Millstone 2
4Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Aug 01, 2014
Identified By: NRC
Item Type: FIN Finding
Inadequate Implementation of Dominion's Design Change Process
The NRC identified a finding of very low safety significance (Green), in that Dominion did not ensure correct implementation of their design change process procedure when establishing licensing basis requirements for removal of the SPS. Specifically, Dominion did not correctly evaluate the impact of removing the system on the requirements of General Design Criterion (GDC) 17 and did not address the failure mechanism of this new design in the design change documents, as required by their design change procedure. Dominion entered this issue into the corrective action program for resolution (CR 553967 and CR 551068).
The team determined that Dominion's failure to implement their design change process procedure was a performance deficiency. This performance deficiency was more than minor because it was associated with the design control attribute of the Initiating Events Cornerstone and affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown and power operations. The team performed a risk screening in accordance with IMC 0609, Appendix A, "Significance Determination Process for Findings At-Power," using Exhibit 1, "Initiating Events Screening Questions," Section C, "Support System Initiators." The answer to the question in Section C would be NO, because the finding did not increase the likelihood of a loss of two transmission lines with one line out of service (OOS), and affect mitigation equipment. The team determined that this finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence, because the design change process procedure was not adequately followed, in that the impact of the change on the current design basis and licensing bases was not evaluated correctly [H.8]
Inspection Report# : 2014011 *(pdf)*

Mitigating Systems

Significance: G Sep 30, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Review Standing Orders
The inspectors identified a Green NCV of Technical Specification (TS) 6.8.1.a, for Dominion's failure to implement procedures as required by Regulatory Guide 1.33, Revision 2, Appendix A.1, "Administrative Procedures", during the performance of watch turnover. This resulted in multiple operators across multiple crews in both Unit 2 and 3 standing watch without performing a review of the applicable standing orders for up to 4 months from March to July 2016. Dominion entered the condition in their corrective action program (CAP) as condition report (CR)1042287.

The inspectors determined that the finding was more than minor because if left uncorrected the performance deficiency could lead to a more significant event. Specifically, the operators did not review TS amendments, emergency action level classifications, emergency operating procedures, and plant computer issues impacting the

plant prior to taking watch. Without reviewing the standing orders to understand the information contained within, operators could potentially take improper actions to control the plant during evolutions and abnormal conditions. The finding was determined to be of very low safety significance (Green) because it did not affect design or qualification of a mitigating structure, system, and component (SSC), did not represent a loss of system function, and did not involve external event mitigation systems. The inspectors determined that the finding has a cross-cutting aspect in the Human Performance cross-cutting area associated with Field Presence, where leaders are commonly seen in the work areas of the plant observing, coaching, and reinforcing standards and expectations. Specifically, Dominion leadership observations in the control room or management review of monthly standing order audits could have discovered the deviation from standards and expectations.

Inspection Report# : 2016003 *(pdf)*

Significance: G Aug 11, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
Unaaproved OMA in Lieu of Meeting III.G.2 Fire Protection Requirements for Fire Area R-14, Lower 4kV Swithchgear Room and Cable Vault
The team identified a finding of very low safety significance (Green) involving a non-cited violation of Millstone Power Station, Unit 2, Renewed Facility Operating License Condition 2.C.(3) to implement and maintain in effect all provisions of the approved fire protection program as described in the Final Safety Analysis Report (FSAR). Specifically, Dominion failed to maintain the #2 steam generator (SG) atmospheric dump valve (ADV) free from fire damage, which may have affected the availability to maintain hot shutdown conditions from the main control room for a fire in Fire Area R-14, Lower 4.16kV Switchgear Room and Cable Vault. Dominion promptly entered this safe shutdown issue into their corrective action program as condition report (CR) 1043458. Immediate corrective actions included implementing compensatory measures in the form of fire watches for fire area R-14 that are being tracked by Reasonable Assurance of Safety (RAS) determination 3037040. Longer term corrective actions included submitting an exemption request to the NRC for use of a local operator manual action (OMA) to operate the #2 SG ADV in lieu of meeting fire protection requirements for fire area R-14. The team considered Dominion's immediate and longer term corrective actions appropriate.

The performance deficiency was more than minor because it affected the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to an external event to prevent undesirable consequences in the event of a fire. Specifically, the use of an OMA during post-fire safe shutdown is not as reliable as normal systems operation which could be utilized had the requirements of 10 CFR Part 50, Appendix R, Section III.G.2 been met and, therefore, prevented fire damage to credited components and/or cables, specifically the #2 SG ADV. The inspectors used IMC 0609, Appendix F, Fire Protection Significance Determination Process, Phase 1 and determined the reactor is able to reach and maintain a hot safe shutdown condition because the SG ADVs are used for transition to cold shutdown, therefore this finding was of very low safety significance (Green). This finding does not have a cross cutting aspect because the performance deficiency occurred greater than three years ago when the June 30, 2011 exemption request letter to the NRC was supplemented by letter on February 29, 2012, and is not indicative of current licensee performance.

Inspection Report# : 2016008 *(pdf)*

Significance: G Jul 22, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Take Corrective Action to Preclude Repetition of the Condition that Caused Premature Failure of a Battery Cell

The inspectors identified a finding of very low safety significance involving a NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action," for Dominion's failure to take corrective actions to preclude repetition of a significant condition adverse to quality. On February 26, 2014, Millstone Unit 2 station battery '201B,' cell 27, failed, which was screened as a significant condition adverse to quality in accordance with Dominion's procedures. Dominion evaluated the issue and identified three potential causes but did not institute corrective actions to preclude repetition. Dominion entered the issue into the corrective action program as condition report CR1041881.

This finding is more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," 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. Specifically, absent corrective actions to preclude repetition of the cause of the failure of battery '201B,' cell 27, the objective to ensure the reliability of safety related direct current (dc) battery systems was adversely affected. The inspectors also observed conditions which were consistent with precursors to the potential failure modes identified by Dominion that were not previously entered into a tracking database or the corrective action program. In accordance with Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 4, "Initial Characterization of Findings," and IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions", Section A, "Mitigating Systems, Structures or Components and Functionality," the finding screened to be of very low safety significance (Green), because the finding did not represent an actual failure of a system, function, or train of equipment and did not involve equipment specifically designed to mitigate a seismic, flooding, or severe weather initiating event (e.g., seismic snubbers, flooding barriers, tornado doors). The inspectors determined that this finding has a cross-cutting aspect in the area of Human Performance, Challenging the Unknown, because Dominion identified three potential causes and when faced with an uncertain condition decided to not take corrective action to preclude repetition.
Inspection Report# : 2016009 *(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.

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Miscellaneous

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