

## South Texas 1

# 1Q/2013 Plant Inspection Findings

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## Initiating Events

**Significance:** G Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Perform Pressure Testing of the Reactor Vessel Flange Leak-Off Lines**

Inspectors identified a non-cited violation of 10CFR50.55a(g)(4) involving the licensee's failure to perform a system pressure test of the reactor vessel flange leak-off line of Units 1 and 2, in accordance with the applicable edition of Section XI of the American Society of Mechanical Engineers Boiler and Pressure Vessel Code. Contrary to the above, prior to November 1, 2012, the licensee failed to perform the required pressure test of the reactor vessel flange seal leak-off line for both units. Specifically, the licensee failed to implement the American Society of Mechanical Engineers Boiler and Pressure Vessel Code, Section XI, Class 2 requirements for pressure retaining components as provided by Article IWC 5220, "System Leakage Test." The licensee entered the finding into their corrective action program as Condition Report 12-28600.

The inspectors determined that the licensee's failure to perform a pressure test of the reactor vessel flange leak-off line was a performance deficiency. This finding was more than minor because it affected the Initiating Events Cornerstone attribute of Equipment Reliability and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. Using Manual Chapter 0609, Attachment A, "The Significant 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# : [2012005](#) (*pdf*)

**Significance:** G Dec 31, 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 very low safety significance of Technical Specification 6.8.1.a and Regulatory Guide 1.33, for the failure to follow procedures that ensured abrasive tools for use on stainless steel systems were not contaminated with carbon steel. Specifically, the inspectors determined that the licensee was not maintaining tools as required by Procedure 0PGP03-ZG-0001, "Control of Materials and Products By User Groups," Revision 30, and Procedure 0PNP01-ZP-0032, "Tools and Measuring & Test Equipment Control," Revision 6, because inspectors observed multiple instances of tools coded for use on stainless steel or aluminum bronze stored with tools marked for use on carbon steel, rust deposits on tools marked for use on stainless steel, and 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 coded tools and 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 Condition Report 12-28689.

Inspectors determined the failure to assure that abrasive tools designated for exclusive use on stainless steel were stored separately from tools used on other materials was a performance deficiency. This finding was more than minor because it affected the Initiating Events Cornerstone attribute of Equipment Reliability and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. Using Manual Chapter 0609, Attachment A, "The Significant 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 finding had a cross-cutting aspect in the area of human performance work practices in that the licensee failed to effectively communicate expectations regarding procedural compliance, and personnel did not follow procedures. Specifically, the inspectors observed that although there were requirements to segregate tools, tools were not consistently segregated when returned to the storage locations as required by procedures [H.4(b)].

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

**Significance:**  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Maintain Adequate Fire Penetration Seal Material Thickness**

The inspectors identified a non-cited violation of Technical Specification 6.8.1.d, "Fire Protection Program Implementation," for the failure to follow work order package instructions requiring the use of Drawing C012- 00081-F7F, "Detail "E-1" Silicone Elastomer Typical Electrical Pen. Seals (Walls & Floors)," to establish 6 inches of fire retardant sealant material for penetrations in Units 1 and 2. The inspectors noticed that Unit 1 train B safety-related 4160 Vac switchgear room electrical penetration F4476 had gaps around the edge. A design change installed new electrical cables that required the penetration be sealed using work order package 139376, that stated "the penetration seal WILL BE IAW the Penetration Seal Permit and detail Drawing C012- 00081-F7F." During the repair activities to correct the gaps, it was discovered that a portion of the seal was only 4.5 inches. The licensee captured this issue as Condition Report 12-28283. Corrective actions included restoring the seal to 6 inches, performing additional analysis to support a 3-hour fire barrier with just 5 inches, and performing extent of condition inspections.

The finding was more than minor because it was associated with the Initiating Events Cornerstone attributes of Design Control and Procedure Quality, and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions because it resulted in multiple fire penetration seals being declared nonfunctional as a result of being less than the design thickness. The inspectors used Manual Chapter 0609, Attachment 0609.04, to determine that fire protection issues are processed through Appendix F, "Fire Protection Significance Determination Process," dated February 28, 2005. The inspectors used Appendix F, Attachment 1, to determine that the finding was of very low safety significance because it was a Moderate A fire confinement issue that screened out using Task 1.3.2 questions, since the seals would still have provided a 2-hour fire endurance rating or a 20 minute fire endurance rating without the seal being subject to direct flame impingement. In addition, this finding had human performance cross-cutting aspects associated with work practices because the licensee did not communicate human error prevention techniques such as self and peer checking, commensurate with the risk, such that the work activity was performed safely [H.4(a)].

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

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## **Mitigating Systems**

**Significance:**  Oct 31, 2012

Identified By: NRC

Item Type: VIO Violation

### **Failure to Timely Correct Conditions Adverse to Fire Protection**

The team identified a violation of License Condition 2.E for the failure to correct a noncompliance. Procedure OPOP04-ZO-0001, "Control Room Evacuation," Revision 35, was not consistent with the post-fire safe shutdown analysis in that it failed to ensure the actions met critical time requirements. The licensee failed to implement timely corrective actions to correct this deficiency. Inspection Report 05000498/2011006 and 05000499/2011006 documented a violation involving the failure to implement and maintain in effect all provisions of the approved fire protection program. During this inspection, the team identified that the licensee had failed to restore compliance with its license condition within a reasonable time.

The licensee's failure to implement timely corrective actions to correct conditions adverse to fire protection as required by its Operations Quality Assurance Plan is a performance deficiency. This performance deficiency was of more than minor safety significance because it was associated with the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events (such as fire) to prevent undesirable consequences. Specifically, the licensee failed to ensure reliability of its post-fire safe shutdown systems by demonstrating that it could achieve safe shutdown following a fire in the control room by using approved actions. The significance of this finding could not be evaluated using Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," because the performance deficiency involved a control room fire that led to control room evacuation. A senior reactor analyst determined that the upper bound for the overall change in core damage frequency that resulted from this performance deficiency was  $2.702E-7/\text{yr}$  and was not significant with respect to large early release frequency. The analyst therefore determined that this performance deficiency was of very low risk significance (Green). The team determined that the performance deficiency had a cross-cutting aspect in the corrective action component of the problem identification and resolution cross-cutting area because the licensee did not thoroughly evaluate the problem such that resolutions addressed the cause. Specifically, the licensee failed to take adequate corrective actions to ensure that operators could perform all necessary manual actions as approved prior to exceeding the regulatory requirements (P.1(c)).

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

**Significance:** G Sep 28, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Promptly Correct a Condition Adverse to Quality**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to promptly identify and correct a condition adverse to quality. Specifically, the licensee failed to correct a longstanding leak from the body-to-bonnet gasket on the safety injection system hot leg check valve 1N122XSI0010A, a portion of the reactor coolant system Class 1 pressure boundary.

This finding was more than minor because it affected the Mitigating Systems Cornerstone. The inspectors performed the significance determination using NRC Inspection Manual Chapter 0609. Because the finding affected the Mitigating Systems Cornerstone while the plant was at power, Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, evaluates the finding using Appendix A. Using Appendix A, Exhibit 2, Mitigating Systems Screening Questions, the finding was determined to be of very low safety significance because it was not a design or qualification issue confirmed not to result in a loss of operability or functionality; did not represent an actual loss of safety function of the system or train; and did not result in the loss of one or more trains of nontechnical specification equipment. This issue has been entered into the licensee's corrective action program as Condition Report 11-23693. Because the licensee evaluated the condition during the recent refueling outage in November 2011 prior to NRC involvement and considered actions to repair the seal cap enclosure weld adequate without considering the condition of the pressure retaining boundary, this issue was considered indicative of current plant performance. In addition, this finding had a human performance cross-cutting aspect

associated with decision making, because the licensee failed to use conservative assumptions when making decisions and did not demonstrate that nuclear safety was an overriding priority [H.1(b)].

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

**Significance:**  Jun 29, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Follow ASME Code Requirements**

The inspectors identified a non-cited violation of 10 CFR 50.55a(g)(4) for the failure to follow in-service inspection requirements of Section XI of the 2004 ASME Boiler and Pressure Vessel Code. Specifically, the inspectors determined that the licensee had not correctly applied Section XI, IWA-5250, to boric acid residues that were discovered under the base lip of the refueling water storage tank on September 20, 2011. The inspectors questioned the licensee's operability determination of fully operable and engineering disposition of "acceptable for use," because the degradation mechanism was not readily apparent and the licensee had not characterized the flaw. The licensee documented the issues in Condition Reports 12-20019 and 12-20026 and changed the operability determination to operable but degraded.

This finding is more than minor because it affected 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, and if left uncorrected it would have the potential to become a more significant safety concern because the structural integrity of the safety injection system's primary source of cooling water could be compromised. 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 not a design or qualification deficiency; it did not result in the loss of a system safety function; it did not represent a loss of a single train for greater than technical specification allowed outage time; it did not represent a loss of one or more nontechnical specification risk-significant equipment for greater than 24 hours; and it did not screen as potentially risk significant due to seismic, flooding, or severe weather. In addition, this finding had a human performance cross-cutting aspect associated with decision making because the licensee did not make safety-significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained [H.1(a)].

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

## **Barrier Integrity**

**Significance:**  Mar 30, 2013

Identified By: NRC

Item Type: FIN Finding

### **Failure to Initiate a Condition Report for Spent Fuel Pool Cooling Low Flow Alarms**

The inspectors identified a Green finding for the failure to follow Procedure 0PGP03-ZX-0002, "Condition Reporting Process," Revision 43, step 4.2.1, which required initiation of a condition report for an abnormal or unexpected condition on a structure, system, or component." On October 11, 2012, the inspectors toured the Unit 1 control room and observed operators starting the spent fuel pool cooling pumps. Shortly after starting the pumps, a low flow annunciator alarm was received. The operators dismissed the alarm as expected. However, the inspectors questioned the response to the alarm and determined that there was no documented explanation for the alarm to be expected. The

inspectors reviewed several years of historical pump starts and determined that the alarms were not consistent between the trains, and the licensee failed to evaluate the inconsistency. The inspectors concluded this condition warranted the initiation of a condition report. During troubleshooting, the licensee concluded that they had installed the incorrect type of pulsation dampener (snubber) in the flow line which caused the low flow annunciator alarm. The licensee's corrective actions included replacing the snubber, updating procedures, and training of maintenance and operations personnel about the condition.

This finding was more than minor because it affected the Barrier Integrity Cornerstone attribute of Structures, Systems, and Components' Performance (area of instrumentation to maintain functionality of the spent fuel pool cooling system), and it affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding) protect the public from radionuclide releases caused by accidents or events. Specifically, if left uncorrected it would have the potential to become a more significant safety concern because it could have resulted in unreliable instrumentation, or alarms, that are used to ensure adequate cooling to the spent fuel pool. The inspectors performed the significance determination using NRC Inspection Manual Chapter 0609 because the finding affected the Barrier Integrity Cornerstone while the plant was at power. Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, evaluates the finding using Appendix A. Using Appendix A, Exhibit 3, Barrier Integrity Screening Questions, the finding was determined to be of very low safety significance because the finding did not: (1) result in the spent fuel pool temperature exceeding the maximum analyzed temperature limit; (2) result from fuel handling errors that caused fuel cladding damage; (3) result in a loss of inventory below the minimum analyzed level limit; and (4) affect the spent fuel pool neutron absorber, fuel pattern loading, or soluble boron concentration. In addition, the NRC determined the finding had a human performance cross-cutting aspect associated with decision making because the licensee did not use conservative assumptions when dismissing the low flow alarm instead of having it evaluated to ensure that it was safe to proceed [(H.1(b))].

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

**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

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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

**Significance:** N/A Oct 31, 2012

Identified By: NRC

Item Type: FIN Finding

### **SOUTH TEXAS PROJECT ELECTRIC GENERATING STATION, 2012, Biennial Problem Identification and Resolution Inspection Summary**

The team reviewed approximately 210 condition reports, including associated work orders, engineering evaluations, root and apparent cause evaluations, and other supporting documentation. The purpose of this review, focused on documentation of higher-significance issues, was to determine if problems were being properly identified, characterized, and entered into the corrective action program for evaluation and resolution. The team reviewed a sample of system health reports, self assessments, trending reports and metrics, and various other documents related to the corrective action program. The team concluded that with limited exceptions, the licensee maintained a corrective action program in which issues were generally identified at an appropriately low threshold. Issues entered into the corrective action program were appropriately evaluated and timely addressed, commensurate with their safety significance. Corrective actions were generally effective, addressing the causes and extents of condition of problems.

The licensee appropriately evaluated industry operating experience for relevance to the facility and entered applicable items in the corrective action program. The licensee used industry operating experience when performing root cause and apparent cause evaluations. The licensee performed effective quality assurance audits and self assessments, as demonstrated by its self identification of some needed improvements in corrective action program performance and of ineffective corrective actions.

The licensee maintained a safety-conscious work environment in which personnel felt free to raise nuclear safety concerns without fear of retaliation. All individuals interviewed by the team were willing to raise these concerns by at

least one of the several methods available.

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

Last modified : June 04, 2013