

## McGuire 2 2Q/2013 Plant Inspection Findings

---

### Initiating Events

**Significance:** G Mar 31, 2013

Identified By: Self-Revealing

Item Type: FIN Finding

#### **Failure to Revise Turbine Inlet Pressure Calibration Procedure**

A self-revealing finding was identified for the licensee's failure to follow the requirements of the station modification program manual EDM 601 during implementation of a high pressure turbine replacement modification revision. This resulted in Anticipated Transient Without Scram Mitigation System Actuation Circuitry (AMSAC) calibration procedures not being revised with the proper setpoints.

The performance deficiency (PD) was more than minor because it affected the Design Control attribute of the Initiating Events Cornerstone and adversely affected the cornerstone objective in that AMSAC actuated causing a turbine trip. The finding was determined to have very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. The cause of this finding was related to the cross-cutting aspect of the need for work groups to maintain appropriate interfaces and communicate, coordinate with each other during important work activities as described in the Work Control component of the Human Performance cross-cutting area because necessary revisions to the AMSAC input device calibration procedures were not adequately communicated.

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

---

### Mitigating Systems

**Significance:** G Feb 15, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Modifications Result in Nonfunctional Fire Doors**

An NRC identified Green non-cited violation of McGuire's Selected Licensing Commitment 16.9.5, Fire Rated Assemblies was identified for the licensee's inadequate implementation of modifications that results in nonfunctional fire doors. The Licensee has entered the finding into the corrective action program as PIP M-13-01454, declared the doors as nonfunctional and implemented fire watches for the fire areas of concern.

The licensee's inadequate implementation of fire door modifications that resulted in the failure to meet the requirements of Selected Licensee Commitment 16.9.5, Fire Rated Assemblies, was a performance deficiency. The performance deficiency was more than minor because it adversely affected the Mitigating Systems cornerstone attribute of Protection Against External Events. Specifically, the welding modifications performed on nine doors adversely affected their capability to provide the required 3-hours of fire resistance. In accordance with NRC IMC 0609 Appendix F, Part 1; "Fire Protection Significance Determination Process Phase 1 Worksheet" the inspectors determined the finding to be of very low safety significance (Green) because the fire doors would still provide a minimum of 20 minutes fire endurance protection. A cross-cutting aspect was not assigned because the performance

deficiency does not reflect current licensee performance. (Section 1R05.02)

Inspection Report# : [2013007](#) (*pdf*)

**Significance:**  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to maintain complete and accurate pre-fire plans**

An NRC-identified Green non-cited violation (NCV) of the Unit 2 Facility Operating License, Condition 2.C.4, Fire Protection Program, was identified for failure to maintain pre-fire plans in areas that contain safety-related equipment. The inspectors identified that all copies of fire strategy plan view for the Unit 2 lower annulus and containment were missing from their pre-fire plans and unavailable to the Fire Brigade Leader and Operations personnel in the event of a fire in the Unit 2 reactor building. Corrective actions included replacement of the missing fire strategy plan views and additional review of the fire strategy books located in the Fire Brigade Leader's Kit, Control Room, and Emergency Preparedness office. This violation was entered into the licensee's corrective action program (CAP) as Problem Investigation Program (PIP) M 12-08270.

The performance deficiency (PD) was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Protection Against External Events (Fire) and adversely affected the cornerstone objective, in that, it degraded the manual fire suppression capability. The finding was determined to be of very low safety significance (Green) because the fire brigade consisted of plant personnel familiar with the plant layout and associated fire hazards and appropriate fire-fighting equipment was available. The cause of the PD was directly related to the aspect of complete, accurate, and up-to-date procedures of the Resources Component in the cross-cutting area of Human Performance because the Fire Brigade Program Administrator failed to include all approved plan view updates into the fire brigade response strategies. [H.2(c)]

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

**Significance:**  Sep 30, 2012

Identified By: NRC

Item Type: FIN Finding

**Failure to correctly implement technical specifications adversely affects requalification operating test quality**

An NRC-identified finding was identified associated with the quality of the simulator scenarios developed by the licensee for the licensed operator requalification annual operating test. The licensee failed to follow the Technical Specification (TS) rules of usage for concurrent inoperability as shown in TS Example 1.3-3. The licensee entered this issue into their corrective action program (CAP) as PIP M-12-4157.

The performance deficiency (PD) was determined to be more than minor because it was associated with the Human Performance attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone objective in that it impacted the licensee's ability to evaluate and ensure operator performance. The significance determination was performed in accordance with Manual Chapter 0609, Appendix I, and determined to be of very low safety significance (Green). The cause of the finding was directly related to the cross-cutting aspect of personnel training and qualifications in the Resources component of the cross-cutting area of Human Performance, in that the licensee failed to ensure the quality of the operating tests used to evaluate the knowledge, skills, abilities, and training provided to operators to assure nuclear safety. [H.2(b)]

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

**Significance:**  Aug 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to perform required extent of condition assessments for quick cause evaluations in accordance with McGuire's quality assurance program**

•Green. A finding of very low safety significance and associated non-cited violation of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, was identified by inspectors for the licensee's failure to perform required extent of condition assessments for Quick Cause Evaluations (QCE) in accordance with McGuire's Quality Assurance Program. Specifically, Nuclear System Directive (NSD) 212, "Cause Analysis," requires in part that an Extent of Condition review shall be conducted as soon as possible when a QCE is performed. One example included the licensee's failure to perform an extent of condition assessment for a QCE of the safety-related NSW system. To address this issue, the license entered PIP M-12-6309 into their CAP.

The failure to perform the required extent of condition assessments for QCE in accordance with NSD 212 was considered a performance deficiency. The finding was determined to be more than minor because it adversely affected the mitigating systems cornerstone objective of ensuring the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences. Specifically, the licensee's failure to evaluate events for extent of condition applicability for the Nuclear Service Water issue (PIP M-12-0106) was not only a failure to follow a procedure requirement, but allowed the station to be susceptible to the existence of similar discrepancies in other systems, units, organizations, programs, processes, components, or trains. The finding was determined to be of very low safety significance (Green) because the finding did not result in a loss of system safety function or a loss of safety function of a single train for greater than allowed technical specification allowed outage time. The team identified a cross-cutting aspect in the work practices component of the Human Performance area, because the licensee did not define and effectively communicate expectations regarding procedural compliance and personnel did not follow procedures [H.4(b)]. (Section 4OA2.a(3))

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

---

## **Barrier Integrity**

---

## **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

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

Identified By: NRC

Item Type: FIN Finding

### PI&R Summary

The inspectors concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The licensee was generally effective at identifying problems and entering them into the corrective action program (CAP) for resolution. Generally, prioritization and evaluation of issues, formal root cause evaluations for significant problems, and corrective actions specified for problems were consistent with licensee CAP procedures. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner.

The inspectors determined that audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, plant operations, and cause evaluations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.

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

Last modified : September 03, 2013