

Perry 1

3Q/2015 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Operating Procedure for Diesel Generator Building Ventilation System

The inspectors identified a finding of very low safety significance and associated non-cited violation (NCV) of Title 10 of the Code of Federal Regulations Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the licensee’s failure as of July 8, 2015, to establish and maintain an adequate procedure for operation of the Diesel Generator Building Ventilation System (DGBVS). Specifically, the DGBVS operating procedure did not ensure that diesel room temperature would remain below limits during testing.

The failure to establish and maintain an adequate procedure was a performance deficiency and resulted in the Division 2 Diesel Generator room temperatures exceeding specified limits. The performance deficiency was more than minor, and thus a finding, because it was associated with the equipment performance 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. The inspectors determined that the finding was of very low safety significance because the finding is a deficiency affecting the design or qualification of a mitigating structure, system, and component (SSC) that maintained its operability. This finding has a cross-cutting aspect in the area of human performance, design margins, because the licensee did not incorporate the degree of redundancy specified in the Updated Safety Analysis Report for DGBVS into the applicable operating procedures (H.6).

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

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Properly Implement Steps Outlined in a Technical Specification Surveillance Procedure

A finding of very low safety significance and associated NCV of Technical Specification (TS) 5.4.1., “Procedures,” was self-revealed on August 5, 2015, when an unexpected isolation of the reactor core isolation cooling (RCIC) system occurred as a result of the licensee’s failure to properly implement the steps outlined in TS Surveillance Procedure, SVI–E31–T5395B, “RCIC Steam Line Flow High Channel Functional for 1E31–N684B.” Specifically, during performance of the surveillance, several steps were marked as not applicable that were applicable to prevent the isolation of the RCIC system. As a result, the licensee failed to lift leads as required by the procedure and the RCIC steam supply inboard isolation valve then closed when the isolation trip signal was applied during the test. The licensee took immediate actions to restore system operability and availability and conducted a human performance event response investigation. A standing order for both Operations and Instrumentation and Controls personnel was initiated addressing interim actions for control room surveillance performance and to reinforce maintenance

fundamentals and human performance behaviors.

The licensee's failure to properly implement the steps in the procedure was a performance deficiency that was determined to be more than minor, and thus a finding, because it was associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance because it did not represent an actual loss of function of one or more non-Technical Specification trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule program for greater than 24 hours. This finding has a cross-cutting aspect in the area of human performance, avoid complacency, for failing to recognize and plan for the possibility of mistakes, and for failure to implement appropriate error reduction tools, such as proper self-checks and peer checks, which resulted in an isolation of the RCIC system (H.12).

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

Significance:  Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

FAILURE TO INITIATE A TRANSIENT COMBUSTIBLE PERMIT

The inspectors identified a finding of very low safety significance and associated NCV of Perry Operating License Condition 2.C(6) for failure to follow the site Fire Protection Program. Specifically, a large quantity of material from the previous space utilized as the Diesel Maintenance Shop had been placed in the Diesel Generator (DG) Hallway to allow reconstruction of the space as a storage area for post-Fukushima equipment and awaiting completion of a new maintenance shop location. However, as of the inspectors' observations on February 3, 2015, the licensee failed to evaluate the impact of this large quantity of combustibles or to issue a transient combustible permit as required by Perry Administrative Procedure (PAP) 1910, Fire Control Program. This finding was entered into the licensee's corrective action program for resolution as Condition Report 2015-01280 and immediate corrective action was taken to evaluate and issue a transient combustible permit for the DG Hallway.

The failure to comply with the site Fire Protection Program was determined to be more than minor performance deficiency because it was associated with the protection against external factors (i.e., 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 failure to evaluate the fire impact of the stored material and process a permit for the excess combustible material stored in the DG Hallway fire area prevented the licensee from initiating compensatory fire watch actions, and additionally did not address the potential issue of restricting the availability of fire protection equipment in the area. The inspectors determined that the finding was of very low safety significance because the impact of a fire would have been limited to no more than one train of equipment important to safety. The finding has a cross-cutting aspect in the area of human performance, work management, in that the licensee work process did not provide for management of the risk commensurate to the work and the need for coordination with different groups or job activities, specifically fire safety personnel (H.5).

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

Significance:  Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

LIQUID PENETRANT TESTING PROCEDURE WAS NOT QUALIFIED FOR ITS FULL APPLICABILITY RANGE

The inspectors identified a finding of very low safety significance and associated NCV of Title 10 of the Code of

Federal Regulations (CFR) Part 50, Appendix B, Criterion IX, “Control of Special Processes,” for the licensee’s failure to properly qualify a non-destructive testing procedure in accordance with applicable codes. Specifically, a liquid penetrant testing procedure was not qualified for its full applicability temperature range in accordance with American Society for Mechanical Engineers (ASME) Code, Section V, “Non-Destructive Examination.” This finding was entered into the licensee’s corrective action program as Condition Report 2015–03175.

The failure to qualify a liquid penetrant testing procedure in accordance with ASME Section V was determined to be a more than minor performance deficiency because if left uncorrected, it has the potential to lead to a more significant safety concern. Specifically, since the liquid penetrant testing procedure was not qualified for its full applicability temperature range, liquid penetrant examinations would not be assured to detect flaws in the unqualified temperature range and as a consequence, the potential would exist for a rejectable flaw to go undetected, unknowingly impacting the operability of the inspected system. The inspectors determined the finding was of very low safety significance because it did not result in the loss of operability or functionality for any mitigating systems; thus, the inspectors answered “No” to the screening questions. The licensee completed a review of liquid penetrant examination records, and did not find an example where the procedure was implemented in the unqualified temperature range. The inspectors did not identify a cross-cutting aspect associated with this finding because it was not confirmed to reflect current performance due to the age of the performance deficiency. Specifically, the inadequate qualifications were performed more than 3 years ago.

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

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Unevaluated Preconditioning of Emergency Service Water Motor Operated Valves and Check Valves prior to conducting As-Found Inservice Surveillance Testing

The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion XI, “Test Control,” for the licensee’s unevaluated preconditioning, on October 15, 2014, of emergency service water (ESW) pump discharge motor-operated valves and check valves prior to performing as-found inservice testing (IST). This finding was entered into the licensee’s corrective action program for resolution as Condition Report 2014-15759.

The unevaluated preconditioning was a performance deficiency that was determined to be more than minor, and thus a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone, and adversely affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, unevaluated preconditioning of valves could mask their actual as-found conditions and result in an inability to verify their operability, as well as make it difficult to determine whether the valves would perform their intended safety function during an event. The inspectors determined that the finding was of very low safety significance because the finding was confirmed not to result in a loss of operability or functionality of the ESW system. The finding has a cross-cutting aspect in the area of human performance associated with the work management component because the licensee did not implement a process of planning, controlling, and executing work activities to prevent preconditioning of valves prior to testing (H.5).

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

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Procedure for Performing an Acceptable Technical Specification Required Channel Check

The inspectors identified a finding of very low safety significance and associated NCV of Technical Specification (TS) 5.4.1.a., “Procedures,” was identified for the licensee’s failure to establish and maintain a correct surveillance inspection procedure for redundant reactivity control system (RRCS) channel checks. The licensee entered the issue into the corrective action program as Condition Report 2014–17635 and took immediate actions for a missed surveillance in accordance with TS.

The inspectors determined that the failure to establish and maintain a correct surveillance procedure required by TS 5.4.1.a. was a performance deficiency and resulted in the licensee’s failure to perform a channel check that meets the TS definition of a channel check. The performance deficiency was determined to be more than minor, and thus a finding, because it was associated with the procedure quality 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 channel check surveillance procedure did not compare the channel indication and status to other indications or status derived from available independent instrument channels measuring the same parameter. The inspectors determined that the finding was of very low safety significance because the finding (1) did not affect a reactor protection system trip signal and the function of other redundant trips or diverse methods of reactor shutdown, (2) did not involve control manipulations that unintentionally added positive reactivity, and (3) did not result in a mismanagement of reactivity by operators. No cross-cutting aspect is assigned as this performance deficiency first occurred in 1986 and is not indicative of current licensee performance.

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

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Follow Licensee Procedure to Properly Screen and Evaluate Temporary Changes to Plant Facilities / Structures, Systems, or Components

The inspectors identified a finding of very low safety significance and associated NCV of Technical Specification 5.4.1.a, “Procedures,” for the licensee’s failure to implement the requirements of Nuclear Operating Business Practice (NOBP)–LP–4003A, “FENOC 10 CFR 50.59 User Guidelines.” This finding was entered into the licensee’s corrective action program for resolution as Condition Report 2015–00284.

The inspectors determined that the failure to complete a Regulatory Applicability Determination (RAD) specified in NOBP–LP–4003A was a performance deficiency. The performance deficiency was more than minor, and thus a finding, because it was associated with the procedure quality 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. The finding was determined to have very low safety significance because the finding: (1) was not a design or qualification issue confirmed not to result in a loss of operability or functionality; (2) did not represent an actual loss of safety function and/or system; (3) did not result in the loss of one or more trains of TS equipment; and (4) does not represent the loss of a non-TS train of equipment.

The finding has a cross-cutting aspect in the area of human performance associated with the change management component, in that leaders use a systematic process for evaluating and implementing change so that nuclear safety remains the overriding priority (H.3).

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

Barrier Integrity

Significance:  Aug 07, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Adequately Evaluate Damaged CRD Flange

The inspectors identified a finding of very low safety significance and an associated NCV of 10CFR50, Appendix B, Criterion III, "Design Control," for the licensee's failure to adequately evaluate a non-conforming safety-related component prior to returning it to service. Specifically, the inspectors identified that the licensee had misapplied a generic vendor evaluation on June 18, 2013, to evaluate the surface damage on control rod drive (CRD) 30-15 and therefore, failed to adequately evaluate the "Use As-Is" disposition on the damage to the flange surface prior to returning it to service. As part of the licensee's immediate corrective actions, the licensee performed a prompt operability determination of CRD 30-15 flange which adequately documented the basis for acceptance of "Use As-Is" for the flange.

Inspection Report# : [2015007](#) (*pdf*)

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

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