross-cutting aspect of Proper Work Planning in the Work Control component of the area of Human Performance, in that the licensee failed to appropriately plan work activities to minimize the risk associated with a large quantity of oil in a safety-related fire zone without compensatory measures (H.3 (a)).

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

Significance: G Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Translate Moderate Energy Line Break Study Output into a Plant Procedure

Thee inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, Design Control for the licensee's failure to correctly translate a design document into operating procedures. Specifically, from original Licensing until the beginning of this reporting period, the licensee failed to translate into procedures guidance that would ensure that the plant could be safely shut down following a non-isolable break in the piping connecting the refueling water storage tank (RWST) to the emergency core cooling system in the auxiliary building. The licensee entered this issue into the corrective action program as PER 341568 and corrective actions have been completed to address the issue.

This finding was determined to be more than minor because it adversely affected the Mitigating Systems cornerstone attribute of procedure quality and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, flood protection was degraded due to a lack of procedures to mitigate flooding from the RWST into the auxiliary building with accompanying damage to both trains of the containment spray motors. This finding was evaluated using the SDP Phase 1 screening criteria in accordance with IMC 0609, Attachment 4, and was determined to require a Phase 3 analysis. The phase 3 analysis was performed by regional SRA's and determined to be of very low safety significance. The cause of the finding extends back to original plant licensing. Therefore, it is not related to current performance and is not assigned a cross-cutting aspect.

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

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