

## Farley 2

### 3Q/2013 Plant Inspection Findings

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## Initiating Events

**Significance:** G Sep 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to control transient combustible materials in the Unit 2 auxiliary building**

The NRC identified a non-cited violation (NCV) of Technical Specification (TS) 5.4.1.c, "Fire Protection Program Implementation," for failing to properly control combustible material in fire risk-significant areas without a continuous fire watch as required by FNP-0-SOP-0.4, "Fire Protection Program Administration Procedure" and FNP-0-ACP-35.2, "Flammable Material and Combustible Material Control." This issue was captured in the licensee's corrective action program (CAP) as condition reports (CRs) 669286, 669554 and 686872. The licensee immediately removed the combustible materials from the fire risk significant areas. This violation is applicable to Unit 2.

Storing transient combustibles in fire risk significant areas without establishing a continuous roving fire watch was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the protection against external factors (fire) attribute of the initiating events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown and power operations. Also, the finding was similar to example 4.k of Inspection Manual Chapter (IMC) 0612, Appendix E, for identified transient combustibles in a combustible free zone required for separation of redundant trains. The inspectors evaluated this finding using the NRC's SDP and IMC 0609 Attachment 4, "Initial Characterization of Findings." Because the finding involved a failure to adequately implement fire prevention and administrative controls for transient combustible materials, 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 due to the amount of combustibles identified combined with an hourly fire watch previously established in those areas. The cause of this finding was directly related to the cross-cutting aspect of procedural compliance in the work practices component of the human performance area because plant staff failed to comply with written procedures and posted instructions regarding storage of combustible materials in fire risk significant areas [H.4(b)]. (Section 1R05)

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

**Significance:** G Jun 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to properly maintain procedures to ensure reactor vessel head vent path was preserved**

Green. A self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4.1,"Procedures," was identified for the licensee's failure to establish procedures recommended in Regulatory Guide (RG) 1.33. Specifically, the licensee did not properly establish written procedures for maintaining a vent path of the unit 2 reactor vessel head. As a result of not maintaining a vent path during a refueling outage, the indicated reactor coolant system level did not match actual level and operator action was required to restore level to 128 feet, 6 inches. The licensee wrote condition report (CR) 632668 to document the event.

The failure to establish procedures to ensure an open vent path of the reactor vessel head when required was a

performance deficiency. This performance deficiency was more than minor because it was associated with the procedural quality attribute of the initiating events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown operations. The procedure quality attribute of the initiating event (IE) cornerstone was determined to be adversely affected because procedure FNP-2-SOP-1.11, "Reactor Coolant System Filling and Venting – Dynamic Method," did not provide instructions to establish a reactor vessel vent path as required by procedure FNP-2-UOP-4.1, "Controlling Procedure for Refueling." This resulted in an unplanned RCS level decrease to 127 feet, 6 inches when the licensee was controlling level at 128 feet, 6 inches. The significance of this finding was screened using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process" and IMC 0609, Appendix G, Attachment 1: "Phase 1 Operational Checklists for both PWRs and BWRs." The finding screened as Green, because it did not require a quantitative assessment per checklist 3 of the attachment and it did not represent an inadvertent loss of two feet of RCS inventory when not in midloop as described in Table 1 of Appendix G.

The finding was related to the cross-cutting aspect of human error prevention techniques (pre-job briefings) in the work practices component of the human performance area because the licensee failed to discuss the expected configuration of the reactor vessel head vent path to ensure a vent path was properly established as required [H.4(a)]. (Section 1R20)

A violation of very low safety significance that was identified by the licensee has been reviewed by the NRC. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This violation and corrective action tracking number are listed in Section 4OA7 of this report.

Inspection Report# : [2013003](#) (pdf)

## Mitigating Systems

**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*)

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## Barrier Integrity

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## Emergency Preparedness

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## 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*)

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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 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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