

Diablo Canyon 2

3Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Appropriately Scope 230 KV Switchyard into the Maintenance Rule Monitoring Program

The inspectors identified a Green, non-cited violation of 10 CFR 50.65(b)(2) for the licensee's failure to appropriately scope the 230 kV switchyard in the Maintenance Rule monitoring program. Specifically, from the inception of the facilities' monitoring program through May 18, 2015, the licensee failed to properly scope or evaluate the 230 kV switchyard to include the entire switchyard up through the first inter-tie circuit breakers CB262 and CB282 into the Maintenance Rule program. Electrical faults within the 230 kV switchyard can cause loss of offsite power which is relied upon to mitigate accidents and cause an actuation of a safety-related systems, such as, emergency diesel generators, and should have been included into its Maintenance Rule program. This issue was entered into the licensee's corrective action program as Notifications 50702970 and 50703118.

The inspectors determined that the licensee's failure to scope the 230 kV offsite power source including the switchyard up through the first breakers from the transmission system into the Maintenance Rule program was contrary to the requirements of 10 CFR 50.65 and therefore a performance deficiency. The performance deficiency was determined to be more than minor because it is associated with the initiating events attribute of protections against external factors and adversely affected the cornerstone objective, in that, a 230 kV switchyard failure can upset plant stability and challenge critical safety functions during shutdown as well as power operations. Failure to monitor the performance or condition of 230 kV offsite power source (including the switchyard up through the first breakers from the transmission system) in a manner sufficient to provide reasonable assurance the offsite power was capable of fulfilling the intended functions affected the reliability of the plant equipment to perform their safety function. The inspectors determined if the 230 kV switchyard was properly scoped into the Maintenance Rule program the loss of offsite power due to the flash over event may have been prevented. However the direct cause of the event has been identified as untimely corrective actions associated with an ineffective corrective action program. As such, improper Maintenance Rule scoping was not the direct cause. Therefore, the inspectors determined the finding could be evaluated using the significant determination process in accordance using IMC 0609, Appendix A, "Significance Determination Process (SDP) for Findings At-Power," Exhibit 1, "Initiating Events Screening Questions." The inspectors determined that the finding was of very low safety significance (Green) because the finding was determined not to be the cause of the actual 230 kV failure such that all of the screening questions in Exhibit 1 could be answered "no." The inspectors determined that since the scoping of the switchyard systems had occurred more than 3 years ago, and the opportunity to reevaluate system scoping had not recently occurred, the finding did not represent current licensee performance and therefore a cross-cutting aspect was not assigned.

Inspection Report#: [2015002](#) (*pdf*)

Significance: G Jun 30, 2015

Identified By: Self-Revealing

Item Type: FIN Finding

High Voltage Insulator Flashover Resulted in Loss of 230 kV Offsite Power and Start of Emergency Diesel Generators

The inspectors reviewed a self-revealing, Green finding for the licensee's failure to adequately implement procedure OM7.ID1, Problem Identification and Resolution, to prevent a high voltage insulator flashover event in the 230 kV switchyard that occurred on October 31, 2014. Specifically, corrective actions from three previous root cause evaluations were not effective to prevent a loss of the 230 kV start-up power and subsequent auto start of all of the safety standby emergency diesel generators (EDGs). This issue was entered into the licensee's corrective action program as Notification 50699230.

The licensee's failure to adequately implement procedure OM7.ID1, Problem Identification and Resolution was a performance deficiency. The performance deficiency was more than minor because it was associated with the human performance attribute of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions. Specifically, this failure resulted in another high-voltage insulator flashover, which resulted in loss of 230 kV offsite startup power and activation of all safety-related EDGs, on October 31, 2014. In accordance with IMC 0609.04, "Initial Characterization of Findings," the inspectors determined that the impact of the finding on Unit 1 should be evaluated using Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," and further determined that this finding required a detailed risk evaluation by the regional senior risk analyst because the finding involved a partial loss of offsite power, a support system that contributes to the likelihood of an initiating event and affected mitigation equipment.

The risk analyst determined that, with the 230 kV system de-energized, any plant transient would result in a plant-centered loss of offsite power. Therefore, the risk analyst calculated the incremental conditional core damage probability for an exposure period of 9 hours to be 2.09×10^{-7} , which is lower than the 1×10^{-6} threshold in the significance determination process; this finding is of very low safety significance (Green) for Unit 1. In accordance with IMC 0609.04, "Initial Characterization of Findings," the inspectors determined that the impact of the finding on Unit 2 should be evaluated using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," because the finding pertained to operations, an event, or a degraded condition while the plant was shut down. Unit 2 was shutdown in a refueling outage when the event occurred on October 31, 2014. Because of the shutdown configuration of Unit 2, the loss of 230 kV support system did not impact the ability to continue to provide decay heat removal for the unit. Therefore, the analyst determined qualitatively that this finding is also of very low safety significance (Green) for Unit 2. This finding has a cross-cutting aspect of work management, in the area of human performance, for failing to implement a process of planning, controlling, and executing work activities such that nuclear safety is an overriding priority. Specifically the licensee failed to effectively plan and coordinate preventative maintenance strategies associated with root causes from previous high-voltage insulators flashover or failures since 2008 to prevent the loss of offsite 230 kV and the transient on October 31, 2014 [H.5].

Inspection Report# : [2015002](#) (pdf)

Mitigating Systems

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Document an Adequate Evaluation for a Change in Seismic Load Combination Methodology

The inspectors identified a Severity Level IV, Green, non cited violation of 10 CFR 50.59(d)(1) which requires, in part, that the licensee shall maintain records of changes in the facility, of changes in procedures, and of tests and experiments made pursuant to paragraph (c) of this section. These records must include a written evaluation which provides the bases for the determination that the change, test, or experiment does not require a license amendment pursuant to paragraph (c)(2). Specifically, the licensee changed the method for combining earthquake loads and loss

of coolant accident loads from the absolute summation method to square root sum of the squares (SRSS) method without sufficient justification to demonstrate the change did not require prior NRC approval.

The licensee's failure to implement the requirements of 10 CFR 50.59 and adequately evaluate changes to determine if prior NRC approval is required was a performance deficiency. The licensee entered the issue into the corrective action program as Notification 50811191. In accordance with the licensee's corrective action program, this issue will be addressed by the licensee through a re-evaluation of the methodology change and the required actions that need to be taken by the licensee will be implemented. Additionally, the licensee performed an operability determination for the affected structures, systems, and components that established a reasonable expectation for operability pending final resolution of the issue.

This performance deficiency was more than minor, and therefore a finding, because it was associated with the design control attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the reliability, availability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed to determine that use of SRSS in the Watts Bar safety evaluation report cited in the PG&E evaluation represented a change in a method of evaluation, in that the Watts Bar safety evaluation report was very narrow in scope and not appropriate for the intended application at Diablo Canyon. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the issue screened as having very low safety significance (Green) because it was a design or qualification deficiency that did not result in the inoperability of the system. Because this performance deficiency had the potential to impact the NRC's ability to perform its regulatory function, the inspectors also evaluated the performance deficiency using traditional enforcement. Since the violation is associated with a Green finding having very low safety significance, the traditional enforcement violation was determined to be a Severity Level IV violation, consistent with the example in paragraph 6.1.d(2) of the NRC Enforcement Policy. This finding had a cross cutting aspect in the area of human performance associated with design margins because individuals failed to ensure margins were carefully guarded and changed only through a systematic and rigorous process [H.6].

Inspection Report# : [2015003](#) (pdf)

Significance:  Jun 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Maintain Operator Licensing Examination Integrity

The inspectors reviewed a self-revealing, Severity Level IV non-cited violation of 10 CFR 55.49, "Integrity of Examinations and Tests," and an associated Green finding for the licensee's failure to provide adequate examination security measures during administration of the 2015 biennial requalification examination. On May 26, 2015, a licensed operator was able to obtain plant computer information that led to the discovery of specific plant events contained on the NRC-required annual operating test. The licensee entered this issue into the corrective action program as Notification 50704195 and retested the crew with a new scenario.

The failure of the licensee to provide adequate measures for examination security for the biennial requalification examinations was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it adversely affected the human performance attribute of the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using NRC Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 4, Tables 1 and 2 worksheets (issue date June 19, 2012); and the corresponding Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)," Flowchart Block #10 (issue date December 6, 2011), the finding was determined to have very low safety significance (Green). Although the 2015 finding resulted in a compromise of the integrity of biennial dynamic simulator examinations had no compensatory actions been taken, the equitable and consistent administration of the biennial dynamic simulator examination was not actually affected

by this compromise. The traditional enforcement violation was determined to be a Severity Level IV violation consistent with Section 6.4.d of the Enforcement Policy. This finding has a cross-cutting aspect in the resources component of the human performance cross-cutting area because the licensee failed to ensure the procedures are adequate to ensure nuclear safety [H.1].

Inspection Report# : [2015002](#) (*pdf*)

Significance:  Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Design Control for High-Energy Line Break Vent Flow Path

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” involving the licensee’s failure to ensure credited design features, such as flow vent paths, protect safety-related systems, from temperature and pressure effects of a high-energy line break (HELB) in the auxiliary building. Specifically, the licensee allowed obstruction of a credited flow path with acrylic glass plates not qualified in the original design and not verified to function under a HELB scenario. The licensee entered this issue into the corrective action program as Notifications 50697910 and 50698102, and took immediate actions to remove the acrylic glass plates from the vent path doors in the auxiliary building.

The performance deficiency was determined to be more than minor because it affected the Mitigating Systems Cornerstone attribute of Design Control and adversely affected the cornerstone objective of ensuring the reliability, availability and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee did not have adequate measures in place to ensure that qualified components were available to mitigate the consequences of a HELB in the auxiliary building. The finding screened as of very low safety significance (Green) because the finding did not affect the design or qualification of mitigating structures, systems, and components; the finding did not represent a loss of system and/or function; the finding did not represent an actual loss of a function of a single train for greater than the technical specification (TS) allowed outage time; the finding did not represent an actual loss of a function of one or more non-TS trains of equipment; and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding was not assigned a cross-cutting aspect since the performance deficiency is not indicative of current plant performance.

Inspection Report# : [2015002](#) (*pdf*)

Significance:  Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Provide Adequate Design Review of Emergency Diesel Generator 2-3

The inspectors documented a self-revealing violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for the licensee’s failure to ensure that design control measures shall provide for verifying or checking the adequacy of design by the performance of design reviews and design control measures shall be applied to items such as maintenance, and repair; and delineation of acceptance criteria for inspections and tests. Specifically, the licensee failed to identify that a terminal block cover was removed from the existing diesel generators as corrective actions following previous emergency diesel generator 1-2 and 1-1 trips and incorporate this modification into the design and installation of emergency diesel generator 2-3.

The licensee’s failure to identify that a terminal block cover was removed from the existing diesel generators as corrective actions following previous emergency diesel generator 1 2 and 1 1 trips, and incorporate this modification into the design and installation of emergency diesel generator 2 3, 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 objective and adversely affected the objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the

performance deficiency adversely affected the diesel generator's capability to operate loaded for the technical specification required time. Using Inspection Manual Chapter 0609, Attachment 04, "Initial Characterization of Findings," and Appendix A, "The Significance Determination Process For Findings At-Power," dated July 1, 2012, the inspectors determined that the finding could not be screened as Green, or very low safety significance due to loss of a function of a single train for greater than its technical specification outage time. As a result, a detailed risk evaluation was performed by a senior risk analyst. The detailed risk evaluation resulted determined that the findings was Green, or very low safety significance.

This finding did not have a cross-cutting aspect because the most significant contributor did not reflect current licensee performance.

Inspection Report# : [2015001](#) (*pdf*)

Significance: **G** Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Implement Fire Protection Program

The inspectors identified a non-cited violation of the licensee's approved fire protection program as defined in Diablo Canyon Unit 2 Facility Operating License Condition 2.C(4) for failure to effectively implement the fire protection program. Specifically, the inspectors identified that maintenance personnel inappropriately disabled a fire hose reel credited for fire protection of the mechanical penetration area. The licensee entered the condition into the corrective action program as Notifications 50663810 and 50663589.

The failure to effectively implement all fire prevention controls and processes as required in the approved fire protection program was a performance deficiency. The performance deficiency was more than minor because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. The inspectors evaluated this finding using Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process." The finding affected fixed fire suppression systems. Using Inspection Manual Chapter 0609, Appendix F, Attachment 1 "Fire Protection SDP Phase 1 Worksheet," the deficiency affected a fixed fire suppression system and the finding affects only a manually actuated suppression system for an area which is accessible by the fire brigade; therefore the finding was of very low safety significance (Green). This finding had a cross cutting aspect in the area of human performance associated with the work management component, because the organization did not implement a process of planning, controlling and executing work activities such that nuclear safety is the overriding priority [H.5]. (Section 1R05)

Inspection Report# : [2014005](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Significance: **W** Oct 17, 2014

Identified By: NRC

Item Type: VIO Violation

Failure to Obtain Prior Approval for a Change Which Decreased the Effectiveness of the Emergency Plan

(Initial Entry)

The inspectors identified an apparent Severity Level III violation of 10 CFR 50.54(q) and an associated preliminary finding of low to moderate significance (White) for failing to obtain prior approval for an emergency plan change which decreased the effectiveness of the emergency plan. Specifically, on November 4, 2005, without approval from the NRC, the licensee removed instructions in emergency plan implementing procedures for making protective action recommendations for members of the public on the ocean within the 10-mile emergency planning zone, decreasing the plan's effectiveness.

The plan change, as implemented, resulted in a failure to meet the planning standard requirement of 10 CFR 50.47(b) (10) to develop and have in place procedures for the issuance of protective action recommendations (PARs) for the plume exposure pathway emergency planning zone, specifically, for areas of the ocean. This change constituted a decrease in effectiveness of the plan and, therefore, implementing the change without prior approval from the NRC is a performance deficiency. This performance deficiency is more than minor because it impacts the Emergency Response Organization performance attribute of the Emergency Preparedness Cornerstone objective to ensure that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Using the examples in Table 5.10-1, "Significance Examples § 50.47(b)(10)," of Appendix B to Inspection Manual Chapter 0609, "Emergency Preparedness Significance Determination Process," the inspectors concluded that this finding represents a degradation of the licensee's risk-significant planning standard function. The required planning standard function was degraded because the licensee's procedures did not direct the licensee to issue appropriate protective action recommendations to cover affected areas over the ocean within 5 to 10 miles of the site. The planning standard function was degraded, rather than lost, because default procedural actions of local governments would have resulted in effective protective actions for affected areas within 5 miles of the site. The finding does not present an immediate safety concern because, even without appropriate protective action recommendations from the licensee, the local governments would have ordered adequate protective actions for members of the public in the affected areas. No cross-cutting aspect is proposed as this performance deficiency occurred in 2005 and is not indicative of current licensee performance.

(First Update)

The NRC concluded that the violation is appropriately characterized as Severity Level III, and that the associated finding is appropriately characterized as White, meaning a finding of low to moderate safety significance.

Inspection Report# : [2014502](#) (pdf)

Inspection Report# : [2015502](#) (pdf)

Occupational Radiation Safety

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Secure a Locked High Radiation Area

The inspectors reviewed a self-revealing non-cited violation (NCV) of Technical Specification 5.4.1(a), "Procedures," for failure to secure a locked high radiation area. Specifically, the padlock on the Letdown Filter 1-1 locking bar was found unlocked. Upon discovery, the licensee guarded the area until properly secured. This issue was entered into the licensee's corrective action program as Notification 50710852.

The failure to secure a locked high radiation area was a performance deficiency. The performance deficiency was more than minor because, if left uncorrected, it had the potential to lead to a more significant safety concern. Specifically, failure to adequately secure the locked high radiation area could result in unintended exposure to high

levels of radiation. Using Inspection Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated August 19, 2008, the inspectors determined the violation was of very low safety significance (Green) because: (1) it was not an as low as reasonably achievable (ALARA) finding, (2) there was no overexposure, (3) there was no substantial potential for an overexposure, and (4) the ability to assess dose was not compromised. The finding had an avoid complacency cross-cutting aspect, in the area of human performance, because individuals failed to recognize and plan for the possibility of mistakes, even while expecting positive outcomes. Specifically, licensee personnel failed to ensure that the padlock was secured after completing the task [H.12].

Inspection Report# : [2015003](#) (*pdf*)

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Control Access to a High Radiation Area With Dose Rates Greater Than 1 Rem/Hour

The inspectors reviewed a self-revealing non-cited violation of Technical Specification 5.7.2 because the licensee failed to control access to a high radiation area with dose rates greater than 1 rem/hour. A radiation protection technician assumed responsibility for guarding the area and reestablished compliance with technical specification requirements. Licensee representatives documented the occurrence in the corrective action program and performed an apparent cause evaluation.

The failure to control access to a high radiation area with dose rates greater than 1 rem/hour is a performance deficiency. The requirement not met was Technical Specification 5.7.2. The significance of the performance deficiency was more than minor because, if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern if workers had entered an uncontrolled high radiation area and received unintended radiation dose. The Occupational Radiation Safety Cornerstone was affected; therefore, the inspectors used Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," August 19, 2008, to determine the significance of the violation. The violation had very low safety significance because: (1) It was not an as low as is reasonably achievable (ALARA) finding, (2) there was no overexposure, (3) there was no substantial potential for an overexposure, and (4) the ability to assess dose was not compromised. This violation has a cross cutting aspect in the human performance area, associated with avoiding complacency, because individuals did not recognize and plan for the possibility of mistakes, latent issues, and inherent risk and did not implement appropriate error reduction tools [H.12]. (Section 2RS1)

Inspection Report# : [2014005](#) (*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

Last modified : December 30, 2015