



Home > Nuclear Reactors > Operating Reactors > Reactor Oversight Process > Plant Summaries > Perry 1 > Quarterly Plant Inspection Findings

Perry 1 – Quarterly Plant Inspection Findings

4Q/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: NOPD Jun 30, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Notify the NRC

Severity Level IV. The inspectors identified a Severity Level IV Non-Cited Violation (NCV) of Title 10 of the *Code of Federal Regulations* (10 CFR) 50.72(b)(3)(v)(A) and (D), "Immediate Notification Requirements for Operating Nuclear Power Reactors," for the licensee's failure to report an event to the NRC within eight hours that at the time of discovery could have prevented the fulfillment of a safety function. Specifically, the licensee did not recognize there was a loss of safety function associated with multiple instrumentation functions as a result of a main steam turbine bypass valve opening at 100 percent reactor power. Therefore, the licensee did not make the required non-emergency eight hour report. After the inspectors questioned the licensee's conclusion, the licensee recognized there was indeed a loss of safety function and submitted the eight-hour notification report on May 3, 2017. They also entered this issue into the corrective action program (CAP) as condition report (CR) 2017-04939, CR 2017-04868, and CR 2017-05022.

The failure to make an applicable non-emergency eight-hour event notification report within the required timeframe was a performance deficiency. The inspectors determined that traditional enforcement was applicable to the issue because it impacted the NRC's regulatory process. In accordance with Section 2.2.2.d, and consistent with the examples included in Section 6.9.d.9 of the NRC Enforcement Policy, this violation was screened as a Severity Level IV violation that was more than minor. In accordance with Inspection Manual Chapter 0612, because this violation involved traditional enforcement and does not have an associated finding that would be considered more-than-minor, a cross-cutting aspect was not assigned to this violation. (Section 1R15)

Inspection Report# : 2017002 (*pdf*)

Significance: **G** May 15, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Implement Procedures for Combating a Loss of Shutdown Cooling

A finding of very-low safety significance and associated NCV of TS 5.4, "Procedures," was identified by the inspectors for the failure to implement procedures for combating a loss of shutdown cooling (SDC). Specifically, the licensee failed to implement its procedure for combating a loss of SDC resulting from emergency service water (ESW) inoperability and during high decay heat load. This finding was entered into the licensee's Corrective Action Program to perform analyses for various conditions to identify available alternate methods of decay heat removal and provide associated procedural guidance.

The performance deficiency was determined to be more-than-minor because it was associated with the Mitigating Systems cornerstone attribute of design control and affected the cornerstone objective of ensuring the availability, reliability, and capability of mitigating systems to respond to initiating events to prevent undesirable consequences.

The finding screened as very-low safety significance (Green) because it did not impact the operability or Probabilistic Risk Assessment functionality of any mitigating structures, systems, and components. The inspectors did not identify a cross-cutting aspect associated with this finding because it did not reflect current performance due to the age of the performance deficiency.

Inspection Report# : 2017001 (*pdf*)

Significance: **W** Apr 27, 2017

Identified By: NRC

Item Type: TE Traditional Enforcement w/o associated F

Division 2 Diesel Generator Failure to Start due to a Failed Diode in the 125 VDC Control Power Circuit

The inspectors identified a finding preliminarily determined to be of low to moderate safety significance (White), and an associated apparent violation of Title 10 of the Code of Federal Regulations (10 CFR) 50, Criterion III, "Design Control," for the licensee's failure to implement measures for the selection and review for suitability of application of voltage suppression diodes installed in the control circuitry for the Division 2 Standby Diesel Generator, which was a component subject to the requirements of 10 CFR Part 50, Appendix B. Specifically, Engineering Change Package 04-00049 failed to consider the effects of a shorted diode on the control circuitry for the Division 2 Standby Diesel Generator, and instead, introduced new components (diodes) into the control circuitry that resulted in the eventual failure of this safety-related equipment. This rendered the standby diesel generator inoperable and unable to start for longer than its technical specification allowed outage time, which was a violation of Technical Specification 3.8.1, "AC Sources-Operating." The licensee documented the issue in CR 2016-13183, and subsequently replaced the failed component and then modified circuitry to remove the replacement diode and the remaining diodes from similar components.

The inspectors determined that the licensee's failure to evaluate the effects of voltage suppression diode failure on the Standby Diesel Generator control circuit was contrary to the requirements of 10 CFR Part 50, Appendix B, Criterion III and a performance deficiency which was within the licensee's ability to foresee and prevent. The inspectors determined

that the performance deficiency was of more than minor significance because it was associated with the design control 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 (i.e., core damage). Specifically, the design of the Division 2 Standby Diesel Generator control circuit resulted in the inoperability and unavailability of the Division 2 Standby Diesel Generator from April 2, 2015, to November 8, 2016, when the failed diode was replaced. A Significance and Enforcement Review Panel, using IMC 0609, Appendix A, "Significance Determination Process for Findings At-Power," dated June 19, 2012, preliminarily determined the finding to be of low-to-moderate safety significance. The inspectors did not identify any cross-cutting aspects associated with this finding because the condition had existed since at least 2007, when the diodes were originally installed in the DC control power circuits, and therefore, was not indicative of current plant performance.

Inspection Report# : 2017009 (*pdf*)

Inspection Report# : 2017010 (*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 : February 01, 2018

Page Last Reviewed/Updated Monday, November 06, 2017