

Diablo Canyon 2

1Q/2013 Plant Inspection Findings

Initiating Events

Significance:  Mar 23, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Provide Adequate Guidance To Address General Welding Standard Requirements

On February 14, 2013, the inspectors observed field welders add a partial circumferential weld on one side of the pipe in efforts to repair the pipe misalignment prior to the completion of the final visual inspection. This action represents a violation of 10 CFR Part 50, Appendix B, Criterion IX, "Control of Special Processes," because the licensee's procedure established special controls for critical distortions but failed to adequately define what situations fit that category. The licensee reviewed the stress calculation for the piping in question and concluded that the addition of the weld filler material did not affect the fatigue resistance of the weld, but acknowledged that a definition and additional guidance for the term "critical" was missing in the procedure and could have adverse effects on future final welds. The licensee entered the finding into their corrective action program as Notification 50542347.

The inspectors determined that the failure of the site's welding standard to provide adequate guidance to identify what constitutes a weld distortion during welding activities is a performance deficiency. The finding is more than minor because if left uncorrected, it has the potential to lead to a more significant safety concern. Specifically, Procedure GSW ASME did not provide the necessary guidance for welders and quality assurance personnel to identify and understand what constitutes critical distortion of a weld. The welding process can introduce effects of weld shrinkage (stresses) and distortion that could adversely affect the final condition of the weld, potentially leading to a service induced failure. Using Manual Chapter 0609, Attachment A, "The Significance Determination Process (SDP) for Findings At-Power," the finding was determined to be of very low safety significance (Green) because the finding did not result in exceeding the reactor coolant system leak rate for a small loss-of-coolant accident and did not affect other systems used to mitigate a loss-of-coolant accident resulting in a total loss of their function. The inspectors determined the finding had a cross cutting aspect in the human performance area associated with work practices, procedural compliance, because the licensee did not adequately define or train welders to know what constituted a critical distortion, and did not effectively communicate the expectation of questioning the procedure if the welding activity required skill of the craft. [H.4(b)]

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 23, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Identify Existing Indications During Prior Ultrasonic Examinations Of Pressurizer Structural Weld Overlays

The inspectors identified a Green non-cited violation of 10 CFR 50.55a(a)(3)(i), which requires that proposed alternatives to industry codes and standards provide an acceptable level of quality and safety. The NRC staff approved relief request REP 1 U2 dated March 28, 2007, for installing six structural weld overlays on the pressurizer safety, relief, spray and surge nozzles. The request established acceptance criteria of laminar flaws during weld acceptance examinations limited to only the third 10 year inservice inspection interval. Contrary to the above, the licensee failed

to identify unacceptable flaws as defined by the approved request following completion of these welds in 2008. The licensee entered the finding into their corrective action program as Notification 50540188.

The inspectors determined that the licensee's failure to identify indications that exceeded the acceptable linear dimension of laminar flaws prior to placing the system in service is a performance deficiency. The performance deficiency is more than minor because it is associated with the initiating events cornerstone attribute of equipment performance, and adversely affects the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, during the months of February and March 2013, the licensee identified that three out of the six pressurizer structural weld overlays exhibited laminar flaws that exceeded the linear dimensions approved by the safety evaluation. Using Manual Chapter 0609, Attachment A, "The Significance Determination Process (SDP) for Findings At Power," the finding was determined to be of very low safety significance (Green) because the finding did not result in exceeding the reactor coolant system leak rate for a small loss-of-coolant accident and did not affect other systems used to mitigate a loss-of-coolant accident resulting in a total loss of their function. This issue did not have a cross-cutting aspect associated with it because it is not indicative of current performance.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 23, 2013

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Effectively Evaluate Design Change for High Voltage Bushing

The inspectors reviewed a self-revealing finding for failure to effectively and accurately evaluate all available resources to procure appropriate equipment for plant modifications. Specifically, design engineering staff was not effective in using applicable station design documents, in conjunction with industry standards to determine minimum creepage distance for high voltage insulators when replacing ceramic bushings with polymer bushings on the main bank transformer. As a result, the licensee approved installation of an insulator stack that did not provide adequate ground protection, which caused a plant trip on October 11, 2012. The licensee entered the condition in their corrective action program as Notification 50518473.

Failure to effectively and accurately evaluate all available resources to procure appropriate equipment for plant modifications was a performance deficiency. The performance deficiency was more than minor because it was associated with the design control attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenged critical safety functions during power operations, and is therefore a finding. Using Inspection Manual Chapter 0609, Attachment 04, "Initial Characterization of Findings," and Appendix A, Exhibit 1, "Initiating Events Screening Questions," this finding was determined to be of very low safety significance (Green) because, although it resulted in a reactor trip, it did not result in the loss of mitigating equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. This finding had a cross-cutting aspect in the area of human performance, associated with the decision making component, because the licensee did not use conservative assumptions in decision making when considering the suitability of the design for the environment [H.1(b)].

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Update Emergency Operating Procedures

The inspectors identified a self-revealing non-cited violation of Technical Specification 5.4.1(b) for failure to maintain emergency operating procedures after personnel reviewing a temporary modification failed to identify and change affected emergency operating procedures. Specifically, the emergency operating procedure EOP E-0.1, "Reactor Trip

Response,” Revision 28, was not updated to be consistent with a temporary modification of steam generator water level low-low bistable setpoints. The licensee entered the condition into the corrective action program as Notifications 50517883, 50520697, and 50518355.

The failure to update emergency operating procedure E-0.1 “Reactor Trip Response,” Revision 28, to account for higher low-low water level bistable reset setpoints introduced by Temporary Modification 60044709 was a performance deficiency. The finding was more than minor because it was associated with the procedure quality attribute of the Initiating Events cornerstone. Using Inspection Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” this finding was determined to be of very low safety significance (Green) because the finding does not represent a loss of system and/or function and does not represent an actual loss of function of at least a single train for greater than its Technical Specification allowed outage time, or two separate safety systems out-of-service for greater than its Technical Specification allowed outage time. This finding had a crosscutting aspect in the area of human performance, associated with the resources component, because the licensee did not ensure complete, accurate and up-to-date procedures were available and adequate to ensure nuclear safety
Inspection Report# : [2012005](#) (*pdf*)

Significance:  Jun 22, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedure for the Control of Tools for Use on Stainless Steel

Inspectors identified a non-cited violation of Technical Specification 5.4.1.e, for the failure to follow procedures that ensured hand files and wire brushes designated for stainless steel weld preparation were stored and maintained separately from hand files and wire brushes used on carbon steel. Specifically, the inspectors determined that the licensee was not segregating tools as required by Procedure MA1.ID12, “Control of Tools for Use on Stainless Steel,” Revision 1, because inspectors observed rust deposits on stainless steel components in the plant. This indicated that carbon steel contaminated tools may have been used on these systems. The licensee took corrective actions to segregate the stainless steel tools that were mixed with tools used on carbon steel. The licensee established segregated locations in tool rooms for the separation of abrasive tools, trained tool room attendants to properly store and mark abrasive tools designated for use on stainless steel and evaluated the systems with indications of rust deposits. This issue was entered into the licensee’s corrective action program as Notifications 50475217 and 50475779.

Failure to assure that hand files and wire brushes designated for exclusive use on stainless steel were stored separately from tools used on other materials was a performance deficiency. This finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events Cornerstone and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and, if left uncorrected, could become a more significant safety concern. Using Inspection Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” this finding was determined to be of very low safety significance because the issue would not result in exceeding the technical specification limit for identified reactor coolant system leakage or affect other mitigating systems resulting in a total loss of their safety function. This finding has a cross-cutting aspect in the area of human performance, work practices, in that the licensee failed to ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported.

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

Significance:  Jun 22, 2012

Identified By: NRC

Item Type: FIN Finding

Feedwater System Weld Flaw

The inspectors identified a finding for failure to follow applicable ASME Code requirements prior to returning the feedwater system to service after code repairs for flow accelerated corrosion. The licensee failed to recognize a rejectable indication in feedwater piping weld 2K16-550-30 FW 33 observable in the original acceptance radiography

film. The licensee entered the issue into their corrective action program as Notifications 50473769 and 50475897 and re-examined the radiographic films for welds performed during Refueling Outage 2R16. A random re-examination of other radiographic films will be completed at a later date.

This finding was more than minor because it is associated with the human performance attribute of the Initiating Events Cornerstone and directly affected the cornerstone objective of limiting events that challenge plant stability. Based on the results of the engineering evaluation that was performed when the flaw was recognized, the inspectors determined that the structural integrity of the feedwater piping was not affected. Based on the results of a significance determination process Phase 1 evaluation, the finding was determined to be of very low safety significance (Green) because it did not contribute to the likelihood of a loss of coolant accident, did not contribute to a loss of mitigation equipment, and did not increase the likelihood of a fire or an internal/external flood. This finding has a cross-cutting aspect in the area of human performance, work practices, in that the licensee failed to ensure human error prevention techniques, such as self- and peer-checking were used so that work activities are performed safely.

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

Mitigating Systems

Significance:  Dec 20, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Maintain Required Firewater System Configuration

The team reviewed a self-revealing non-cited violation of License Conditions 2.C(4) for Unit 1 and 2.C(5) for Unit 2, “Fire Protection Program,” due to the licensee inadvertently isolating the firewater yard loop for approximately three days, reducing the plant’s fire protection capability without compensatory actions. The licensee entered this issue in their corrective action program as Notification 50513006.

The failure to maintain the fire water system configuration as required in the approved fire protection program was a performance deficiency. The performance deficiency was more than minor because it was associated with the protection against external events (fire) attribute of the Mitigating Systems Cornerstone and it adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The performance deficiency affected the fire protection defense-in depth strategies involving post-fire safe shutdown systems. The major fire loading in the yard area resulted from the 12 large transformers. The senior reactor analyst made the bounding assumption that any transformer fire without suppression would result in an unrecoverable loss of offsite power. A bounding value was calculated by multiplying the fire ignition frequency by the conditional core damage probability. This resulted in a change to core damage frequency of 1.2×10^{-7} . Therefore, the subject finding was of very low safety significance (Green).

This performance deficiency had a cross-cutting aspect in the area of resources associated with providing complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components. Specifically, the licensee did not provide sufficient details in procedures for operators to successfully align an infrequently operated valve with no position indication. [H.2(c)]

Inspection Report# : [2012008](#) (*pdf*)

Significance:  Dec 20, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Compensatory Measures for Fire Protection Program Deficiencies

The team identified a non-cited violation of License Conditions 2.C(4) for Unit 1 and 2.C(5) for Unit 2, “Fire Protection Program,” due to the licensee’s failure to establish or adequately implement compensatory measures for non-compliances with the licensee’s approved fire protection program. These non-compliances were identified during the licensee’s ongoing transition to a new fire protection program in compliance with National Fire Protection Association Standard 805, “Performance-Based Standard for Fire Protection for Light Water Reactor Electric Generating Plants,” (NFPA 805). The licensee entered this issue in their corrective action program as Notifications 50521360 and 50531363.

The failure to establish or maintain appropriate compensatory measures for identified deficiencies in the approved fire protection program was a performance deficiency. The performance deficiency was more than minor because it was associated with the protection against external events (fire) attribute of the Mitigating Systems Cornerstone and it adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. A senior reactor analyst evaluated the significance of this performance deficiency.

A fire that results in the loss of switchgear room ventilation would cause a loss of all ac and dc power if operators did not take action to recover cooling. The analyst determined that the licensed operators would have at least two clear annunciators indicating that ventilation had been lost and that room temperatures were increasing. Additionally, Procedure CP-M10, “Fire Protection of Safe Shutdown Equipment”, was available to assist in providing portable fan cooling to the rooms.

For a fire to result in an intersystem loss of coolant accident, it would have to cause a 3 phase hot short on both of two shutdown cooling suction valves. Given that each valve is on a different electrical train, the analyst determined that the conditional probabilities of the hot shorts involved would best be modeled as independent. Accounting for the risk associated with both issues evaluated, the analyst estimated the change to core damage probability to be 1.5×10^{-7} per unit. Therefore, the performance deficiency was considered to be of very low safety significance (Green).

This finding did not have a cross-cutting aspect because it was not indicative of the licensee’s present performance. Inspection Report# : [2012008](#) (*pdf*)

Significance: G Sep 30, 2012

Identified By: NRC

Item Type: VIO Violation

Inadequate Corrective Actions to Update the Final Safety Analysis Report Update (FSARU) with Required Information

The inspectors identified a cited violation of 10 CFR Part 50.71(e), “Maintenance of Records, Making of Reports,” for failing to update the Final Safety Analysis Report. Specifically, the licensee failed to update the Final Safety Analysis Report to include the information describing the extent to which plant structures, systems, and components met 10 CFR 50, Appendix A, or describing and justifying exceptions to those General Design Criteria. This failure to update the Final Safety Analysis Report was previously identified as a non-cited violation in NRC’s “Diablo Canyon Power Plant Integrated Inspection Report 05000275/2009003 and 05000323/2009003.” The licensee entered the condition into the corrective action program as Notification 50513243.

The failure to correct missing information that was required to be in the Final Safety Analysis Report Update was a performance deficiency. The inspectors concluded that the finding is more than minor because, if left uncorrected, this could lead to a more significant safety concern because future changes to the facility, procedures, and programs would not be able to consider the licensing basis information that was removed or never inserted. The finding was screened using Manual Chapter 0609, “Significance Determination Process.” The inspectors concluded that the finding was of very low safety significance (Green) because while the finding was a deficiency affecting design or qualification of a

mitigating system, it did not result in the loss of operability or functionality of a system. The finding also affected the NRC's ability to perform its regulatory function and was evaluated using the traditional enforcement process. The finding was determined to be Severity Level IV because the required information was not used to make an unacceptable change to the facility or procedures, which was consistent with the determination that the issue had very low safety significance. The inspectors concluded that this finding had a crosscutting aspect in the area of human performance associated with the decision making component because the licensee did not use conservative assumptions in decision making and did not adopt a requirement to demonstrate that the proposed action is safe in order to proceed.

Inspection Report# : [2012004](#) (pdf)

Significance:  Jun 22, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Preferred Offsite Power System Design Control

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," after plant engineers failed to adequately translate regulatory requirements and the design bases into the offsite power interface calculation on May 6, 2011. As a result, the licensee failed to demonstrate that the 230 kilo-Volt preferred offsite power source had adequate capacity and capability to supply the minimum required terminal voltage to plant engineering safety features following a limiting transmission system contingency. The licensee took corrective actions to limit the plant load that would automatically transfer to the preferred power source following a unit trip and entered the condition into the corrective action program as Notification 50492766.

The failure to ensure that the 230 kV power system had adequate capability and capability as defined in the current licensing basis requirements was a performance deficiency. This performance deficiency was more than minor because it was associated with the modification design control 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. The inspectors concluded this finding was of very low safety significance because the duration of potential losses of a single offsite power source safety function was less than the technical specification allowed outage time, did not represent an actual loss of safety function of risk significant 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 cross-cutting aspect in the area of human performance, associated with the decision making component, because the licensee did not demonstrate that the proposed action was safe in order to proceed while assessing the CLB requirement during decision making.

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

Significance:  Jun 22, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a 50.59 Evaluation

The inspectors identified a non-cited violation of 10 CFR 50.59, "Changes, Tests, and Experiments," because the licensee failed to document an evaluation providing a basis that changes made to the facility and associated changes to Procedure OP J-2:VIII, "Guidelines for Reliable Transmission Service for DCCP," did not require prior NRC approval. When a 50.59 review was performed, the licensee incorrectly concluded that only a screening was needed. Plant operators use Procedure OP J-2:VIII to determine the operability of the preferred offsite power system for various transmission system configurations. This change accepted a reduction in the preferred offsite power capacity and capability, below the minimum specified by the current licensing basis, due to local service area load growth. This condition would have likely required prior NRC approval had a 50.59 evaluation been performed. The licensee entered this finding into the corrective action program as Notification 50492767.

The failure to perform a 50.59 evaluation was also a performance deficiency. The inspectors concluded that this issue involved traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory

function. This performance deficiency is more than minor because it was associated with modification design control 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. The inspectors concluded this finding was of very low safety significance because the duration of potential losses of a single offsite power source safety function was less than the technical specification allowed outage time, did not represent an actual loss of safety function of risk significant 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 cross-cutting aspect in the area of human performance, associated with the decision making component, because the licensee did not use conservative assumptions to adopt the licensing basis requirement during decision making. Inspection Report# : [2012003](#) (*pdf*)

Barrier Integrity

Significance:  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Operability Evaluation

The inspectors identified a non-cited violation of 10 CFR, Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," after personnel failed to adequately assess the impact of an unanalyzed condition on control room envelope operability. Specifically, personnel performed a problem screening for a nonconforming condition that impacted operability of the control room ventilation system operability and determined that a review by the Shift Foreman, work control Shift Foreman, or Shift Manager was not required. The licensee entered the condition into the corrective action program as Notification 50497774.

The failure to adequately assess the impact of an unanalyzed, non-conservative condition on control room habitability system operability was a performance deficiency. This finding was more than minor because it was associated with the Barrier Integrity Cornerstone objective design control attribute to provide reasonable assurance for the control room physical design to protect from radionuclide releases caused by accidents or events. Using the Inspection Manual Chapter 0609, Appendix A, "Significance Determination Process (SDP) for Findings At-Power," the inspectors concluded that the finding was of very low safety significance (Green) because the finding only represented a degradation of the radiological barrier function provided for the control room. This finding had a cross-cutting aspect in the area of problem identification and resolution, associated with the corrective action program component, because the licensee did not thoroughly evaluate the impact of non-conservative control room atmospheric dispersion factor methodology on control room habitability system operability,

Inspection Report# : [2012005](#) (*pdf*)

Significance:  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Non-conservative Decision Making Resulted in a Violation of Technical Specification

The inspectors identified a non-cited violation of Technical Specification 3.7.10, "Control Room Ventilation System (CRVS)," after the control room envelope boundary for both units was inoperable for a greater duration than permitted by the out-of-service time. Specifically, the licensee operated Units 1 and 2 without an operable control room envelope from between at least September 2011 and December 2012, which is greater than the 90 day allowed outage time. The licensee entered the condition into the corrective action program as Notifications 50483820, 50497328, and

50485800

The failure to comply with Technical Specification 3.7.10 was a performance deficiency. The finding was more than minor because it was associated with the Barrier Integrity Cornerstone objective design control attribute to provide reasonable assurance that the control room physical design would protect operators from radionuclide releases caused by accidents or events. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors concluded that the finding was of very low safety significance (Green) because the finding only represented a degradation of the radiological barrier function provided for the control room. This finding had a crosscutting aspect in the area human performance associated with decision-making component because the licensee did not use conservative assumptions in their decision to implement compensatory actions following the inoperability of the control room envelope boundary,

Inspection Report# : [2012005](#) (*pdf*)

Significance: G Mar 23, 2012

Identified By: NRC

Item Type: VIO Violation

Incomplete and Inaccurate Information Provided to the NRC in Response to Generic Letter 2003-01, "Control Room Habitability"

The inspectors identified a Green finding and Severity Level III violation of 10 CFR 50.9, "Completeness and Accuracy of Information," after Pacific Gas and Electric failed to submitted complete and accurate information in response to Generic Letter 2003-01, "Control Room Habitability." Generic Letter 2003-01 requested that the licensee submit information demonstrating that the control room habitability system was in compliance with the current licensing and design bases. The licensee was specifically requested to verify that the most limiting unfiltered in-leakage into the control room envelope was no more than the value assumed in the design basis radiological analyses for control room habitability. On April 22, 2005, the licensee reported to the NRC that testing performed in the most limiting configuration for operator dose demonstrated that there was no unfiltered in-leakage into the control room envelope. This was material because the NRC used this information to close out Generic Letter 2003-01. In September 2011, the inspectors identified that the control room test results were greater than the value assumed in the design basis radiological analysis and that the licensee's testing was not performed in the most limiting configuration for operator dose. Using the actual control room in-leakage rates, the inspectors concluded that the resultant operator dose could have exceeded the limit established by current licensing and design bases during an accident.

The inspectors concluded that the failure of Pacific Gas and Electric to provide complete and accurate information in response to Generic Letter 2003-01 was a performance deficiency. The finding was more than minor because the information was material to the NRC's decision making processes. The inspectors screened the issue through the Reactor Oversight Process because the finding included a performance deficiency that was reasonably within the licensee's ability to control. The inspectors concluded that the finding was of very low safety significance (Green) because only the radiological barrier function of the control room was affected. The inspectors also screened the issue through the traditional enforcement process because the violation impacted the regulatory process. The inspectors concluded that the violation was a Severity Level III because had the licensee provided complete and accurate information in their letter dated April 22, 2005, the NRC would have likely reconsidered a regulatory position or undertaken a substantial further inquiry. The inspectors did not identify a cross-cutting aspect because the performance deficiency was not reflective of present performance.

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

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 : June 04, 2013