

# McGuire 2

## 2Q/2012 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to implement planned compensatory measures for impaired auxiliary building fire hose stations**

An NRC-identified non-cited violation (NCV) of Technical Specification (TS) 5.4.1.d was identified for failure to implement adequate compensatory measures for multiple impaired manual fire hose stations (FHSs) in accordance with the approved fire protection program. Gated wye valves were not installed as required during a periodic flush of multiple auxiliary building (AB) FHSs rendering them inoperable. The licensee took actions to install the gated wye valves in the affected FHSs to restore them to operable. This violation was entered into the licensee's corrective action program (CAP) as Problem Investigation Program (PIP) M-12-2816.

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 manual fire suppression capability was impaired. The finding was determined to be of very low safety significance because it represented a low degradation of the manual fire suppression function. The cause of this finding was directly related to the cross-cutting aspect of planning and coordination of work activities in the Work Control component of the Human Performance area, in that the licensee did not plan and coordinate work activities to ensure that adequate compensatory measures were established for impaired fire hose stations. [H.3(a)] (Section 1R05)

Inspection Report# : [2012003](#) (*pdf*)

**Significance:**  Jun 18, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Evaluate Potential Blocking of TDCA Pump Lube Oil Cooler During Certain Fire Events**

The NRC identified a NCV of License Condition 2.C.4 for failure to evaluate potential blockage of the Turbine Driven Auxiliary Feedwater (TDCA) pump lube oil cooler when pump suction is aligned to the circulating water (RC) system. Specifically, during certain fire events causing loss of plant control, the NRC identified that if the RC system piping was aligned to the suction of the TDCA pump as in accordance with the licensing basis, it could result in blockage of cooling water flow for the TDCA pump lube oil cooler. Immediate actions included performing a functional assessment and evaluating potential long term corrective actions. The licensee entered this issue in their corrective action program as PIP M-12-2174.

The performance deficiency was determined to be more than minor because it was similar to IMC 0612 Appendix E question 3j in that, there was reasonable doubt as to the operability of the auxiliary feedwater system when suction was supplied from RC system. In addition, the finding was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was evaluated using IMC 0609, Attachment 4, Phase 1, and IMC 0609 Appendix F, Fire Protection Significance Determination Process, Attachment 1, Phase 1 and determined to be of low safety significance because it only affected the ability to reach and maintain cold shutdown. The NRC determined that no cross cutting aspect was applicable to this

performance deficiency because this finding was not indicative of current licensee performance.  
Inspection Report# : [2012007 \(pdf\)](#)

**Significance:**  Jun 18, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Tornado Missile Protection for EDG Exhaust Ventilation System**

The NRC identified a NCV of 10CFR50, Appendix B, Criterion III, "Design Control," for the failure to ensure adequate tornado missile protection for the emergency diesel generator (EDG) exhaust relief and backdraft dampers as required. Specifically, 12 inches of the upper portion of the EDG Building ventilation system exhaust dampers were exposed and not protected from a tornado-generated missile. The licensee initiated compensatory measures in the form of concrete jersey barriers in front of each exhaust damper opening to provide additional shielding for the unprotected opening. The licensee entered this issue in their corrective action program as PIP M-12-2158.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Equipment Performance, and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, there was reasonable doubt the EDG ventilation exhaust would remain functional to support EDG operation in the event tornado-induced missiles damaged the exhaust backdraft relief dampers. The NRC performed a Phase 1 evaluation per IMC 0609, Attachment 4 and determined that the finding was potentially risk significant due to a seismic, flooding, or severe weather initiating events (e.g., tornadoes). Consequently, a Phase 3 analysis was performed by a senior reactor analyst, who determined that the risk significance of the issue was very low (i.e.,  $\Delta\text{-LERF} < 1.0\text{E-}7$ ). The NRC determined there was a cross cutting aspect in the area of Problem Identification and Resolution, in that the licensee did not thoroughly evaluate problems with adequate tornado missile protection such that the resolutions address causes and extent of conditions, as necessary. [P.1(c)]

Inspection Report# : [2012007 \(pdf\)](#)

**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:**  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 40A5.4)

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

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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# Public Radiation Safety

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## Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

Last modified : September 12, 2012