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Diablo Canyon 1 – Quarterly Plant Inspection Findings

2Q/2017 – Plant Inspection Findings

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Initiating Events

Mitigating Systems

Significance: N/A Jun 30, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Conduct Required Biennial Medical Examinations within Two Years

The inspectors identified a Severity Level IV, non-cited violation of 10 CFR 55.21, "Medical Examination," for the licensee's failure to ensure that a medical examination by a physician to determine satisfaction of 10 CFR 55.33(a)(1) requirements was conducted every 2 years for two licensed senior operators. Specifically, one licensed senior operator exceeded the two-year medical examination requirement by approximately 16 months between November 27, 2015, and April 6, 2017. A second licensed senior operator exceeded the 2-year medical examination requirement by 4 months between November 19, 2016, and April 6, 2017. As a corrective action, the licensee has conducted the required medical examination for one senior operator and initiated a license termination request for the other senior operator. This issue was entered into the licensee's corrective action program as Notification 50912407.

The failure of the facility licensee to conduct required biennial medical examinations for two licensed senior operators was a performance deficiency. This issue was evaluated using the traditional enforcement process because it negatively impacted the NRC's ability to perform its regulatory oversight function. Specifically, the failure to comply with medical testing requirements for two operators compromised the facility licensee's ability to assure conformance to medical standards, detect non-conforming medical conditions, and report non-conformances to the NRC. This performance deficiency was determined to be Severity Level IV because it fits the Severity Level IV example of Enforcement Policy Section 6.4.d.1, "Violation Examples: Licensed Reactor Operators." This section states, "Severity Level IV violations involve, for example ... (b) an individual operator who did not meet the American National Standards Institute/American Nuclear Society (ANSI/ANS) 3.4," "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants," Section 5, "Health Requirements and Disqualifying Conditions," as certified on NRC Form 396, "Certification of Medical Examination by Facility Licensee," required by 10 CFR 55.23, Certification, but who did not perform the functions of a licensed operator or senior operator while having a

disqualifying medical condition." No cross-cutting aspect was assigned because the violation was processed using traditional enforcement.

Inspection Report# : 2017002 (*pdf*)

Significance: N/A Jun 30, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Report a Permanent Medical Condition within 30 Days

The inspectors identified a Severity Level IV, non-cited violation of 10 CFR 55.25, "Incapacitation Because of Disability or Illness," for the licensee's failure to notify the NRC within 30 days of a change to one licensed senior operator's medical condition. Specifically, the licensed senior operator developed a permanent medical condition which caused him to permanently leave the site on December 1, 2014, and transition into a long-term disability program on April 23, 2015. The licensee did not notify the NRC of this change in medical condition. As a corrective action, the licensee initiated a license termination request for the affected operator, effective April 6, 2017. This issue was entered into the licensee's corrective action program as Notification 50912407.

The failure of the facility licensee to notify the NRC within 30 days of a change in a licensed senior operator's medical condition was a performance deficiency. This issue was evaluated using the traditional enforcement process because it negatively impacted the NRC's ability to perform its regulatory oversight function. Specifically, the failure to report changes in a licensed senior operator's medical condition prevented the NRC from taking action to issue either a license amendment or termination, as appropriate. This performance deficiency was determined to be Severity Level IV because it fits the Severity Level IV example of Enforcement Policy Section 6.4.d.1, "Violation Examples: Licensed Reactor Operators." This section states, "Severity Level IV violations involve, for example ... (b) an individual operator who did not meet the American National Standards Institute/American Nuclear Society (ANSI/ANS) 3.4," "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants," Section 5, "Health Requirements and Disqualifying Conditions," as certified on NRC Form 396, "Certification of Medical Examination by Facility Licensee," required by 10 CFR 55.23, Certification, but who did not perform the functions of a licensed operator or senior operator while having a disqualifying medical condition." No cross-cutting aspect was assigned because the violation was processed using traditional enforcement.

Inspection Report# : 2017002 (*pdf*)

Significance:  Jun 30, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Expansion Scope of Risk-Informed Welds

The inspectors identified a non-cited violation of the licensee's risk-informed inservice inspection program (which is their alternative to portions of the ASME Code, Section XI inservice inspection program approved in accordance with 10 CFR 50.55a(z)) for the failure to properly expand the scope of additional welds to inspect. Specifically, a rejectable flaw on a pipe weld in the pressurizer spray line was identified during refueling outage 1R19 while performing an ultrasonic examination. The licensee expanded the inspection scope by four additional welds, but failed to select those assigned with the same degradation. For immediate corrective actions, the licensee identified and intended to inspect four additional welds assigned to the same degradation mechanism as required by the risk-informed inservice inspection program. This issue was entered into the licensee's corrective action program as Notification 50920222.

The licensee's failure to properly expand the weld examination scope as required by the risk-informed inservice inspection program was a performance deficiency. The performance deficiency was more than minor because it was associated with the equipment performance attribute of the Mitigating System 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 select additional welds that were susceptible to the

same degradation mechanism as weld WIB-378 placed the plant at an increased risk due to the potential of having an active degradation mechanism that could affect additional components. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, the inspectors determined the finding screened as having very low significance (Green) because: (1) it was not a design deficiency; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time; and (4) did not result in the loss of a high safety-significant non-technical specification train. This finding had a cross-cutting aspect in the area of human performance associated with change management because leaders failed to use a systematic process for evaluating and implementing the change to a risk-informed inservice inspection program. The implementing procedure failed to include the reference to "degradation mechanism" allowing for a misinterpretation of weld expansion requirements once a flaw was identified in a weld WIB-378.

Inspection Report# : 2017002 (*pdf*)

Significance:  Jun 30, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Follow Procedures Results in Partial Loss of Cooling Flow to Shutdown Cooling

The inspectors reviewed a self-revealing, non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because PG&E personnel failed to follow the requirements of AD7.ID14, "Assessment of Integrated Risk," Revision 11. Specifically, PG&E personnel failed to obtain shift manager permission, conduct a protected equipment briefing, and document shift manager approval prior to performing work on protected equipment. This resulted in a loss of flow of cooling water to one of two in-service shutdown cooling residual heat removal heat exchangers and subsequent perturbation in reactor coolant system temperature during refueling outage 1R20.

The inspectors determined that PG&E's failure to follow AD7.ID14, "Assessment of Integrated Risk," Section 5.14 "Performing Work on Posted Protected Equipment," was a performance deficiency within PG&E's ability to foresee and correct. This performance deficiency was considered to be more than minor because it impacted the configuration control attribute of the Mitigating Systems cornerstone and its objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the loss of cooling flow to the RHR heat exchanger while in shutdown cooling mode resulted in a perturbation in RCS temperature of approximately 8 degrees Fahrenheit. The finding was evaluated in accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," and determined to be of very low safety significance (Green) since it did not represent a loss of system safety function of at least a single train for greater than four hours. The finding had a cross-cutting aspect in the area of human performance associated with conservative bias because PG&E personnel did not use decision-making practices that emphasize prudent choices over those that are simply allowable. Specifically, despite being authorized to close component cooling water cross connect valves by the work control process, PG&E personnel did not question the impact of their actions on shutdown cooling.

Inspection Report# : 2017002 (*pdf*)

Significance:  Jul 14, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Inadequate Maintenance Procedure affected the Performance of Safety-Related Emergency Diesel Generator

The inspectors assessed a self-revealed, non-cited violation of Technical Specification 5.4.1.a, "Procedures," for the licensee's failure to implement properly preplanned maintenance procedures that affected the performance of safety-related equipment. Specifically, two maintenance procedures associated with the emergency diesel generators' fuel injectors lacked adequate details on specific key mechanical parameters (capscrew bolt torque setup and fuel injection pump alignment) to ensure that maintenance activities were performed in a manner adequate to the circumstances. In

both examples, the licensee entered the issues into the corrective action program and corrected the condition to restore the emergency diesel generators to an operable status.

This finding was more than minor because it was associated with the procedure quality attribute of the Mitigating Systems cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At Power," issued June 19, 2012, the inspectors determined the finding was of very low safety significance (Green) because the finding did not represent the loss of a system or function, the loss of a train of a technical specification safety system for greater than its allowed outage time, or the loss of a non-technical specification high-safety-significant system for greater than 24 hours. This finding had a cross-cutting aspect in the area of human performance associated with work management - "organization implements a process of planning, controlling, and executing work activities such that nuclear safety is the overriding priority." Specifically, work on the emergency diesel generators fuel oil system components was not effectively planned and executed by incorporating conditions to ensure a successful outcome [H.5].

Inspection Report# : 2016009 (*pdf*)

Barrier Integrity
Emergency Preparedness
Occupational Radiation Safety
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 : September 05, 2017

Page Last Reviewed/Updated Wednesday, June 07, 2017