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## Byron 2 – Quarterly Plant Inspection Findings

### 2Q/2017 – Plant Inspection Findings

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#### Initiating Events

#### Mitigating Systems

**Significance:** G May 19, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

#### **Failure to Perform 10 CFR 50.59 Evaluation for UFSAR Change (Section 1R17.1b)**

Severity Level IV. The inspectors identified a Severity Level IV, Non-Cited Violation of 10 CFR 50.59, "Changes, Tests, and Experiments," Section(d)(1) and an associated finding of very low safety significance (Green) for the licensee's failure to provide a written evaluation which provided the basis for the determination that a change did not require a license amendment. Specifically, the licensee failed to provide a basis for why a change to the surveillance frequencies of emergency diesel generators described in the Updated Final Safety Analysis Report did not require prior NRC approval.

The inspectors determined that the performance deficiency was more than minor because the inspectors could not reasonably determine that the changes would not have ultimately required NRC prior approval. The associated finding screened to Green (very low safety significance) because it did not result in the loss of operability or functionality. The diesel generators passed their most recent surveillances. As a result the violation is categorized as Severity Level IV in accordance with section 6.1.d of the NRC Enforcement Policy. The issue did not have a cross-cutting aspect because it was not reflective of current performance. (Section 1R17.1b)

Inspection Report# : 2017009 (*pdf*)

**Significance:** G Sep 30, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

### **Failure to Use Alteration Log Resulted in Fuel Oil Leak**

Green. A finding of very low safety significance and an associated NCV of Technical Specification (TS) 5.4.1.a, "Written Procedures," was self-revealed on August 24, 2016, when a fuel oil leak of approximately one-eighth gallon per minute was identified coming from a tubing connection after the Unit 2 Train B (2B) DG was started for routine surveillance testing. Technicians replaced a fuel oil relay during the previous shift and did not use the procedurally required tools to track alterations made to each individual input line as required by MA-AA-716-100, "Maintenance Alteration Process." The issue was entered into the licensee's CAP as IR 02707888. As part of their corrective actions, the leak was promptly repaired by tightening the fitting after the diesel generator was shut down; and the technicians reviewed human performance error prevention techniques, including proper use of the Maintenance Alterations Log, with supervisors.

The inspectors determined that the issue was more than minor because it was associated with the Configuration Control attribute of the Mitigating Systems Cornerstone and adversely impacted 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 tighten all fittings during a maintenance activity resulted in a substantial fuel oil leak that could have resulted in a fire or could have impacted the availability of the diesel generator if the tubing had loosened further or become disconnected during a design basis event. The finding was determined to be of very low safety significance, or Green, in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," Appendix A, "The Significance Determination Process (SDP) For Findings at Power," because the inspectors answered Exhibit 2 - Mitigating Systems Screening Question A.1 as "Yes" since the diesel generator remained operable and functional until the fitting was repaired. The inspectors assigned a cross-cutting aspect in the Avoiding Complacency element of the Human Performance Area (IMC 0310 H.12) to this finding because judicious implementation of human performance error prevention tools could have prevented the failure to properly tighten the fitting, even if the Alterations Log was not used as required.

Inspection Report# : 2016003 (*pdf*)

### **Barrier Integrity**

### **Emergency Preparedness**

### **Occupational Radiation Safety**

### **Public Radiation Safety**

**Significance:** G Sep 30, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

### **Failure to Properly Block and Brace a Radioactive Shipment for Transport**

Green. A finding of very low safety significance and an associated NCV of 10 CFR 71.5(a) and 49 CFR 171.1(b)(12) was self-revealed when the licensee failed to properly block and brace a Radioactive Waste (Radwaste) Shipment that was shipped to a waste processing facility for disposal. The failure to properly block and brace the Radwaste Shipment caused a breach of the shipping package while in transit to the waste processing facility. When the shipment breach was discovered at the waste processing facility, contamination surveys were immediately conducted and it was determined that no loss of content had occurred during transportation. The surveys also determined that radiation dose limits from the package were below NRC and Department of Transportation (DOT) limits. The waste processing facility notified the licensee of the breach during transport and the licensee entered the event into their CAP as IR 02665985.

The inspectors determined that the issue was more than minor because it was associated with the Program and Process attribute of the Public Radiation Safety Cornerstone and adversely impacted the cornerstone objective of ensuring adequate protection to public health and safety from exposure to radiation from routine civilian nuclear operations. Specifically, the breach of the transportation package by its content could lead to the inadvertent spread of radioactive contamination to the public domain if conditions had been slightly altered. The finding was determined to be of very

low safety significance, or Green, in accordance with IMC 0609, Appendix D, "Public Radiation Safety Significance Determination Process," dated February 12, 2008, because the finding did not involve: (1) a radioactive shipment above radiation limits; (2) a certificate of compliance issue; (3) the failure to make emergency notifications; or (4) a low-level burial issue. A breach of the transportation package occurred during transit. However, the shipment contained less than a Type A quantity of material (LSA II shipment), and there was no loss of package contents or radioactive contamination. The inspectors assigned a cross-cutting aspect in the Resources element of the Human Performance Area (IMC 0310 H.1) to this finding due to inadequate procedures. (Section 2RS8.4)

Inspection Report# : 2016003 (*pdf*)

## **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 : September 05, 2017

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