

South Texas 1

3Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Jul 04, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Follow Hurricane Plan Procedure to Secure Missile Hazards During Tropical Storm Bill

Inspectors identified a non-cited violation of Technical Specification 6.8.1.a for failure to follow Procedure OPGP03-ZV-0002, "Hurricane Plan," Revision 7. Specifically, on June 15 through 16, 2015, the licensee failed to remove loose trash and materials inside the protected area to protect against potential missile hazards in accordance with Data Sheet 3 of Procedure OPGP03-ZV-0002 in preparation for Tropical Storm Bill. The licensee has entered this issue into the corrective action program as Condition Report 15-17110.

The failure of the licensee to address and control potential missile hazards on site, on the Unit 1 mechanical auxiliary building roof, turbine deck, and around standby transformer 1 was a performance deficiency. Specifically, on June 16, 2015, the licensee failed to follow Data Sheet 3 of Procedure OPGP03-ZV-0002, "Hurricane Plan," Revision 7, to adequately secure potential missile hazards in preparation for Tropical Storm Bill. The performance deficiency was determined to be more than minor because it was associated with the protection against external factor attribute and adversely affected the Initiating Event Cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. Using NRC Inspection Manual 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," the inspectors determined the finding was of very low safety significance (Green) because it did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The inspectors determined the finding had a cross cutting aspect in the area of problem identification and resolution associated with resolution. Specifically, the licensee failed to take effective corrective action from previous NRC-identified instances in the past where the licensee had loose material and debris that could become a missile hazards during a severe weather event [P.3].

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

Mitigating Systems

Significance: G Jul 04, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Properly Check Design and Test Chiller Purge Check Valves

The inspectors documented a self-revealing, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to have adequate measures for the selection and review for suitability of application of parts that are essential to the safety related functions of structures, systems and components. Specifically, the licensee failed to properly inspect and test essential chiller condenser purge check valves during the station's commercial dedication process to ensure proper function in their safety-related application. The licensee has entered the issue into the corrective action program as Condition Report 15-4990 and has implemented corrective actions to

the technical evaluation that will adequately measure and test the purge check valve in the future.

The failure to properly inspect and test essential chiller condenser check valves during the station's commercial dedication process to ensure proper function in the safety-related application was a performance deficiency. This performance deficiency is more than minor because it adversely affected the equipment performance attribute of the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, on January 18, 2015, March 5, 2015, and March 21, 2015, the inadequately dedicated purge check valves resulted in a trip of the essential chiller, rendering the train inoperable and challenging plant operations. Using NRC Inspection Manual 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined the finding was of very low safety significance (Green) because it did not affect the design or qualification of the system, did not result in a loss of system function, did not represent a loss of function of a single train for greater than its technical specifications allowed outage time, and did not cause the loss of function of one or more non-technical specification trains of equipment designated as high safety-significance. The inspectors determined that the finding did not have a cross-cutting aspect because the main contributor to the cause of the performance deficiency occurred in 1993.

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

Significance:  Dec 31, 2014

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Identify a Condition Adverse to Quality on Emergency Diesel Generator

The inspectors documented a self-revealing non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to promptly identify and correct a condition adverse to quality following an unexpected alarm on the train A emergency diesel generator. Specifically, after receiving the, "E-5 Starting Air System Malfunction" alarm, the licensee did not identify the correct cause of the alarm or take the necessary action to ensure the operability and reliability of the emergency diesel generator. As a result, the train A emergency diesel generator was degraded for 20 days, and was later rendered inoperable and non-functional for approximately 26 hours when operators removed the only air start subsystem that remained unaffected from service. This issue was entered into the corrective action program as Condition Report 14-18639, and the cause was corrected.

Failure to identify the cause for the starting air system alarm and recognize that this degraded the starting function was a performance deficiency. This performance deficiency is more than minor because it affected the equipment performance attribute of the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to correctly identify and correct the cause of the "E-5 Starting Air System Malfunction" alarm resulted in the train A emergency diesel generator being degraded and later inoperable. Using NRC Inspection Manual 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the finding was determined to be of very low safety significance (Green) because it did not: 1) affect the design or qualification of a mitigating structure, system, or component; 2) represent a loss of system and/or function; 3) represent an actual loss of function of a single train for greater than its technical specification allowed outage time; and 4) represent an actual loss of function of one or more non-technical specification trains of equipment designated as having high safety-significance. This finding has a cross-cutting aspect in the area of problem identification and resolution associated with Evaluation because the licensee failed to thoroughly evaluate the issue to ensure that resolutions address the causes and extent of conditions commensurate with the safety significance. Specifically, the licensee's failure to fully evaluate the cause of the starting air system alarm, and as a result, failed to recognize and correct the out-of-position valve before it rendered the system inoperable [P.2].

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

Barrier Integrity

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

Significance: N/A Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Update the UFSAR for the Ultrasonic Feedwater Flow Measurement System

The inspectors identified a non-cited violation of 10 CFR 50.71(e), "Maintenance of Records, Making Reports," for the failure to update the Updated Final Safety Analysis Report with information on the installation and use of the ultrasonic feedwater flow measurement system to control reactor power and calibrate nuclear instruments, which was installed in both units by the end of 1999. This violation was entered into the corrective action program as Condition Report 15-420.

The failure to update the Updated Final Safety Analysis Report, as required by 10 CFR 50.71(e), with a description of the ultrasonic feedwater flow measurement system was a performance deficiency. The inspectors determined that this performance deficiency was not more than minor. However, because it had the potential to impact the NRC's ability to perform its regulatory oversight function, the inspectors assessed more the significance of the violation using traditional enforcement. Using the NRC Enforcement Policy to evaluate the significance, the violation was determined to be a Severity Level IV violation in accordance with Section 6.1.d.3, since the lack of information in the Updated Final Safety Analysis Report was not used to make an unacceptable change to the facility or procedures. Cross-cutting aspects are not assigned to traditional enforcement violations.

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

Significance:  Dec 18, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Perform Proper Material Package Searches to Ensure Identification Prior to Entry into Protected Area

The team identified a non-cited violation of 10 CFR 73.55(h)(3)(i) for the failure to properly search personnel items (lunch boxes, briefcases, packages) before granting access to protected areas. Specifically, security personnel did not follow Security Instruction 2101, "Access Control," by allowing owners of packages to manipulate their packages when officers needed to search those packages for contraband prior to gaining entry into the protected area. The licensee entered the issue into the corrective action program as Condition Report 14-22811, developed, and reviewed a pre-job brief specifically for search train requirements with every oncoming officer, and covered management expectations and procedure details at all shift turnovers.

The failure to follow Security Instruction 2101 "Access Control," requirements by allowing the owners (non-security officers) to manipulate those packages that needed to be hand inspected when x-ray inspection reveals complex images or suspicious or unidentifiable images was a performance deficiency. The performance deficiency is more than minor because it was associated with the Access Control attribute and adversely affected the Safeguards/Security cornerstone objective to provide assurance that the licensee's security system uses a defense in-depth approach and can protect against the design basis threat of radiological sabotage from external and internal threats, and therefore a finding. The finding adversely affected the cornerstone objective because it could have resulted in undetected weapons or contraband being taken into the protected and vital areas.

Using the Physical Protection Significance Determination Process, the inspector determined that the cumulative total for the finding was two points. This was calculated by factoring the impact area (Vital Area) against Tier I element 71130.02-02.02(c) Search Activities, under the Access Control attribute. Because the calculated point total did not exceed the range for a Green determination (zero to six points), the inspector determined the finding to be of very low security significance. The inspectors determined that this finding has a cross-cutting aspect in the human performance area associated with complacency in that security force personnel did not implement appropriate error reduction tools due to the repetitive nature of the search train activities and the expectation of successful outcomes H.12.

Inspection Report# : [2014010](#) (*pdf*)

Last modified : December 15, 2015