



Home > Nuclear Reactors > Operating Reactors > Reactor Oversight Process > Plant Summaries > Farley 2 > Quarterly Plant Inspection Findings

Farley 2 – Quarterly Plant Inspection Findings

3Q/2017 – Plant Inspection Findings

On this page:

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness
- Occupational Radiation Safety
- Public Radiation Safety
- Security

Initiating Events

Mitigating Systems

Significance: TBD Jun 30, 2017

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Follow Procedure Resulted in Inoperable 2B Diesel Generator (1R22)

To Be Determine (TBD): The NRC identified apparent violation (AV) of Technical Specification (TS) 5.4.1, "Procedures," for the licensee's failure to implement corrective maintenance work order instructions to identify and replace a degraded jacket water fitting on the 2B Emergency Diesel Generator (EDG) jacket water keep warm system piping. As a result, a leak occurred on the 2B EDG jacket water piping system during surveillance testing which rendered the EDG inoperable.

The inspectors determined that the failure to follow work order instructions to replace degraded jacket water system piping during corrective maintenance on the 2B DG on March 3, 2017 was a performance deficiency. The inspectors determined that the finding was more than minor because it affected the equipment reliability attribute of the Mitigating Systems Cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The significance of this finding was evaluated using IMC 0609, Appendix A, "The Significance Determination Process (SDP) for findings at Power," dated June 19, 2012. Initial screening by the resident inspectors using the Sapphire Farley 1 & 2 SPAR Model resulted in a potentially greater than green significance. Therefore, a detailed risk analysis was required to be performed by a regional senior risk analyst (SRA). The inspectors determined the finding had a cross-cutting aspect of Field Presence in the Human Performance area, because senior managers did not ensure adequate supervisory and management oversight of corrective maintenance performed on the 2B EDG on March 3, 2017.[H.2] (Section 1R22)

Inspection Report# : 2017002 (*pdf*)

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*)

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: **G** 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 : November 29, 2017

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