

Brunswick 1

2Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a 10 CFR 50.59 Evaluation for a Plant Modification

The inspectors identified a severity level IV NCV of 10 CFR 50.59, “Changes, Tests, and Experiments” for failing to perform a written safety evaluation prior to implementing a change to the facility as described in the Updated Final Safety Analysis Report (UFSAR), when the Unit 1 and Unit 2 reactor building instrument air standby compressors were permanently abandoned. The licensee entered the issue into their corrective action program and performed a written safety evaluation of the condition.

The inspectors determined that, until identified by NRC inspectors, the licensee had not performed a 10 CFR 50.59 safety evaluation for the abandonment of the instrument air standby compressors, and this is a performance deficiency. Because this is a violation of 10 CFR 50.59, it is considered to be a violation which potentially impedes or impacts the regulatory process. Therefore, such violations are dispositioned using the traditional enforcement process instead of the Significance Determination Process. This finding was determined to be more than minor because there was a reasonable likelihood that the change requiring a 10 CFR 50.59 safety evaluation would require Commission review and approval prior to implementation in accordance with 10 CFR 50.59(c)(2). This likelihood is based on the increased likelihood of loss of reactor building instrument air, reactor scram, and closure of the outboard MSIVs, which is an occurrence of a malfunction of a structure, system, or component (SSC) that is analyzed in the UFSAR. To determine the significance of the violation, the inspectors completed a significance determination review using IMC 0609, Appendix A, Significance Determination of Reactor Inspection Findings for At Power Situations. The finding impacted the initiating events cornerstone. Because the finding does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, this finding has very low safety significance. The cause of the finding is not related to a cross-cutting aspect because the performance deficiency is not indicative of current licensee performance.

Inspection Report# : [2009002](#) (*pdf*)

Mitigating Systems

Significance: TBD May 28, 2009

Identified By: NRC

Item Type: AV Apparent Violation

Inability to Operate the EDGs Locally as Required by the Safe Shutdown Analysis Report

An apparent violation of 10 CFR 50, Appendix B, Criterion III, Design Control, was identified for failure to correctly translate the design basis into EC 66274 to replace control relays on all four EDGs. Specifically, termination points for linking control power to the EDG lockout relay reset circuitry were incorrectly designated in the EC. This resulted in the wiring for control relays being installed such that the EDGs could not be operated locally as required by the Safe Shutdown Analysis Report. Upon discovery, the licensee initiated Action Request (AR) 292232 and re-wired and tested each affected EDG. The local control function was restored to all EDGs on August 21, 2008.

The failure to correctly translate the design basis into EC66274 is a performance deficiency. This finding is more than minor because it is associated with the reactor safety mitigating system cornerstone attribute of protection against external events, i.e., fire. It also affects the cornerstone objective of ensuring the availability of systems that respond to events in that the EDGs could not be operated locally as required by the Safe Shutdown Analysis Report. This

finding was assessed using the applicable SDP, which resulted in a calculated core damage frequency (CDF) risk increase over the base case between 1E-5 and 1E-6 per year. The dominant accident sequences involved are initiated by a fire situated such as to cause both a loss of offsite power (LOOP) and a forced main control room evacuation. For these dominant accident sequences, the performance deficiency will result in a station blackout (SBO) to either or both units. The exposure period for this condition was one year. As a result, the finding was preliminarily determined to be of low to moderate safety significance (White). The cause of the finding is considered to have a cross-cutting aspect related to accurate design documentation [H.2(c)], as described in the resources component of the human performance cross-cutting area.

Inspection Report# : [2009009](#) (*pdf*)

Significance:  Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correctly Perform Biennial Written Examination for a Licensed Operator

The inspectors identified a non-cited violation of 10 CFR Part 55.59(a)(2) for failure to correctly evaluate and grade a written examination during the biennial requalification examination for licensed operators. The licensee operations training staff incorrectly allowed two correct answers for a question, where the answers were diametrically opposed (opposite one another) which is prohibited by the examination guideline NUREG-1021.

This finding is more than minor because if left uncorrected, it could become a more significant safety concern in that licensed operators would not be adequately tested to ensure an acceptable knowledge level for performing licensed duties. Using the Licensed Operator Requalification Significance Determination Process, this finding was determined to be of very low safety significance (Green) because the individual that failed was a part of a crew that passed their biennial examinations and no issues resulted during the actual watch standing of this crew. All other operators involved were able to perform assigned licensed duties. The finding was a result of the licensee not in compliance with the requirements of TAP-403, "Conduct of Examinations," and TAP-411, "Continuing Training Annual/Biennial Exam Development, Administration and Security." The finding was related to the cross-cutting aspect of procedural compliance of the work control component of the cross-cutting area of Human Performance (H.4(b)) because the examination developers did not comply with procedure requirements to ensure examination integrity was maintained. The licensee has initiated a root cause analysis to determine the primary and contributing causes of this event.

Inspection Report# : [2008005](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Correct a Condition Adverse to Quality Affecting the Operability of the Standby Gas Treatment Train B

The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" which states in part, that for conditions adverse to quality, measures shall assure that the cause of the condition is determined and corrective action taken. Specifically, the licensee failed to correct a condition that allowed leakage through a penetration seal in the Unit 1 reactor building supply air ventilation room floor onto the 1B standby gas treatment (SBGT) train control panel, rendering the 1B SBGT inoperable. The licensee entered the issue into their corrective action program and repaired the degraded penetration.

The deficiency associated with this event is not adequately sealing the floor penetration in the Unit 1 reactor building supply air ventilation room. The finding is more than minor because it was associated with the containment barrier performance attribute of the barrier integrity cornerstone to provide reasonable assurance that physical design barriers provide protection against radionuclide releases caused by accidents or events. In accordance with Inspection Manual Chapter (IMC) 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," the inspectors conducted a Phase I significance determination process (SDP) screening and determined

the finding to be of very low safety significance (Green). The finding was of very low safety significance (Green) because the finding only represents a degradation of the radiological barrier function provided for the SBT system. The cause of the finding is not related to a cross-cutting aspect because the occurrence was greater than three years ago and is not indicative of current licensee performance.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Maintenance Procedure for the Control Room Air Conditioning and Emergency Ventilation Instrument Air System

A self-revealing Green NCV of Technical Specification (TS) 5.4.1, Procedures, was identified for inadequate maintenance procedures for the control room air conditioning and emergency ventilation system instrument air dryer. As a result, on January 21, 2009, the control room air conditioning and emergency ventilation instrument air system lost air pressure, rendering the control room air conditioning (AC) system and the control room emergency ventilation (CREV) system inoperable. The licensee entered the issue into their corrective action program and changed maintenance and operating procedures to prevent recurrence.

The failure to implement adequate maintenance procedures for the control room air conditioning and emergency ventilation instrument air system is a performance deficiency. This performance deficiency is more than minor because it is associated with structure, system, and component (SSC), and barrier performance attribute of the Barrier Integrity Cornerstone. It also adversely affected the cornerstone objective of maintaining a radiological barrier for the control room. The finding was determined to be of very low safety significance because it only affected the radiological barrier function of the control room, and does not represent a degradation of the smoke or toxic atmosphere barrier function of the control room. The finding affects the cross-cutting area of human performance, resources component, complete and accurate documentation aspect because the licensee did not incorporate adequate guidance for maintaining the control room AC and CREV instrument air dryer in their maintenance procedures. (H.2. (c))

Inspection Report# : [2009002](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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.

Miscellaneous

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