

Farley 1

3Q/2013 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to implement fire protection program requirements

A self-revealing NCV of TS 5.4.1.c, "Fire Protection Program Implementation," was identified, because the licensee failed to implement written procedures to cover activities of the Fire Protection Program as documented in Appendix 9B of the updated final safety analysis report (UFSAR). As a result, an inadvertent carbon dioxide (CO2) discharge occurred on August 3, 2013 which required evacuation of the Unit 1 auxiliary building and an Alert Emergency declaration. The licensee completed the low pressure (LP) CO2 system maintenance, replaced the hazard pilot valve and verified it was left in the correct position. Performance of licensee procedure FNP-0-FSP-57.0 was planned for completion per technical evaluation (TE) 704305. This issue was captured in the licensee's CAP as CR 682967. This violation is applicable to Unit 1.

Failure to verify proper operation of hazard pilot valve N1V43G076 following maintenance as required in work order (WO) SNC 54604 was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the protection against external events (fire) attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the inadvertent discharge of CO2 into the Unit 1 auxiliary building resulted in an atmosphere that was determined to be an immediate danger to life and health (IDLH). Respirators would be required in this area which would cause an undue burden on the operators' ability to respond to events requiring manual operator actions. The inspectors evaluated this finding using the NRC's SDP and IMC 0609 Attachment 4, "Initial Characterization of Findings." Because the finding involved a fixed fire protection system, an evaluation using IMC 0609 Appendix F, Attachment 1, "Fire Protection SDP Worksheet," was required. The finding screened to Green because it would not affect the ability to reach and maintain safe shutdown conditions. The inspectors concluded that the time critical operator actions needed to support safe shutdown could be achieved with the use of respirators and operators are properly trained and qualified to use respirators. The cause of this finding was directly related to the cross-cutting aspect of maintenance scheduling in the work control component of the human performance area, because the licensee deferred the performance of procedure FNP-0-FSP-57.0 which would have identified the hazard pilot valve was partially open following completion of maintenance on the valve. [H.3(b)]. (Section 40A2.2)

Inspection Report# : [2013004](#) (*pdf*)

Significance:  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform 50.59 Evaluation for Replacement of TDAFW Pump Governor

Green. An NRC-identified Green finding and associated Severity Level IV, NCV, of 10 CFR 50.59(d)(1), were identified for the failure to perform an evaluation of a turbine-driven auxiliary feed water (TDAFW) pump governor modification on Units 1 and 2 against the criteria in 10 CFR 50.59(c)(2), as directed by site procedure NMP-AD-010 and the self-imposed industry guidelines in Nuclear Energy Institute document NEI 96-07, Revision 1, for the implementation of 10 CFR 50.59. The licensee entered the issue in the corrective action program as condition report (CR) 606427 and addressed the operability of the TDAFW pumps. In addition, one of the corrective actions of the CR is the completion of the required 50.59 evaluation.

The licensee's failure to perform a 50.59 evaluation as required by 10 CFR 50.59(d)(1) was a performance deficiency. This performance deficiency was more-than-minor because it is associated with the design control 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 to prevent undesirable consequences (i.e., core damage). Specifically, the licensee did not fully demonstrate that the availability, reliability, and capability of the TDAFW pump would be maintained through the modification of the pump governor. Additionally, the failure to perform a 50.59 evaluation was determined to be more-than-minor in accordance with the guidance in the NRC Enforcement Manual for traditional enforcement violations because there was a reasonable likelihood that the change could require Commission review and approval prior to implementation. The inspectors evaluated the significance of the finding using Inspection Manual Chapter 0609, "Significance Determination Process (SDP)," and determined the finding was of very low safety significance (Green). In accordance with the NRC Enforcement Policy, the violation of 10 CFR 50.59 was determined to be a Severity Level IV violation because it resulted in a condition evaluated as having very low safety significance (i.e., Green) by the SDP. This finding has a cross cutting aspect in the decision making component of the human performance area because the most significant causal factor of the performance deficiency was that the licensee did not use conservative assumptions in the determination of whether the TDAFW governor modification introduced adverse effects that required a 50.59 evaluation. [H.1(b)].

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

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2012

Identified By: NRC

Item Type: FIN Finding

Failure to monitor for auxiliary building airborne radioactivity levels as described in the FSAR

The inspectors identified a Green finding for failure to meet the FSAR continuous online radiation monitor design bases as described in FSAR Section 12.2.4, Airborne Radioactivity Monitoring. Specifically, six of the nine continuous online radiation monitors, R-30 series, provided to monitor airborne radiation concentrations within select Unit 1 and Unit 2 Auxiliary Building locations have been out of service (OOS) for extended periods of time over the past two and half years. Further, no reviews were completed to evaluate the significance of the OOS monitors nor were compensatory sampling activities performed during the extended OOS periods. The licensee entered this issue

into their corrective action program as Condition Report (CR) 44407, and CR 463051, and implemented compensatory activities.

The inspectors determined that the failure to monitor airborne radioactivity levels as described in FSAR Section 12.2.4 was a performance deficiency. The finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of Plant Facilities/Equipment and Instrumentation and adversely affects the cornerstone objective of ensuring the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Inadequate monitoring of areas with the potential for airborne radioactivity could lead to worker contamination and increased exposure. The finding was assessed using the Occupational Radiation Safety Significance Determination Process (SDP). Based on the facts that this was not an ALARA planning issue, there were no overexposures nor substantial potential for overexposures, and the licensee's ability to assess worker dose was not compromised, the finding was determined to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Human Performance [H.2(d)] because the licensee did not ensure that equipment was adequate and available to assure nuclear safety. (Section 2RS5)

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

Significance: N/A Dec 31, 2012

Identified By: NRC

Item Type: VIO Violation

Deliberate Failure to Conduct Fire Watches

10 CFR 50.48, Fire Protection, requires that a licensee must have a fire protection plan that, in part, outlines the plans for fire protection, fire detection, suppression capability, and limitation of fire damage. Site Procedure FNP-0-SOP-0.4 requires that hourly fire watches be conducted for degraded fire barriers or increase in combustibles in an area. Contrary to the above, from September 2011 through December 2011, roving fire watch patrols assigned to monitor specific fire protection (FP) areas with degraded barriers for indication of the presence of a fire, in the non-radiological portions of the plant, failed to conduct hourly fire watch patrols as required by FNP-0-SOP-0.4.

AVs 2012008-01 and 2012008-02 are now VIO 2012008-01

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

Inspection Report# : [2013009](#) (*pdf*)

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