

# River Bend 1

## 3Q/2007 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 30, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

#### **Failure to Implement Vendor Recommendations**

A self-revealing finding was identified involving the failure to implement 1998 vendor recommendations associated with the potential for vibration induced degradation of recirculation loop gate valves. This resulted in the failure to identify and implement timely corrective actions prior to disk to stem separation of recirculation Pump A discharge gate valve that occurred on May 21, 2007. This issue was entered into the licensee's corrective action program as condition Report CR-RBS-2007-02113.

The finding was more than minor because it was associated with the initiating events cornerstone attribute of equipment performance and affected the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have a very low safety significance because the finding did not contribute to the likelihood that mitigation equipment or functions would not be available following a reactor trip.

Inspection Report# : [2007003](#) (*pdf*)

**Significance:**  Jun 30, 2007

Identified By: NRC

Item Type: FIN Finding

#### **Inadequate Work Instructions**

The inspectors identified a finding involving inadequate maintenance instructions for opening a stuck closed feedwater regulating Valve A isolation valve. Specifically, the instructions failed to account for the system being pressurized resulting in unexpected valve stem movement while technicians were removing the manual operator from the valve on June 10, 2007. This deficiency could have resulted in personnel harm or an unexpected and uncontrolled plant transient. This issue was entered into the licensee's corrective action program as condition Report CR-RBS-2007-02576.

The finding was more than minor because it could become a more significant safety concern if left uncorrected. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because the deficiency did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. No violation of NRC requirements occurred. The cause of this finding was related to the human performance crosscutting component of resources because the licensee did not ensure a complete and accurate work package was available prior to the start of the job (H.2(c)).

Inspection Report# : [2007003](#) (*pdf*)

**Significance:**  Jun 30, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Install Scram Discharge Instrument Volume Vent Plug**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified involving the failure to follow a surveillance procedure for scram discharge instrument volume water level channel calibration. Specifically, on February 9, 2007, an instrument line plug was not replaced following surveillance testing. As a result, on May 5, 2007, following a reactor scram, reactor water sprayed out of the scram discharge instrument volume and

contaminated some accessible portions of the containment building causing three inadvertent personnel contamination events. This issue was entered into the licensee's corrective action program as condition Report CR-RBS-2007-01809.

The finding was more than minor because it was associated with the initiating event cornerstone attribute of equipment performance and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. A Phase 2 estimation was required, as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones," because the associated performance deficiency resulted in a reactor coolant leak greater than the Technical Specification limit for identified reactor coolant system leakage. Using the plant-specific Phase 2 risk-informed notebook, this violation was determined to have very low safety significance because the violation only increased the likelihood of a small-break loss of coolant accident by a very small amount and mitigation capability was unaffected. The cause of the finding was related to the human performance crosscutting component of work practices because neither self nor peer checking actions identified the failure to replace the vent plug (H.4(a)).

Inspection Report# : [2007003](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

#### **Failure to Follow Maintenance Instructions**

A self-revealing finding was identified involving the failure of maintenance personnel to follow maintenance instructions resulting in the failure to properly seal the desiccant retention strainer of an instrument air dryer. As a result, desiccant was released from the dryer tower and became lodged in an outlet shuttle valve causing it to stick open that resulted in lowering the instrument air header pressure. This condition caused operators to enter the abnormal operating procedure for loss of instrument air, an automatic start of standby air compressors, and the automatic cross-connect of service air to the instrument air header. These actions restored instrument air pressure preventing a significant plant transient. This issue was entered into the licensee's corrective action program as CR-RBS-2007-00438.

The finding was more than minor because it would become a more significant safety concern if left uncorrected in that an air dryer failure could result in a complete loss of instrument air. The finding affected the initiating event cornerstone. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because there was no actual loss of instrument air. The cause of the finding was related to the crosscutting element of human performance in that the maintenance technicians failed to properly self and peer check the adequacy of the retention strainer seal during maintenance of instrument air Dryer 2 on January 12, 2007. As a result, desiccant was released causing an outlet shuttle valve to stick open.

Inspection Report# : [2007002](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to identify and correct discrepancies between the design function and observed response of the feedwater isolation valves prior to reactor restart**

An NRC-identified noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," was identified for the failure of licensee personnel to identify and correct a condition adverse to quality in a timely manner. Specifically, following the reactor scram on October 19, 2006, licensee personnel failed to properly evaluate discrepancies between the expected response of Feedwater Isolation Valves FWS-MOV7A and FWS-MOV7B, operator observation of valve indication, and indication of actual plant parameters affected by the valves, prior to restarting the reactor on October 22, 2006.

This violation was greater than minor because it was associated with the problem identification and resolution and the human performance attributes of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown, as well as power operations. A Phase 2 estimation was required, as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers

Cornerstones," because the associated performance deficiency represented an increase in the likelihood of both a reactor trip and the likelihood that the power conversion system would be unavailable. Using the appropriate plant-specific Phase 2 worksheets, this violation was determined to have very low safety significance because the violation only increased the initiating event likelihood by a very small amount and the power conversion system was actually recoverable. This finding has a cross-cutting aspect in the area of problem identification and resolution, in that, the licensee did not implement a corrective action program that ensured timely resolution of conditions adverse to quality.

The licensee entered this performance deficiency into their corrective action program for resolution.

Inspection Report# : [2006013](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure of reactor operators to perform an adequate control board walkdown resulting in failure to identify that feedwater isolation valves were closing**

A self-revealing noncited violation of Technical Specification, Section 5.4, "Procedures," was identified for the failure of licensee personnel to accomplish activities affecting quality in accordance with prescribed conduct-of-operations procedures. Specifically, on October 19, 2006, two senior reactor operators (one on-coming and one off-going), conducting turnover activities, and the at-the-controls reactor operator failed to identify that the push buttons for Main Feedwater Isolation Valves 7A and 7B were out of alignment upon panel inspection during panel walk downs conducted in accordance with Entergy Operations Procedure EN-OP-115, "Conduct of Operations," Revision 2.

This violation was greater than minor because it was associated with the human performance attribute of the initiating events cornerstone and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown, as well as power operations. A Phase 2 estimation was required, as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones," because the associated performance deficiency represented an increase in the likelihood of both a reactor trip and the likelihood that the power conversion system would be unavailable. Using the appropriate plant-specific Phase 2 worksheets, this violation was initially determined to have very low safety significance because the violation only increased the initiating event likelihood by a very small amount and the power conversion system was actually recoverable. This violation has a cross-cutting aspect in the area of human performance, work practices component associated with the failure to effectively use human error prevention techniques, such as self and peer checking.

The licensee entered this performance deficiency into their corrective action program for resolution.

Inspection Report# : [2006013](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**Licensee personnel failed to identify, place in the corrective action program, and correct deficiencies with Chart Recorder C33-R608 prior to restarting the reactor**

An NRC-identified noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," was identified for the failure of licensee personnel to identify and correct a condition adverse to quality in a timely manner. Specifically, on October 19, 2006, a licensed reactor operator noted a nonconforming condition with Strip Chart Recorder C33-R608 following the fall of the chart paper mechanism and discussed this with his supervision. However, this condition was not documented in the condition reporting process, the recorder was not properly inspected and repaired by qualified maintenance technicians prior to reactor restart, and at least one member of the on-site safety review committee may have been misinformed about the extent and composition of the evaluation and repair activities conducted on control room recorders prior to authorizing plant restart on October 22, 2006.

This finding was greater than minor because it was associated with the problem identification and resolution and the human performance attributes of the initiating events cornerstone and affected the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations because the chart recorder was left in a condition that had resulted in a reactor scram. A Phase 2 estimation

was required, as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones," because the associated performance deficiency represented an increase in the likelihood of both a reactor trip and the likelihood that the power conversion system would be unavailable. Using the appropriate plant-specific Phase 2 worksheets, this finding was determined to be of very low safety significance because it only impacted the plant for a 2-day period. This finding has a cross-cutting aspect in the area of problem identification and resolution, in that, the licensee did not implement a corrective action program with a low threshold for identifying issues.

The licensee entered this performance deficiency into their corrective action program for resolution.

Inspection Report# : [2006013](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**Licensee personnel failed to provide complete corrective actions to address the probable cause of the October 19, 2006, scram, prior to restarting the reactor**

An NRC-identified noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," was identified for the failure of licensee personnel to correct a condition adverse to quality. Specifically, following the reactor scram on October 19, 2006, licensee personnel determined that the probable cause of the scram was a human performance error while handling the chart recorder. However, while significant corrective actions were taken, these actions did not completely address this probable cause prior to restarting the reactor on October 22, 2006, in that, expectations for working over control panels were not fully conveyed.

This violation was greater than minor because it was associated with the problem identification and resolution and the human performance attributes of the initiating events cornerstone and affected the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations because expectations and/or guidance were not provided to licensed operators on how to correct paper take up problems on strip chart recorders while minimizing the risk of dropping components on controls. A Phase 2 estimation was required, as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones," because the associated performance deficiency represented an increase in the likelihood of both a reactor trip and the likelihood that the power conversion system would be unavailable. Using the appropriate plant-specific Phase 2 worksheets, this violation was determined to be of very low safety significance because it only impacted the plant for a limited period of time. This finding has a cross-cutting aspect in the area of problem identification and resolution, in that, the licensee did not implement a corrective action program that ensured timely resolution of conditions adverse to quality.

The licensee entered this performance deficiency into their corrective action program for resolution.

Inspection Report# : [2006013](#) (*pdf*)

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## Mitigating Systems

**Significance:**  Apr 27, 2007

Identified By: NRC

Item Type: FIN Finding

**Foreign Material Found in Residual Heat Removal Room Sump Pump Discharge Check Valve**

The team identified a finding because the licensee failed to address control of foreign material in the Train B residual heat removal room in June 2003. Consequently, on March 5, 2007, maintenance technicians found foreign material in one of the sump pump discharge check valves. This failure to control foreign material resulted in sump high level alarms, which had caused the operators to enter the emergency operating procedure for auxiliary building room flooding on three different occasions. The licensee documented this deficiency in Condition Report 2007-00859.

The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of

equipment performance and affected the associated cornerstone objective to ensure the availability of the residual heat removal system. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because there was no actual loss of the residual heat removal system function and it did not screen as potentially risk significant for an internal flooding event. The cause of the finding was related to the crosscutting element of human performance work practices in that licensee management failed to communicate and enforce compliance with the site foreign material control program. Inspection Report# : [2007009](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: NRC

Item Type: FIN Finding

#### **Failure to Implement Freeze Protection Compensatory Measures**

The inspectors identified a finding involving the failure of operators to implement compensatory measures for cold weather conditions when a ventilation heater for a safety related standby cooling tower pipe chase was out of service during the winters from 2003 through 2006. This issue was entered into the licensee's corrective action program as CR-RBS-2007-00399.

The finding was more than minor because it was associated with the mitigating system cornerstone attribute of equipment performance and affected the associated cornerstone objective. The finding was determined to have very low safety significance because it did not result in an actual loss of the standby service water system and it was determined by a Phase 3 analysis not to be risk significant due to external events. The cause of the finding was related to the crosscutting aspect of problem identification and resolution in that the licensee failed to identify that freeze protection equipment in the area was out of service each winter from 2003 through 2006 requiring compensatory measures.

Inspection Report# : [2007002](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Promptly Identify and Correct a Degraded Residual Heat Removal System Valve**

A self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified involving the failure to promptly identify and correct a condition adverse to quality. Specifically, on August 3, 2005, residual heat removal Train A fuel pool cooling assist Valve E12-MOVF037A failed to fully close during actuation. The failure to correct the problem resulted in recurrence of the valve failing to fully close on April 11, 2006, and January 7, 2007. This issue was entered into the licensee's corrective action program as CR-RBS-2006-01326.

The finding was more than minor because it was associated with the mitigating systems cornerstone attribute of equipment performance and affected the associated cornerstone objective. The finding had very low safety significance because it did not represent a loss of the residual heat removal system safety function. The cause of the finding was related to the crosscutting element of problem identification and resolution in that the licensee did not thoroughly evaluate the problem such that the resolution would address the cause of the failure of Valve E12-MOVF037A to fully close on August 3, 2005.

Inspection Report# : [2007002](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Maintenance Instructions for Installation of a Compression Fitting**

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," for the licensee's failure to provide adequate work instructions for repairing a failed tubing compression fitting on the Division I emergency diesel generator jacket cooling water system. Specifically, the repair inappropriately had tubing entering a compression fitting at an angle that could result in failure as had previously been encountered on the same fitting. This issue was entered into the licensee's corrective action program as CR-RBS-2007-01496.

The finding was more than minor because it would become a more significant event if left uncorrected in that failure to install and repair tubing fittings correctly can lead to subsequent failure. The finding affected the mitigating systems cornerstone. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because the repair did not result in an actual loss of function of the Division I emergency diesel generator. The cause of the finding was related to the crosscutting element of human performance in that the licensee did not effectively communicate expectations for proper assembly of tubing fittings on safety related equipment.

Inspection Report# : [2007002](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to place the reactor mode switch in the SHUTDOWN position following a reactor scram as required by abnormal operating procedures**

A self-revealing noncited violation of Technical Specification, Section 5.4, "Procedures," was identified for the failure of licensee personnel to accomplish activities affecting quality in accordance with prescribed procedures. Specifically, the at-the-controls operator failed to perform an immediate action required by Abnormal Operating Procedure AOP-0001, "Reactor Scram," Revision 22, which required him to place the mode switch in the SHUTDOWN position. The failure to reposition the mode switch resulted in an inadvertent main steam isolation, complicating the scram recovery.

This violation was greater than minor because it was associated with the human performance attribute and affected the mitigating systems cornerstone objective to ensure the availability, reliability, or function of a system or train in a mitigating system. A Phase 2 estimation was required because this violation represented a loss of function of the steam side of the power conversion system as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones." Using the appropriate plant-specific Phase 2 worksheets, this violation was determined to have very low safety significance because the errors only impacted the plant for a short period of time and the power conversion system was actually recoverable. This violation has a cross-cutting aspect in the area of human performance, work practices component associated with the failure to effectively use human error prevention techniques.

The licensee entered this performance deficiency into their corrective action program for resolution.

Inspection Report# : [2006013](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to verify that the reactor mode switch was in the SHUTDOWN position following a reactor scram as required by emergency operating procedures**

An NRC-identified noncited violation of Technical Specification, Section 5.4, "Procedures," was identified for the failure of licensee personnel to accomplish activities affecting quality in accordance with prescribed procedures. Specifically, the control room supervisor failed to follow Emergency Operating Procedure EOP-0001, "Reactor Pressure Vessel Control," Revision 20, which required him to verify that the mode switch was in the SHUTDOWN position. The failure to reposition the mode switch resulted in an inadvertent main steam isolation, complicating the scram recovery.

This violation was greater than minor because it was associated with the human performance attribute and affected the mitigating systems cornerstone objective to ensure the availability, reliability, or function of a system or train in a mitigating system. A Phase 2 estimation was required because this violation represented a loss of function of the steam side of the power conversion system, as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones." Using the appropriate plant-specific Phase 2 worksheets, this violation was determined to have very low safety significance because the errors only impacted the plant for a short period of time and the power conversion system was actually recoverable. This violation has a cross-cutting aspect in the area of human performance, work practices component associated with the failure to provide adequate management oversight in this situation.

The licensee entered this performance deficiency into their corrective action program for resolution.  
Inspection Report# : [2006013](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**Operators failed to permit the safety/relief valves to cycle in automatic and to manually operate the safety/relief valves without driving level outside the prescribed level band as required by AOPs**

An NRC-identified noncited violation of Technical Specification, Section 5.4, "Procedures," was identified for the failure of licensee personnel to accomplish activities affecting quality in accordance with prescribed procedures. Specifically, licensed operators operated the safety/relief valves manually contrary to Abnormal Operating Procedure AOP-0001, OSP-0053, Attachment 1B, "Post Scram Pressure Control Strategies," Revision 5, requirements to operate them in automatic with the main steam isolation valves closed. Additionally, operators failed to manually operate the safety/relief valves, as required, to control pressure in the prescribed pressure band, without driving level outside the prescribed level band.

This violation was more than minor because it was associated with the human performance attribute and affected the mitigating systems cornerstone objective to ensure the availability, reliability, or function of a system or train in a mitigating system because manual actions affect licensed operator capability to perform simultaneous actions. Using the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones," the finding was of very low safety significance because it did not represent a loss of safety function nor did it screen as potentially significant to external initiators. This violation has a cross-cutting aspect in the area of human performance, work practices component associated with the effectiveness of communicating expectations regarding procedural compliance.

The licensee entered this performance deficiency into their corrective action program for resolution.  
Inspection Report# : [2006013](#) (*pdf*)

**Significance:**  Feb 28, 2007

Identified By: NRC

Item Type: FIN Finding

**Senior reactor operator relieved the watch during a transient without waiting for the plant to be in a stable condition, resulting in an inadvertent main steam isolation**

The team identified a finding for the failure of licensed operators to accomplish activities affecting quality in accordance with the standards established in the conduct-of-operations procedures. Specifically, on October 19, 2006, the on-coming control room supervisor relieved the watch during the loss of feedwater transient, instead of waiting for the plant to be in a stable condition, a self-imposed standard documented in Entergy Operations Procedure EN-OP-115, "Conduct of Operations," Revision 2. Although licensee personnel stated that turnover activities were essentially complete at the time, changing the watch at this time caused the at-the-controls reactor operator and other control room personnel to misunderstand who was in charge of the event response and contributed to the at-the-controls operator not placing the mode switch in the SHUTDOWN position, as required by Procedure AOP-0001, "Reactor Scram," Revision 22. The failure to reposition the mode switch resulted in an inadvertent main steam isolation.

This finding was greater than minor because it was associated with the human performance attribute and affected the mitigating systems cornerstone objective to ensure the availability, reliability, or function of a system or train in a mitigating system, namely the main feedwater system. A Phase 2 estimation was required because this finding resulted in a loss of function of the steam side of the power conversion system as determined by the Manual Chapter 0609, Appendix A, Phase 1 Worksheet, "SDP Phase 1 Screening Worksheet for Initiating Events, Mitigation Systems, and Barriers Cornerstones." Using the appropriate plant-specific Phase 2 worksheets, this finding was determined to have very low safety significance because the finding only increased the initiating event likelihood by a very small amount and the power conversion system was actually recoverable. This finding has a cross-cutting aspect in the area of human performance, work practices component associated with the failure to implement the roles and responsibilities of the senior reactor operators in the main control room as designed.

The licensee entered this performance deficiency into their corrective action program for resolution.

**Significance:**  Dec 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to identify a degraded condition of steam leak detection system Transmitter E31-N084B**

A self-revealing, noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified involving the failure to identify a degraded condition affecting the steam leak detection and Division II isolation logic for residual heat removal/reactor core isolation cooling systems. The degraded condition resulted in a spurious isolation of the reactor core isolation cooling system during power operations on November 23, 2006. This issue was entered into the licensee's corrective action program as CR-RBS-2006-04460.

The finding was more than minor because it is associated with the mitigating system cornerstone attribute of equipment performance and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using NRC Manual Chapter 0609, "Significance Determination Process," a Phase 2 analysis concluded that the finding was of very low safety significance. The cause of the finding is related to the crosscutting aspect of problem identification and resolution in that the licensee failed to completely and accurately identify the condition that caused a previous isolation of the reactor core isolation cooling system on October 1, 2004. This failure resulted in the spurious reactor core isolation cooling system isolation on November 23, 2006.

Inspection Report# : [2006005](#) (pdf)

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## Barrier Integrity

**Significance:**  Jun 30, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to Follow Instructions Resulted in Exceeding Load Line Analysis Limit**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified involving the failure to follow procedure. Specifically, during control rod withdrawal a reactor engineer noted that reactor power, as calculated by a heat balance, was inconsistent with predicted power. Although this inconsistency was identified the reactor engineers and operators failed to fully evaluate this condition, as required by procedure, and continued with power ascension resulting in an automatic rod withdrawal block. Upon further review the event was caused from feed flow and temperature data not automatically updating resulting in calculated power being less than actual power. This issue was entered into the licensee's corrective action program as condition Report CR-RBS-2007-01691.

The finding was more than minor because it was associated with the barrier integrity cornerstone attribute of configuration control and it affected the cornerstone objective to provide reasonable assurance that physical design barriers, such as fuel cladding, protect the public from radio-nuclide releases caused by accidents or events. Using the Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have a very low safety significance because it did not have the potential to affect the integrity of the RCS barrier. The cause of this finding is related to the human performance cross cutting component of work practices because neither self nor peer checking actions prevented the automatic rod withdrawal block (H.4(a)).

Inspection Report# : [2007003](#) (pdf)

**Significance:**  Dec 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Inadequate work instructions result in isolation of annulus pressure control system and automatic start of the Division II standby gas treatment system**

A self-revealing, noncited violation of Technical Specification 5.4.1.a was identified involving the failure to provide adequate maintenance instructions for replacement of relays in the Division I standby gas treatment system initiation

logic. As a result, on November 21, 2006, during relay replacement, the annulus pressure control system tripped and the Division II standby gas treatment system automatically initiated. This issue was entered into the licensee's corrective action program as CR-RBS-2006-04445.

This finding was more than minor because it is associated with the barrier integrity cornerstone attribute of human performance affecting the cornerstone objective to provide reasonable assurance that the secondary containment barrier protects the public from radionuclide releases caused by accidents and events. Using the NRC Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because only the standby gas treatment system was affected. The cause of the finding is related to the crosscutting element of human performance in that the licensee failed to provide complete, accurate, and up-to-date instructions in the work package to replace the relays in the Division I standby gas treatment system initiation logic. Inspection Report# : [2006005](#) (*pdf*)

**Significance:**  Dec 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to follow procedure resulted in loss of power to safety-related instrumentation bus and isolation of reactor water cleanup system**

A self-revealing, noncited violation of Technical Specification 5.4.1.a was identified involving the failure to follow Procedure SOP-0048, "120 Vac System," Revision 303. Due to ineffective self- and peer-checking a procedure step was missed, resulting in inadvertent isolation of the reactor water cleanup and the suppression pool cooling and cleanup systems. This issue was entered into the licensee's corrective action program as CR-RBS-2006-03874.

The finding was more than minor because the loss of the reactor water cleanup system, providing reactor water chemistry control, affects the fuel barrier integrity cornerstone attribute of configuration control. Using the NRC Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because only the fuel cladding barrier was affected. The cause of the finding is related to the crosscutting element of human performance in that operations personnel failed to make proper use of human performance techniques of self- and peer-checking.

Inspection Report# : [2006005](#) (*pdf*)

**Significance:**  Dec 31, 2006

Identified By: Self-Revealing

Item Type: FIN Finding

**Newly installed reactor water cleanup pump coupling failed because it was beyond its expected service lifetime**

A self-revealing finding was identified involving the installation of a pump coupling that exceeded vendor shelf- and service-life recommendations on November 15, 2006. As a result, the reactor water cleanup Pump A coupling failed on November 28, 2006, requiring operators to remove from service the reactor water cleanup pump and a demineralizer affecting the primary means of reactor water chemistry control. This issue was entered into the licensee's corrective action program as CR-RBS-2006-04488 and -04517.

The finding is greater than minor because it would become a more significant safety concern if left uncorrected, since failure of similar couplings affecting other plant components, such as the drywell floor and equipment drain pumps, would require a plant shutdown to make repairs. The finding affected the barrier integrity cornerstone. Using the NRC Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because the finding only affected the fuel cladding barrier.

Inspection Report# : [2006005](#) (*pdf*)

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## Emergency Preparedness

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## Occupational Radiation Safety

**G****Significance:** Jul 13, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Conspicuously Post Radiation Areas**

The team identified a noncited violation of 10 CFR 20.1902(a) because the licensee failed to post radiation areas in the radwaste building with a conspicuous sign or signs bearing the radiation symbol and the words "Caution, Radiation Area." The licensee posted radiation area signs only at the entrances to the different elevations of the building, instead of at the discrete radiation areas, even though most of the radwaste building was not a radiation area. Dose rates in unposted radiation areas were as high as 15 millirems per hour. As corrective action, the licensee posted the discrete areas. Additional corrective action is still being evaluated.

The finding was greater than minor because it was associated with one of the cornerstone attributes (exposure control and monitoring) and the finding affected the Occupational Radiation Safety cornerstone objective, in that, uninformed workers could unknowingly accrue additional radiation dose. Using the Occupational Radiation Safety Significance Determination Process, the team determined that the finding was of very low safety significance because it did not involve: (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. Also, this finding had a cross-cutting aspect in the area of human performance and component of work control because the licensee did not coordinate work activities by incorporating actions to address the need to keep personnel apprised of plant conditions that may affect work activities.

Inspection Report# : [2007010](#) (*pdf*)**G****Significance:** Dec 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Licensee failed to perform a radiological survey in off-gas sample room after radiological conditions had changed**

A self-revealing, noncited violation of 10 CFR 20.1501(a)(2) was identified involving the failure of radiation protection personnel to perform a survey in the off-gas sample room during main condenser leak testing. As a result, when a chemistry technician entered the room to obtain a grab sample, his electronic alarming dosimeter alarmed unexpectedly. When another chemistry technician reached into the room to perform a survey of the test equipment, his dosimeter also alarmed. It was later determined that they were exposed to a dose rate of 440 and 521 millirem per hour, respectively. This issue was entered into the licensee's corrective action program as CR-RBS-2006-04340.

The finding was more than minor because it was associated with the occupational radiation safety cornerstone attribute of programs and processes, such as the monitoring of radiological conditions, specifically the failure to perform a survey following changes in radiological conditions in the off-gas sample room, and affects the associated cornerstone objective to ensure the adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Utilizing Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," the inspectors determined that the finding was of very low safety significance because it did not involve: (1) as low as is reasonably achievable planning and controls, (2) an overexposure, (3) a substantial potential for an overexposure, or (4) an impaired ability to assess dose. The cause of the finding was related to the crosscutting element of problem identification and resolution in that the licensee failed to communicate to affected personnel in a timely manner internal operating experience, specifically, while there was off-gas flow through the condenser leak test equipment, radiological conditions would increase.

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## Public Radiation Safety

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings

pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

**Significance:** N/A May 21, 2007

Identified By: NRC

Item Type: FIN Finding

### Identification and Resolution of Problems

The team reviewed approximately 227 condition reports, work orders, engineering evaluations, associated root and apparent cause evaluations, and other supporting documentation to assess problem identification and resolution activities. On most occasions, the team determined that the licensee adequately identified, evaluated, prioritized, and implemented timely and effective corrective actions for conditions adverse to quality. However, the team concluded that the licensee had experienced some continuing challenges in all three areas based upon the number of issues identified during the last 15 months. Examples of poor engineering evaluations continued during this assessment period; however, the licensee had recognized this deficiency and had taken actions to address the weakness. The licensee had also implemented actions to improve their ability to correctly identify and take appropriate actions in response to the Substantive Crosscutting Issue in Problem Identification and Resolution identified in 2006. The licensee improved in their coordination among plant processes when closing condition reports to other corrective action or work control documents although some instances of incorrect closure had recently been identified.

Overall, the licensee appropriately evaluated industry operating experience for relevance to the facility and had entered applicable items into the corrective action program. The licensee appropriately used industry operating experience when performing root cause and apparent cause evaluations. The licensee performed effective Quality Assurance audits and self-assessments, as demonstrated by self-identification of poor corrective action program performance and identification of ineffective corrective actions. The team concluded that the licensee maintains an appropriate safety conscious work environment. The team concluded from interviews that, although no safety conscious work environment concerns existed, the complaints related to general culture factors that have been stated for the last two safety culture surveys, if not addressed, might result in safety conscious work environment concerns.

Inspection Report# : [2007009](#) (*pdf*)

Last modified : December 07, 2007