

South Texas 2 3Q/2012 Plant Inspection Findings

Initiating Events

Significance: G Jun 29, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Report a Condition Prohibited by Technical Specifications

The inspectors identified a non-cited violation of 10 CFR 50.73(a)(2)(i)(B) for the failure to report a condition prohibited by technical specifications to the NRC within 60 days. Specifically, on March 6, 2012, after reviewing licensee records, the inspectors informed the licensee that a violation of Technical Specification 3.4.1.4.2.b had occurred during the Unit 2 spring 2010 Refueling Outage 2RE13, because valves which isolated an unborated water source were not locked in the closed position. The licensee's corrective action included revising the reportability procedures to ensure that both units are addressed in the future.

The failure to report the occurrence of a condition prohibited by technical specifications is a performance deficiency which impacted the regulatory process and is a violation of NRC requirements. The violation was processed using traditional enforcement and determined to be a Severity Level IV violation consistent with Section 6.9 of the Enforcement Policy dated June 7, 2012.

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

Mitigating Systems

Significance: G Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Change on Class 1E 4160 Vac ESF Transformers

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criteria III, "Design Control," for the failure to ensure that design standards were correctly translated into drawings, procedures, and instructions. Specifically, the design specifications of the Class 1E 4160 Vac buses were not maintained with the installation of a new transformer. The root cause investigation determined that the design change package that installed the new transformers on Units 1 and 2 in October 2009 and April 2010, respectively, was not modeled correctly. The licensee captured this event as Condition Report 11-10205 and implemented immediate compensatory measures of increased monitoring on the Class 1E 4160 Vac buses by implementing temporary logs to ensure that the Class 1E loads were within their technical specifications surveillance procedure acceptance criteria until the new design change package could be implemented on each unit.

The finding was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Design Control and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inadequate design change package resulted in the licensee declaring the Unit 2 Class 1E 4160 Vac E2B bus inoperable because it was outside of the technical specification surveillance procedure acceptance criteria for longer than allowed by technical specifications. The

inspectors performed the significance determination using NRC Inspection Manual Chapter 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," dated January 10, 2008, because it affected the Mitigating Systems Cornerstone while the plant was at power. The finding was determined to be of very low safety significance because it was a design deficiency that did not result in a loss of functionality per Part 9900 Technical Guidance, "Operability Determinations & Functionality Assessments for Resolution of Degraded or Nonconforming Conditions Adverse to Quality or Safety," dated April 16, 2008. In addition, this finding had human performance cross-cutting aspects associated with work practices in that the licensee did not ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety was supported [H.4(c)].
Inspection Report# : [2011005](#) (*pdf*)

Barrier Integrity

Significance:  Jun 29, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify Conditions Adverse to Quality

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the failure to promptly identify conditions adverse to quality. Specifically, on May 21, 2012, the inspectors observed water was dripping from the isolation valve cubicle roof at several drops per minute and informed Unit 1 and 2 operations personnel to investigate further. The licensee confirmed that train C and D steam generator power operated relief valves in each unit were leaking steam directly to the atmosphere. The licensee entered the conditions into the corrective action program and plans to repair the valves at the next available opportunity.

The finding is more than minor because it is associated with the Barrier Integrity Cornerstone attribute of barrier performance and affected the cornerstone objective to protect the public from radionuclide releases caused by accidents or events because steam generator tube leakage events would release radionuclides directly to the atmosphere. The inspectors performed the significance determination using NRC Inspection Manual Chapter 0609, Appendix H, dated May 6, 2004. The finding was determined to be of very low safety significance because it did not affect core damage frequency and the components involved were not identified as being important to large early release frequency. In addition, this finding has a human performance cross-cutting aspect associated with decision making because the licensee did not use conservative assumptions and adopt a requirement to demonstrate that the proposed action is safe in order to proceed [H.1(b)].

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

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedures and Maintain Doses ALARA

On November 1, 2011, the inspectors identified a non-cited violation of Technical Specification 6.8.1.a, for the failure to follow procedures and minimize occupational doses during an outage maintenance activity for the disassembly of the Unit 2 reactor head. Specifically, Work Activity Number 376357 was not properly planned and managed, which resulted in unplanned worker dose. This work activity for the disassembly of the Unit 2 old reactor vessel closure head during the Unit 2 spring 2010 outage had a projected dose of 8.396 rem. However, the job ended with an actual collective dose of 14.072 rem. This exceeded the dose estimate by 68 percent. The licensee addressed this issue in the corrective action program as Condition Reports 10-6669, 10-7863, and 11-29161.

This finding is more than minor because it affected the Occupational Radiation Safety Cornerstone attribute of Program and Process, in that, failure to follow ALARA procedures caused increased collective radiation dose for the job activity to exceed 5 person-rem and exceeded the planned dose by more than 50 percent. Using the Occupational Radiation Safety Significance Determination Process, the inspectors determined this finding to be of very low safety significance because although it involved ALARA planning and controls, the licensee's latest rolling 3-year average does not exceed 135 person-rem per unit. Furthermore, the finding had an associated cross-cutting aspect in the area of human performance, work control component because the licensee did not fully incorporate risk insights, job site conditions, plant structures, systems, and components, and radiological safety, as well as the need for planned contingencies to maintain doses ALARA [H.3(a)].

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

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

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