

Summer 3Q/2016 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Prescribe Work Instructions for a Temporary Repair on a Safety-Related Component

Green. The inspectors identified a Green, non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," involving the failure to prescribe instructions for a temporary repair of the safety-related 'C' component cooling water (CCW) pump outboard bearing. The licensee entered condition report, CR-16-04576, in their corrective action program for appropriate response.

The inspectors determined that the failure to prescribe documented work instructions of a type appropriate to the circumstances for the temporary repair of the 'C' CCW pump outboard bearing was a performance deficiency (PD). The inspectors reviewed IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, and determined that the PD was more than minor and therefore a finding because it impacted the Mitigating Systems Cornerstone by adversely affecting the cornerstone objective to ensure in part the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the design control attribute was impacted because not prescribing instructions that follow vendor instructions for temporary repairs on the safety-related pump resulted in improper repairs causing reasonable doubt in operability. The inspectors evaluated the finding in accordance with IMC 0609, "Significant Determination Process," Attachment 4 and Appendix A, and determined that the finding was of very low safety significance, Green, because it did not represent an actual loss of a safety-related train since the 'C' CCW pump was operable but degraded. The inspectors reviewed IMC 0310, "Aspects Within Cross Cutting Areas," dated December 4, 2014, and determined the cause of this finding involved the cross-cutting area of Human Performance and the aspect of resources, H.1, because the licensee failed to ensure instructions were adequate and available to support nuclear safety-related work. (Section 40A2.2)

Inspection Report# : [2016003](#) (*pdf*)

Significance:  Apr 29, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Adequately Manage Risk of Maintenance Activities Following Risk Model Updates (Section 1R13)

Green. The inspectors identified a Green, non-cited violation (NCV) of 10 CFR 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," involving the licensee's failure to develop and implement specific risk management actions (RMAs) for a yellow risk condition associated with solid state protection system (SSPS) surveillance testing. The issue was entered into the licensee's corrective action program (CAP) as condition report (CR)-16-02504.

The inspectors identified a performance deficiency (PD) for the failure to manage the increase in risk associated with 'A' train SSPS surveillance testing which was indicative of the lack of programmatic requirements for assessing and managing risk subsequent to equipment out of service (EOOS) model updates. The inspectors reviewed inspector manual chapter (IMC) 0612, Appendix B, "Issue Screening," dated September 7, 2012, and determined that the PD was more than minor and therefore a finding because (1) it was associated with the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure in part the availability of systems that respond to initiating events to prevent undesirable consequences, and (2) if left uncorrected the PD would have the potential to lead to a more significant safety concern. Specifically, the failure to manage the increase in risk jeopardizes the availability of remaining safety systems to combat the consequences of an initiating event. The inspectors reviewed IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," dated May 19, 2005, and determined that the finding was of very low safety significance, Green, because the incremental core damage probability (ICDP) for the SSPS surveillance test was less than 1E-6. The inspectors reviewed IMC 0310, "Aspects Within Cross Cutting Areas," dated December 4, 2014, and determined that this finding had a cross-cutting aspect in the area of Work Management (H.5), because the licensee did not develop specific RMAs for a yellow risk condition which was indicative of the lack of programmatic requirements for assessing and managing risk subsequent to EOOS model updates. (Section 1R13)

Inspection Report# : [2016002](#) (*pdf*)

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Implement Adequate Administrative Controls Following a Departure from NFPA 80-1973 and Provide NRC Staff Complete and Accurate Information

The inspectors identified a Severity Level IV, non-cited violation (NCV) of 10 CFR 50.9(a), "Completeness and accuracy of information," and an associated Green non-cited violation of V.C. Summer, Operating License Condition 2.C.(18) for a NFPA 80-1973 code deviation that was not discussed in the licensee's NFPA 805 license amendment request (LAR), and would result in adversely affecting the ability to achieve and maintain safe shutdown in the event of fire because the associated engineering evaluation relied on inadequate administrative controls to ensure the associated replacement doors in the intermediate building, DRIB/105A&B, were kept closed as a basis for not following NFPA 80-1973 which required the fire doors be self-closing. The licensee entered the violations into their corrective action program as condition reports CR-15-04027 and CR-16-00242 respectively.

The inspectors identified a reactor oversight process (ROP) performance deficiency (PD) for the failure to provide adequate administrative controls to allow departure from NFPA 80-1973 requirements, which resulted in replacement of a self-closing fire door with two non-self-closing fire doors, DRIB/105A&B, that adversely affected the ability to achieve and maintain safe shutdown in the event of fire since they were found open on multiple occasions. The inspectors reviewed Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," dated September 7, 2012, and determined the ROP PD was more than minor because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and the related attribute of protection against external factors such as fire. The inspectors used IMC 0609, "Significant Determination Process," Appendix F, "Fire Protection Significance Determination Process," Attachment 1, dated September 20, 2013, to perform a Phase 1 analysis and determined that the ROP finding was of very low safety significance (Green) based on the response for Question 1.4.3.A in which the combustible loading on both sides of DRIB/105A&B was less than 120,000 BTU/ft². Furthermore, the inspectors determined that the associated fire zone area (IB 7) with multiple equipment trains used a pre-action sprinkler system and automatic fire detection.

The inspectors also determined that the licensee's failure to include the departure from NFPA 80-1973 in their NFPA 805 license amendment request was a violation of 10 CFR 50.9(a). Because this violation of 10 CFR 50.9(a) had the

potential to impact the NRC's ability to perform its regulatory function, the inspectors evaluated this violation using traditional enforcement (TE). Since the TE violation is associated with a Green ROP violation, and the misinformation was identified after the NRC relied on it for issuing a previous operating license amendment, the TE violation was determined to be a Severity Level IV violation, consistent with the language of the NRC Enforcement Policy, Section 2.3.11, "Inaccurate and Incomplete Information." The inspectors reviewed IMC 0310, "Aspects Within Cross Cutting Areas," dated December 14, 2014, and determined the cause of this finding involved the cross-cutting area of problem identification and resolution, P.3, because the licensee failed to ensure that adequate administrative controls were in place after the fire doors were found open multiple times. (Section 4OA5)

Inspection Report# : [2016001](#) (pdf)

Barrier Integrity

Significance: G Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Accomplish Procedure for Diagnostic Testing Resulting in Valve Failures (Section 4OA2.2)

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, which requires in part that activities affecting quality shall be accomplished in accordance with procedures. Specifically, the licensee failed to accomplish preventative maintenance diagnostic testing in accordance with their station administrative program procedure, SAP-160, "Motor Operated Valve Program," Revision 1, to identify degradation of a torque switch that led to two failures of stroke time testing of 'A' train reactor building spray (SP) sump isolation valve, XVG03005A-SP. This also resulted in a loss of safety function involving reactor building spray. The licensee entered the problem into their corrective action program as condition report, CR-15-00541.

The inspectors identified a performance deficiency (PD) for the failure to accomplish the requirements of SAP-160 leading to two failures of XVG03005A-SP. The inspectors reviewed IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, and determined the PD was more than minor because it adversely impacted the barrier integrity cornerstone objective to provide reasonable assurance that the reactor building or containment protects the public from radionuclide releases caused by accidents or events and the related attribute of structures, systems and components (SSC) performance. Specifically, the licensee failed to perform preventative maintenance diagnostic testing required by SAP-160 to identify degradation of a torque switch for XVG03005A-SP. The inspectors used IMC 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," dated July 1, 2012, and IMC 0609, Appendix H, "Containment Integrity Significance Determination Process," dated May 6, 2004, and determined the finding was of very low safety significance or Green, because the finding did not represent a significant impact to Large Early Release Failure. The inspectors reviewed IMC 0310, "Aspects Within Cross Cutting Areas," dated December 4, 2014, and determined the cause of this finding involved the cross-cutting area of problem identification and resolution and the aspect of evaluation, P.2, because the licensee failed to thoroughly evaluate the failures of XVG03005A-SP to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. (Section 4OA2.2)

Inspection Report# : [2015004](#) (pdf)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Meet HRA Entry Requirements (Two Examples)

Green. The inspectors identified two examples of a Green, self-revealing, non-cited violation (NCV) of Technical Specification (TS) 6.12.1, "High Radiation Area." TS 6.12.1 requires that entries into high radiation areas (HRAs) be controlled with issuance of a radiation work permit (RWP) and that individuals entering these areas be made knowledgeable of the dose rates. Contrary to that, on two separate occasions, workers made entries into HRAs without being issued an appropriate RWP and without being knowledgeable of area dose rates. Specifically, on March 28, 2016, a worker tagging a pump on the auxiliary building (AB) 400-01 slab entered a HRA without the required radiological briefing and appropriate RWP. Also, on April 18, 2016, a worker performing dry cask welding operations in the fuel handling building entered a HRA without the required radiological briefing and appropriate RWP. The licensee entered these events into their corrective action program as condition reports CR-16-01528 and CR-16-01863.

This finding was more than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of Human Performance and adversely affects the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The finding was not related to As Low As Reasonably Achievable planning, nor did it involve an overexposure or substantial potential for overexposure and the ability to assess dose was not compromised. Therefore, the finding was determined to be of very low safety significance (Green). This finding involved the cross-cutting aspect of Avoid Complacency (H.12) because in both examples there were repostings, radiation areas were upgraded to HRAs due to changing radiological conditions, and prior to entry the workers failed to stop and get updated conditions and to adhere to the postings.

Inspection Report# : [2016003](#) (*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 08, 2016