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Farley 2 – Quarterly Plant Inspection Findings

2Q/2017 – Plant Inspection Findings

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Initiating Events

Mitigating Systems

Significance: G May 18, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Translate Design Basis Time Requirement into the Time Critical Operator Action Program Procedure (Section 1R21.b.1)

Green: The NRC identified a non-cited violation (NCV) of Title 10 Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to translate the design basis time limit for the alignment of the emergency core cooling system (ECCS) to cold leg recirculation into their time critical operator action procedure. Specifically, the licensee failed to translate the ECCS to cold leg recirculation alignment activity time requirement of 9 minutes and 25 seconds from calculation SM-94-0452-001, "RWST Depletion During Injection Mode with LOCA Until Switchover to Recirculation," Version 5.0, and UFSAR Table 6.3-4, into procedure NMPOS- 014-001, "FNP Time Critical Operator Action Program," Version 4.0. The licensee entered this issue into their corrective action program as condition report 10365952 and determined that operability was not impacted due to conservatism in the calculation and recent operating crew simulator performance.

The performance deficiency was determined to be more than minor because it was associated with the procedure quality attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee's failure to translate the correct design basis time requirement into their acceptance criteria in procedure NMP-OS-014-001 resulted in several unidentified periodic time validation failures without remediation, therefore adversely affecting the licensee's capability and reliability of aligning safety-related equipment needed during a loss of coolant accident within the established design basis time limits. The team determined the finding to be of very low safety significance (Green) because the finding was a deficiency affecting the design and qualification of a mitigating system, structure, or component (SSC), and the SSC maintained its operability. The team determined that no

cross-cutting aspect was applicable because the finding did not reflect current licensee performance. (Section 1R21.2.b.1)

Inspection Report# : 2017007 (*pdf*)

Significance:  Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Comply with NFPA-13 for Pre-action Fire Suppression System 1A-36 and Provide NRC Staff Complete and Accurate Information (1R05)

Green: An NRC-identified Severity Level IV NCV of 10 CFR 50.9(a), "Completeness and accuracy of information," and an associated Green NCV of 10 CFR 50.48(c) and National Fire Protection Association Standard (NFPA) 805, Section 3.9.1, was identified for the licensee's failure to accurately evaluate and report non-compliance with code requirements for the design and installation of the Unit 1 pre-action sprinkler system 1A-36. The licensee's failure to comply with code requirements for the design and installation of the Unit 1 pre-action sprinkler system, 1A-36 was a performance deficiency. The licensee entered the issue into their corrective action program (CR 10261278).

The performance deficiency was more than minor 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 inadequate design and installation of the sprinkler system represented a degradation of a fire suppression component which degraded the fire protection defense in depth element to rapidly detect and suppress fires that occur. The inspectors determined that the finding was of very low safety significance (Green) because the affected fixed fire suppression system would still be able to suppress a fire such that no additional equipment important to safety would be affected by a fire. The inspectors determined the cause of this finding was not associated with a cross-cutting area because it was not reflective of current licensee performance. (Section 1R05)

Inspection Report# : 2016003 (*pdf*)

Significance:  Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Maintain Requalification Examination Integrity (1R11)

Green: An NRC-identified non-cited violation (NCV) of 10 CFR 55.49, "Integrity of examinations and tests," was identified for the licensee's failure to adhere to examination procedure standards that require the use of sequestering and examination security measures to prevent compromise when the same examination is administered to multiple crews on the same day. While observing simulator exam scenarios, the inspectors identified that neither of two crews scheduled to be evaluated on the same scenario that day were sequestered following completion of the first scenario. Both crews were in the same building and were not being monitored. The first crew was placed on the same Examination Security Agreement as examination developers and evaluators prior to participating in the scenario, as a means to prevent compromise of the examination. The licensee Examination Security Agreement Brief allows discussion of the exam with individuals that are on the

Examination Security Agreement. The inspectors informed the licensee of this issue prior to the same scenario being administered to the second crew. The licensee subsequently administered a different scenario to the second crew to prevent any potential examination compromise and entered the issue into their corrective action program (CR 10271868).

This performance deficiency was more than minor because it was associated with the Human Performance attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically,

the failure to adhere to examination security standards adversely affected the integrity of the administration of the operating exams, which tests licensed operator performance in order to ensure timely and correct mitigating actions after an event. Using the Licensed Operator Requalification Significance Determination Process, this finding was determined to be of very low safety significance (Green) because no known compromise of the examinations occurred. The inspectors determined the finding had a cross-cutting aspect of Resources in the cross-cutting area of Human Performance because the licensee failed to ensure that adequate training procedures were available to meet industry standards and ensure that the potential for the compromise of regulatory examinations did not exist. [H.1] (Section 1R11)

Inspection Report# : 2016003 (*pdf*)

Significance: **G** Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Perform Adequate Preventive maintenance on Circuit Breaker Cell Switch (4OA3.2)

Green: An NRC-identified, non-cited violation of Technical Specification (TS) 3.8.9 "Distribution Systems - Operating," occurred when the shared 600 VAC 1-2R load center (LC) was inoperable for longer than allowed by technical specifications for Unit 1. The failure to perform adequate preventive maintenance on the ER05-2 circuit breaker cell switch in accordance with licensee procedure FNP-0-EMP-1322.01 was a performance deficiency. This event was entered in the licensee's corrective action program as CR 10209365. The licensee cycled the ER05-2 cell switch which cleaned the electrical contact enough to establish continuity to power the closing circuit for the ER02-1 supply circuit breaker and reenergize the 1-2R 600VAC load center. An additional corrective action to replace the cell switch is pending.

The performance deficiency was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective because inadequate preventive maintenance on the ER05-2 circuit breaker cell switch led to the inability to detect a degraded electrical contact which resulted in the inoperability of the 1-2R 600 VAC load center on April 13, 2016. This finding required a detailed risk evaluation because it represented an actual loss of function of a single train for greater than the TS allowed outage time. The inspectors used the NRC SPAR model for plant Farley to evaluate the significance of this finding. The regional senior reactor analyst reviewed this evaluation and determined that the increase in risk as a result of the performance deficiency was less than 1E-6 per year, a GREEN finding of very low safety significance. This finding was associated with the cross-cutting aspect of Field Presence in the Human Performance area because if deviations from standards and expectations were corrected promptly, the practice of checking a single electrical contact during the cell switch continuity verification would not have existed. [H.2] (Section 4OA3)

Inspection Report# : 2016003 (*pdf*)

Barrier Integrity

Significance: **G** May 18, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Untimely Corrective Actions for Check Valve Q2E21V0026 (Section 1R21.b.2)

Green: The NRC identified a non-cited violation (NCV) of Title 10 Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to implement timely corrective actions to change the classification of check valve Q2E21V0026 (QV026) from category "C" to category "A/C" in accordance with ASME OM Code-2001, Subsection ISTC-1300, "Valve Categories." The licensee entered this issue into their corrective action program as condition report 10377744, reclassified the valve as category "A/C" in January 2017 to perform the leakage test during the next outage, and determined there was reasonable

assurance the valve could perform its intended safety function until the outage.

The performance deficiency was determined to be more than minor because it was associated with the structure, system, component, and barrier performance attribute of the Barriers Integrity Cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the failure to implement timely corrective actions resulted in the licensee not ensuring reverse flow to the refueling water storage tank (RWST) from the containment sump during the recirculation phase of safety injection (SI) would not exceed the plant's dose rate limits. The team determined the finding to be of very low safety significance (Green) because the finding did not only represent a degradation of the radiological barrier function provided for the control room, auxiliary building, or spent fuel pool, and the finding did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere. The team determined the finding was indicative of present licensee performance and was associated with the cross cutting aspect of Conservative Bias in the area of Human Performance because the licensee failed to use decision making practices that emphasize prudent choices over those that are simply allowable [H.14]. (Section 1R21.2.b.2)

Inspection Report# : 2017007 (*pdf*)

Emergency Preparedness Occupational Radiation Safety

Significance:  May 03, 2016

Identified By: NRC

Item Type: VIO Violation

Inaccurate Training Records

Severity Level IV/Green: The licensee identified a violation of 10 CFR 50.9(a) requirements and an associated finding of very low significance when it was determined that an employee deliberately completed requalification examinations for other employees without their knowledge or consent. Specifically, on three occasions the proctor took annual requalification exams of Fitness-for-Duty, radiation worker, and fire watch training for two other contract employees and made inaccurate entries in training records thereby falsely indicating that the employees actually attempted and passed the examinations. The records inaccurately showed that workers had successfully completed required annual requalification exams for fire watch, fitness for duty and radiation worker training. The licensee was notified about the incident through their employee concerns program and informed the NRC about the concern.

Since the finding involved occupational radiation safety, the inspectors utilized IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated August 19, 2008, to assess its significance. The inspectors determined that the finding did not involve an overexposure; a substantial potential for an overexposure; a compromised ability to assess dose; or unplanned, unintended occupational collective dose. Consequently, the inspectors determined that the finding was of very low safety significance (Green).

The inspectors determined that the finding has a cross-cutting aspect in the area of human performance, field presence, because the licensee did not ensure management oversight of contractor work activities (H.2).

This issue was also dispositioned using traditional enforcement due to the willful aspects of the violation. Furthermore, the failure to provide complete and accurate information has the potential to impact the NRC's ability to perform its regulatory function. In accordance with the guidance of the Enforcement Policy and Enforcement Manual, this issue is considered a Severity Level IV violation because it involved information that the NRC required to be maintained by a licensee that was incomplete or inaccurate and of more than minor

significance.

Inspection Report# : 2016008 (*pdf*)

Public Radiation Safety Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Current data as of : August 03, 2017

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