

San Onofre 2

2Q/2012 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 23, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Degraded Fire Barrier Separating Unit 2 Shutdown Cooling Heat Exchanger Rooms

The inspectors identified a non-cited violation of License Condition 2.C.(14) and the Updated Fire Hazards Analysis for the failure of the licensee to maintain the 3-hour penetration fire seal that separated redundant post-fire safe shutdown equipment. Specifically, prior to May 25, 2012, the licensee failed to maintain the 3 hour fire barrier between fire areas 2-SE-(-15)-138 and 2-SE-(-15)-139. The issue was entered into the licensee's corrective action program as Nuclear Notification NN 202003184.

The performance deficiency is more than minor, and therefore a finding, because it was associated with the external factors attribute (i.e. fire) of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to require additional evaluation under Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process." Using Inspection Manual Chapter 0609, Appendix F, Attachment 2, Table A2.2, the inspectors concluded the penetration fire seal represented a moderate A degradation of the fire confinement element of the fire protection program. Using the supplemental screening for fire confinement findings, the inspectors concluded that the finding was of very low safety significance (Green) because the degraded penetration fire seal provided a minimum of 20 minutes of fire protection and no fire ignition sources or combustible materials would have caused direct flame impingement on the fire barrier. This finding has a cross-cutting aspect in the area of human performance associated with the resources component because the licensee failed to ensure that personnel were adequately trained to inspect this type of penetration [H.2(b)](Section 1R05).

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

Significance:  Jun 23, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Maintain Foreign Material Exclusion Controls in Safety Related Components

The inspectors reviewed a self-revealing non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of maintenance personnel to implement procedures associated with foreign material exclusion controls while performing maintenance activities on safety-related 120Vac inverter equipment. Specifically, between October 2009 and April 2012, maintenance personnel failed to follow Procedure SO123-FO-1, "Site Foreign Material Exclusion Control Program," Revision 6, and Procedure SO123-I-1.18, "Foreign Material Exclusion (FME) Control," Revision 18, to prevent the introduction of a metal air filter frame that was left inside an energized electrical cabinet. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201958287.

The performance deficiency is more than minor, and therefore a finding, because it is associated with the Mitigating Systems Cornerstone attribute for human performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, maintenance personnel failed to prevent the introduction of foreign material into the energized electrical cabinet of inverter 2Y004.

The resident inspectors performed the initial significance determination for the inverter finding. The inspectors used the NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding screened to a Phase 2 significance determination because it involved a potential loss of safety function. A Region IV senior reactor analyst performed a Phase 2 significance determination and attempted to use the pre-solved worksheet from the "Risk Informed Inspection Notebook for the San Onofre Nuclear Generating Station," Revision 2.01a. However, the pre-solved worksheet did not include this inverter. Therefore, the analyst performed a bounding Phase 3 significance determination. The bounding change to the core damage frequency was 1.1E-8/yr, and therefore, determined to be of very low safety significance. The small population of affected equipment (included in the probabilistic risk assessment model) helped to minimize the safety significance. The contributing core damage sequences involved a seismic event and a consequential failure of auxiliary feedwater flow control and bypass valves to one steam generator. This finding has a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component because maintenance personnel failed to have an appropriate threshold for identifying issues associated with a degraded air filter and its impact to foreign material exclusion controls to ensure there would be no adverse impact to system operability [P.1(a)](Section 1R12.1).

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

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Significance: Jun 23, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Foreign Material Exclusion Controls During Maintenance

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of maintenance personnel to implement procedures associated with foreign material exclusion controls while performing maintenance activities on safety-related 120Vac inverter equipment. Specifically, on June 8, 2012, maintenance personnel failed to follow Procedure SO123-FO-1, "Site Foreign Material Exclusion Control Program," Revision 6, and Procedure SO123-I-1.18, "Foreign Material Exclusion (FME) Control," Revision 18, when maintenance personnel failed to implement adequate foreign material exclusions controls during inverter 2Y004 troubleshooting activities. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 202016714.

The performance deficiency is more than minor, and therefore a finding, because it is associated with the Mitigating Systems Cornerstone attribute for human performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, maintenance personnel failed to implement adequate controls, as required, to prevent the introduction of foreign materials during troubleshooting and repair activities associated with electrical cabinet of inverter 2Y004. Using Checklist 4 from the Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process," Phase 1 guidance, the finding is determined to have very low safety significance because all safety function guidelines were met, and thus, the finding did not require a quantitative assessment. This finding has a cross-cutting aspect in the area of human performance associated with the work practices component because the expectations regarding procedural compliance, and that personnel follow procedures were not effectively communicated to maintenance personnel regarding foreign material exclusion controls for unattended and opened electrical components [H.4(b)](Section 1R12.2).

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

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Significance: Jun 23, 2012

Identified By: NRC

Item Type: FIN Finding

Failure to Follow Battery Testing Procedure for Battery Exceeding 85% Service Life

The inspectors identified a finding for the failure to follow the battery testing procedure for non-class 1E batteries. Specifically, licensee personnel failed to implement the non-class 1E battery testing procedure, SO23-I-9.96, "Non-1E Battery Bank Performance Test," Revision 5, for Unit 2 battery 2B011 during refuel R2C17 when the battery is greater than 85% of its expected service life. The licensee submitted and approved an outage scope change request to test the battery during the current outage, and generated Nuclear Notification NN 201997619, to determine when battery 2B011 testing can be performed during the outage. The issue was entered into the licensee's corrective action program as Nuclear Notification NN 201994131.

The performance deficiency is more than minor, and therefore a finding, because it was associated with the human

performance 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 determined to have very low safety significance (Green) since it did not meet any of the greater than green criteria in Table 4A of Manual Chapter 0609, Attachment 04. The finding had a cross-cutting aspect in the human performance area, associated with the decision-making component because the licensee did not use conservative assumptions to demonstrate that the battery would maintain minimum capacity until the next refueling outage [H.1(b)](Section 40A2).

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

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Significance: Mar 24, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Seismic Controls in Safety-Related Areas

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure of operations personnel to follow Procedure SO123-XV-1.20, “Seismic Controls,” Revision 4. Specifically, between March 2 and March 6, 2012, operations personnel failed to follow Procedure SO123-XV-1.20, and allowed tools and equipment in the vicinity of safety-related shutdown cooling components in the room for shutdown cooling heat exchanger train B that could have become an operability hazard during a seismic event. The issue was entered into licensee’s corrective action program as Nuclear Notifications NNs 201884141 and 201910392.

The performance deficiency is more than minor, and therefore a finding, because it was associated with the Mitigating Systems Cornerstone attribute for protection against external events and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Manual Chapter 0609, Appendix M, “Significance Determination Process Using Qualitative Criteria,” was used since Manual Chapter 0609, Appendix G, “Shutdown Operations Significance Determination Process,” does not specifically address the particular condition in cold shutdown, in which time to boil is greater than 2 hours. The management review was performed using the Manual Chapter 0609, Appendix G, Attachment 1, Phase 1 guidance, to establish a bounding analysis. Using the bounding analysis, the finding is determined to have very low safety significance because the finding did not represent a potential loss of both trains of the shutdown cooling system. This finding has a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component because operations and Project Management Organization personnel failed to have an appropriate threshold to identify that tools and equipment in the vicinity of safety-related shutdown cooling components needed to be addressed to ensure there would be no adverse impact to system operability [P.1(a)](Section 1R04).

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

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Significance: Mar 24, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Timely Corrective Actions on a Safety-Related Pumps

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” for the failure of maintenance and engineering personnel to promptly correct a degraded condition associated with safety-related equipment. Specifically, since December 1988, the licensee failed to address long-term pump bearing oil leaks on safety-related component cooling water pumps, and deferred effective corrective actions with temporary gasket sealant. The licensee has issued work orders to install larger size O-rings and remove the sealant material from the outside of the bearing housing. The issue was entered into licensee’s corrective action program as Nuclear Notification NN 201840078.

The performance deficiency is more than minor, and therefore a finding, because it is associated with the design control attribute of the Mitigating Systems Cornerstone and affects the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, engineering personnel determined it was acceptable to use applications of gasket sealant to temporarily repair oil leaks, and delay permanent repairs on CCW pump bearing housings. Using the Manual

Chapter 0609, "Significance Determination Process," Phase 1 Worksheets, the finding is determined to have very low safety significance because it was not a design or qualification deficiency confirmed not to result in loss of operability or functionality; did not result in a loss of system safety function; did not represent an actual loss of safety function of a single train for greater than its technical specification allowed outage time; was not an actual loss of safety function of one or more non-technical specification trains of equipment designated as risk significant per 10 CFR 50.65 for greater than 24 hours; and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding was determined not to have a cross-cutting aspect because it is not reflective of current performance

(Section 1R15).

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

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Significance: Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Emergency Core Cooling System Valves in Required Positions

The inspectors identified a noncited violation of Technical Specification 5.5.1.1.a for the failure of operations personnel to maintain valves in positions required by procedures. The inspectors observed a drain valve, required to be closed by procedure, to be less than fully closed during a partial walk down of the Unit 2 high pressure safety injection system. Specifically, prior to August 17, 2011, operations personnel failed to implement instructions for filling, venting, draining, startup, shutdown, and changing modes of operation for emergency core cooling systems as written to ensure that high pressure safety injection system suction line drain valve 1204MR096 was in the required position. A plant equipment operator verified that the valve was returned to the required position and promptly informed the control room of the out-of-position valve. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201608017. The performance deficiency is more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern and is therefore a finding. Specifically, if seismic class I valves continue to be mispositioned, safety-related plant systems may be unable to accomplish their safety functions after an accident. This finding is associated with the Mitigating Systems Cornerstone. Using Inspection Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the inspectors determined this finding to be of very low safety significance because it did not result in the loss of a system safety function, did not represent the loss of safety function of a single train for greater than its allowed outage time, did not result in the loss of safety function of any non-technical specification equipment, and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events. This finding has a crosscutting aspect in the area of human performance associated with the resources component because the licensee failed to ensure procedures for operation of Keratest valves were adequate [H.2(c)](Section 1R04).

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

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Significance: Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Flood Protection for the Auxiliary Feedwater Steam Supply Piping

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for failure to translate applicable regulatory requirements and the design basis into specifications, drawings, procedures, and instructions. The Updated Final Safety Analysis Report, states, in part that, "In the extreme event that the thunderstorm PMP occurs, no safety-related equipment will be impacted by flooding," since, "Drainage water in the structures which entered from other areas (e.g. from roofs, open areas) will not reach safety-related equipment." Specifically, from original construction until adequate compensatory measure were implemented on May 5, 2011, the steam supply piping to the auxiliary feedwater pump turbine was not adequately protected from all postulated flood levels and conditions, such that, in the extreme event that the thunderstorm probable maximum precipitation occurs, water could have reached the steam supply pipe resulting in steam condensation inside the pipe which could impact auxiliary feedwater pump operability. The compensatory measures will remain in place until the design nonconformance is resolved. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 201448584. The performance deficiency is more than minor and therefore a finding because it is associated with the protection against external events attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events

to prevent undesirable consequences. Using NRC Inspection Manual 0609, Attachment 4, “Phase 1 – Initial Screening and Characterization of Findings,” the finding screened to a Phase 2 significance determination because it involved a potential loss of safety function. A Phase 2 was not appropriate for this external event. The Senior Reactor Analyst determined that the finding had very low significance. This was based on information received from the licensee indicating that the precipitation intensity required to render the turbine-driven auxiliary feedwater pump non-functional had a return frequency well below 1.0E-6/yr. In the case of clogged drains, less intense rain could affect the function of the pump, but would likely not cause a transient. A bounding risk estimate indicated that the delta core damage frequency of this scenario was less than 1.0E-7/yr. No crosscutting aspect was identified because this issue is not reflective of current performance, since this condition has existed since construction (Section 1R15).

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

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Significance: Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Incorporate Calculation Results into Plant Procedures

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure of engineering personnel to ensure that procedures for preventing unacceptable gas accumulation included appropriate qualitative or quantitative acceptance criteria to ensure that this important activity had been satisfactorily accomplished. Specifically, from July 2008 through August 2011, after performing Calculation M-0013-005, “Safety Injection Tank Fluid Nitrogen Evolution,” which determined the maximum permissible back-leakage from the safety injection tanks into the emergency core cooling systems pump discharge headers to preclude unacceptable gas accumulation, engineering personnel failed to incorporate the results of this calculation into plant procedures. This issue was entered into the licensee’s corrective action program as Nuclear Notification NN 201606472. The performance deficiency is more than minor because it is associated with the procedure quality attribute of the Mitigating Systems Cornerstone objective and to ensure the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences, and is therefore a finding. Using Inspection Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the inspectors determined the finding to be of very low safety significance because it did not represent the loss of safety function of any system or train and was not potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance associated with the decision making component because, when confronted with conservatively calculated information, engineering personnel failed to incorporate these conservative assumptions into plant procedures to ensure accumulating gas was identified before reaching an unacceptable volume, instead deciding to use informal trending mechanisms to track safety injection tank leakage [H.1(b)](Section 4OA5).

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

G

Significance: Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Plant Modification in Accordance with Applicable Specifications

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for the failure of licensee personnel to perform a modification to the Unit 3 high pressure safety injection system in accordance with the seismic requirements of the applicable construction specification. Specifically, in March 2010 (Unit 2) and February 2011 (Unit 3), licensee personnel failed to ensure that modifications per Engineering Change Packages NECP 800194395 (Unit 2) and NECP 800229823 (Unit 3) were either accomplished in accordance with Construction Specification CS-P206, “Design Guide for Supporting Small Piping (2 Inch and Under),” Revision 14, as required by the design change packages, or that deviations from the construction specification were controlled. This issue was entered into the licensee’s corrective action program as Nuclear Notification NN 201608558. The performance deficiency is more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, and is therefore a finding. Using Inspection Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the inspectors determined the finding to be of very low safety significance because it did not represent the loss of safety function of any system or train, and because during a seismic event, the absence of seismic supports on the subject pipe would not cause a plant trip or other initiating event, would not degrade two or more trains of a multi-train safety system or function, and would not degrade one or

more trains of a system that supports a safety system or function. This finding has a crosscutting aspect in the area of human performance associated with the work practices component because licensee personnel failed to define and effectively communicate expectations regarding procedural compliance and to ensure that personnel followed procedures [H.4(b)](Section 4OA5).

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

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Significance: Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Assessment of Seismic Qualification of Emergency Diesel Generator Buried Fuel Oil Tanks

The team identified a Green noncited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states in part: "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, from initial construction until July 22, 2011, the licensee had not properly evaluated the seismic qualification of the buried emergency diesel generator fuel oil storage tanks, to ensure that the tank's structures would not fail during a seismic event. The calculation did not accurately reflect the actual installed condition of the fuel oil tanks. The team determined that failure of the tanks to remain intact would impact the capability of the safety related emergency diesel generators to perform their design function following the event. This finding was entered into the licensee's corrective action program as Nuclear Notification NN-201548802.

The team determined that the failure to have an adequate seismic calculation for emergency diesel generator fuel oil storage tanks was a performance deficiency. The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of design control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the inadequate design analysis of these components could have resulted in structural failure, preventing continued operation of the emergency diesel generators after an earthquake. In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding was of very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, the licensee performed a preliminary re-evaluation of the tank shell stresses due to the concrete structures, and determined that the tank stresses were still within the American Society of Mechanical Engineers (ASME) Code allowable stresses following a Safe Shutdown Earthquake (SSE). The team reviewed the evaluation, and concurred that the stresses were below those allowed by ASME Boiler and Pressure Vessel Code. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section 1R21.2.9).

Inspection Report# : [2011010](#) (*pdf*)

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Significance: Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate that Sufficient Voltage would be Available at the Emergency Diesel Generator Air Start Solenoid

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states in part: "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, as of July 22, 2011, the licensee failed to evaluate that the voltage available at the emergency diesel generator diesel engine air start solenoid would be sufficient to ensure starting the diesel engine under design basis conditions. The licensee failed to incorporate the required minimum operating voltage for the emergency diesel generator air start solenoids into Calculation E4C-017. This finding was entered into the licensee's corrective action program as Nuclear Notifications NN-201513266 and NN-201566686.

The team determined that the failure to incorporate the required minimum operating voltage for the emergency diesel generator air start solenoids into Calculation E4C-017 was a performance deficiency. The finding was more than

minor because it was associated with the mitigating systems cornerstone attribute of design control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding was of very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, the licensee performed subsequent analyses and actual tests of the air start solenoids, which demonstrated that the emergency diesel generator air start solenoids would function as required to mitigate an accident. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section 1R21.2.13).

Inspection Report# : [2011010](#) (*pdf*)

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Significance: Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Incorporate Design Requirements into Procedures and Instructions

The team identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," which states in part: "Measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, as of July 22, 2011, the licensee did not incorporate the vendor required amperage limit, identified in engineering change package ECP-040201281-2, for bus load limit requirements, into 480 Volt Switchgear Operating Instructions SO23-6-3. This finding was entered into the licensee's corrective action program as Nuclear Notification NN201570846.

The team determined that the failure to incorporate the vendor required amperage limit, identified in engineering change package ECP-040201281-2, for bus load limit requirements, into 480 Volt Switchgear Operating Instructions SO23-6-3 was a performance deficiency. The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of design control, to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, the licensee had never implemented 480 Volt Switchgear Operating Instructions SO23-6-3 for the purpose of cross tying busses in an emergency, where the limiting load on the bus may have been exceeded. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section 1R21.2.14).

Inspection Report# : [2011010](#) (*pdf*)

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Significance: Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Equipment Important to Safety

The team identified a Green noncited violation of 10 CFR 50.65, "Requirements for monitoring the effectiveness of maintenance at nuclear power plants," which states in part: "Each holder of a license to operate a nuclear power plant shall monitor the performance or condition of structures, systems, or components, against licensee-established goals, in a manner sufficient to provide reasonable assurance that such structures, systems, and components, are capable of fulfilling their intended functions, and when the performance or condition of a system, structure, or component, does not meet established goals, appropriate corrective actions shall be taken." Specifically, as of July 22, 2011, the licensee failed to adequately monitor the condition of the Flood Level Detecting system in a manner to provide reasonable assurance the system could perform its intended function. The licensee failed to properly evaluate Maintenance Rule Functional Failures and take appropriate corrective actions to improve system performance. These level switches are connected to control room annunciation to warn the control room of flooding in a space that has safety-related or important to safety components. This has been entered into the licensee's corrective action program as Nuclear Notifications NN-201567315 and NN-201570575.

The team determined that the failure to properly maintain the flood level sensors which are used for control room annunciation to warn the control room of flooding of a space that has safety related or important to safety components, was a performance deficiency. The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of design control, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee did not maintain flood level sensors appropriately to provide reasonable assurance that the components would be capable of fulfilling their intended function. In accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding represented the degradation of equipment and functions specifically designed to provide notification to the control room of flooding of spaces with safety related or important to safety equipment and components. Therefore, the finding was potentially risk significant and a Phase 3 analysis was required. The preliminary significance determination was based on Inspection Manual Chapter 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." The senior reactor analyst determined qualitatively that the risk was very low for the following reasons: (1) the frequency of internal flooding is very low, (2) floods in most of the problem areas would not cause a transient, (3) redundant indications of flooding exist, including fire and sump pump operations, and (4) none of the potentially flooded areas would likely affect more than one train of safety equipment. This finding involved a cross-cutting aspect in the area of Human Performance, Resources, because the licensee failed to assure that equipment and other resources were available and adequate to assure nuclear safety. Specifically, the licensee was not able to maintain the flood level switches adequately to assure nuclear safety due to long-standing equipment issues [H.2(a)](Section 1R21.3.2).

Inspection Report# : [2011010](#) (pdf)

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Significance: Sep 13, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Control Document Changes

The team identified a Green non-cited violation, with multiple examples, of 10 CFR 50, Appendix B, Criterion VI, "Document Control," which states in part: "Measures shall be established to control the issuance of documents, such as instructions, procedures, and drawings, including changes thereto, which prescribe all activities affecting quality. These measures shall assure that documents, including changes, are reviewed for adequacy and approved for release." Specifically, on June 23, 2011, the team identified numerous drawing inconsistencies where changes to certain components were not changed on all affected drawings and procedural errors where changes were not made to all affected documents. The licensee has entered the errors into their corrective action program under numerous Nuclear Notifications listed in section 4AO2.

The team identified that collectively, from a program perspective, the failure to properly incorporate design changes of components in the plant to all affected drawings, procedures, or instructions, 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 accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the team determined that the finding was of very low safety significance (Green) because it did not represent a design issue resulting in the loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. Specifically, none of the documents with the identified errors had been used in response to any events or plant perturbations. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance (Section 4OA2).

Inspection Report# : [2011010](#) (pdf)

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Significance: Aug 16, 2010

Identified By: NRC

Item Type: VIO Violation

Failure to Ensure At Least One Train of Equipment Necessary to Achieve Hot Shutdown Conditions Is Free of Fire Damage

The team identified a cited violation of License Condition 2.C(14), "Fire Protection," for failure to correct a noncompliance. Specifically, Inspection Report 05000361;362/2007008 documented a noncompliance involving the

failure to ensure that at least one train of safe shutdown equipment would remain free from fire damage in each fire area. The NRC exercised discretion not to cite this violation at that time because the licensee met the criteria described in Enforcement Guidance Memorandum 98-002, Revision 2, and Supplement 2 to that revision. Enforcement Guidance Memorandum 07-004 superseded Enforcement Guidance Memorandum 98-002 and required licensees to complete corrective actions for noncompliances related to post-fire operator manual actions by March 6, 2009. This violation is being cited due to the failure to complete corrective actions and restore compliance within the required time. This finding was entered into the licensee's corrective action program as Notification NN 200940265.

The failure to promptly restore adequate fire protection and/or separation of required safe shutdown systems was a performance deficiency. This performance deficiency was more than minor because it was associated with the protection against external factors (fire) attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events in order to prevent undesirable consequences. Because the violation involved multiple fire areas, the team could not evaluate this issue using Phase 2 of Inspection Manual Chapter 0609, Appendix F, and a Phase 3 significance determination process risk assessment was performed by a senior reactor analyst. The finding was determined to have very low risk significance (Green), with a delta-CDF of 3.2E-8/yr, because of a combination of the availability of long recovery times for feasible operator manual actions and low-probability fire damage scenarios in the nine fire areas with fire sources which could potentially damage cables of required safe shutdown components. This finding involved a cross-cutting aspect in the decision-making component in the human performance area because the licensee failed to make a risk-significant decision using a systematic process when considering the scheduling of corrective actions. Inspection Report# : [2010007](#) (pdf)

Barrier Integrity

Significance:  Jun 23, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Design Control Procedures

The inspectors identified a non-cited violation 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of engineering personnel to follow Procedure SO123-XXIV-10.1, "Engineering Design Change Process – NECPs," Revision 28, to change the design, through physical plant modifications, of a facility used to handle radioactive material. Specifically, on February 2, 2012, engineering personnel issued as-built engineering change package NECP 800841701 which physically modified the design of the fuel reconstitution gantry crane with no turnover when an issued for construction engineering change package with turnover was required. This issue was entered into the licensee's corrective action program as Nuclear Notification NN 202026584.

The performance deficiency is more than minor, and therefore a finding, because it would become a more significant safety concern if left uncorrected since handling fuel with improperly modified equipment could result in fuel barrier damage. This finding cannot be evaluated by the significance determination process because Manual Chapter 0609, "Significance Determination Process," Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and Appendix G, "Shutdown Operations Significance Determination Process," do not apply to the spent fuel pool. This finding affects the Barrier Integrity Cornerstone and is determined to be of very low safety significance by NRC management review because it was a deficiency that did not result in the actual degradation of spent fuel. This finding has a cross-cutting aspect in the area of human performance associated with the work practices component because the expectations regarding procedural compliance, and that personnel follow procedures were not effectively communicated to Design Engineering, Nuclear Fuels Management, and Project Management Organization personnel [H.4(b)](Section 1R18).

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Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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.

Miscellaneous

Last modified : September 12, 2012