# McGuire 1
# 2Q/2014 Plant Inspection Findings

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## Initiating Events

**Significance:** G Mar 31, 2014
Identified By: Self-Revealing
Item Type: FIN Finding
**Failure to implement adequate design control measures for rod control power supply replacement resulting in reactor trip**
A self-revealing finding (FIN) was identified for the licensee's failure to implement adequate design control measures for the rod control power supply modification which resulted in the loss of 24VDC power in the 1AC rod control power cabinet.

The inspectors determined that the licensee's failure to implement adequate design control measures was more than minor because it affected the Design Control attribute of the Initiating Events Cornerstone and adversely affected the cornerstone objective, in that, the insufficient margin in the rod control power supply OVP function caused a multiple drop rod event which resulted in a reactor trip. This finding was determined to have very low safety significance (Green) 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. A cross-cutting aspect was not assigned because the performance deficiency does not reflect current licensee performance. (Section 4OA3)

Inspection Report# : 2014002 *(pdf)*

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## Mitigating Systems

**Significance:** G Jun 26, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
**Inadequately Sealed Safety Related Electrical Cabinet**
An NRC-identified NCV of 10 CFR Part 50 Appendix B, Criterion XVI, Corrective Action, was identified when the licensee failed to promptly identify a condition adverse to quality associated with the inadequate sealing for safety related cabinet 1FWPNRWLP (Unit 1 Refueling Water Storage Tank (RWST) Channel 4 Level Instrumentation loop). Specifically, the licensee did not identify that the seal around a cable bundle entering the top of 1FWPNRWLP had degraded to the point where it would no longer protect against water intrusion into the cabinet. The licensee placed this issue into their CAP as PIP M-14-05643 and took corrective action by replacing the seal. The inspectors determined that the failure to promptly identify a condition adverse to quality associated with the inadequate sealing of 1FWPNRWLP was a performance deficiency.

This performance deficiency was more than minor because it was associated with the equipment performance attribute of the Mitigating System Cornerstone and adversely affected the cornerstone objective of ensuring the capability of the automatic RWST swap over function to respond to initiating events to prevent undesirable consequences. Using IMC 0609, Significance Determination Process, Appendix A, Exhibit 2 - Mitigating Systems Screening Questions,

dated June 19, 2012, the inspectors determined this finding was of very low safety significance (Green) because the finding was not a deficiency affecting the design or qualification and did not represent an actual loss of system and/or function. The finding had a cross-cutting aspect of Procedure Adherence, as described in the Human Performance cross-cutting area because the licensee failed to adequately implement the walkdown process outlined in EDM-203 and promptly identify this degradation (H.8).
Inspection Report# : 2014007 *(pdf)*

**Significance:** G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to adequately control the use of self-extinguishing fire lids**
An NRC-identified NCV of the McGuire Unit 1 and Unit 2 Renewed Facility Operating License Condition 2.C.4, FPP, was identified for the licensee's failure to adequately control the storage of transient combustibles in waste receptacles equipped with self-extinguishing fire lids in accordance with the FPP requirements. The licensee took actions to correct all waste receptacles in the plant that were filled beyond the manufacturer's specification or had loosely fitted lids. This condition was placed in the licensee's corrective action program.

The licensee's failure to control the storage of transient combustibles in accordance with the requirements of NSD-313 was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Protection Against External Factors (Fire) and adversely affected the cornerstone objective in that the self-extinguishing function was not retained which could allow the spread of the fire and adversely affect mitigating system equipment in the area. The finding was determined to be of very low safety significance (Green) because it did not affect the ability of the reactor to reach and maintain cold shutdown conditions. A cross-cutting aspect was not assigned because the performance deficiency does not reflect current licensee performance. (Section 1R05.2)

Inspection Report# : 2014002 *(pdf)*

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## Barrier Integrity

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## 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** Jun 26, 2014
Identified By: NRC
Item Type: FIN Finding
**Biennial PI&R Summary**
The team concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The threshold for initiating Problem Identification Program entries (PIPs) in the corrective action program (CAP) was appropriately low, as evidenced by the types of problems identified and the number of PIPs entered annually into the CAP. However, the team did identify deficiencies in the areas of identification of problems, prioritization and evaluation of identified problems, and effectiveness of corrective actions. The team noted that the licensee's 2014 CAP audit results were in line with the team's observations and findings.
The inspectors determined that overall 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, and plant operations.
Based upon interviews conducted with plant employees from various departments and a review of the 2013 Safety Culture Assessment Report, the team determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.
Inspection Report# : 2014007 *(pdf)*

Last modified : August 29, 2014