

Byron 2

3Q/2010 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

WATER INTRUSION LEADS TO LOSS OF ANNUNCIATORS (SECTION 1R15.b)

The inspectors identified a finding of very low safety significance and associated NCV of Byron Operating License Condition 2.C(6) for Unit 1 and 2.E for Unit 2 for the licensee failing to provide an adequate floor drain system as required by the Fire Protection Program. Specifically, the floor drain system in the Upper Cable Spreading Room (UCSR) was not adequate to prevent firefighting water from entering the Control Room through the floor openings and affecting equipments. The licensee entered this issue into the CAP as IR 1046794 and subsequently sealed the UCSR floor.

The finding is greater than minor because it was associated with the protection against external factors 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. The finding is of very low significance because safety equipment functions remained available to control room personnel. This finding was related to the cross-cutting area of Problem Identification and Resolution and its associated component for Corrective Action Program (P.1(d)) because the licensee failed to take appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity. (Section 1R15.b)

Inspection Report# : [2010003](#) (*pdf*)

Mitigating Systems

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE EVALUATION OF SHIM PACK FOR THE UPPER STEAM GENERATOR LATERAL SUPPORTS

The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the inadequate design evaluation of the shim packs for the Upper Steam Generator Lateral Supports. Specifically, the licensee's calculations failed to demonstrate that the stresses in the shims and the concrete met the acceptance criteria. The licensee entered the issue into the corrective action program (CAP) as Issue Report (IR) XXXXXX to perform/revise the design basis calculations.

The finding was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attributes of Design Control and Equipment Performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because it was a design qualification deficiency confirmed not to result in the loss of operability or functionality. This finding does not have a cross-cutting aspect due to its age. (Section 1R15.b)

Inspection Report# : [2010003](#) (*pdf*)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

LOOSE DEBRIS INSIDE OF UNIT CONTAINMENT AT THE START OF THE REFUELING OUTAGE

The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to follow procedure BAP 1450-1, "Access to Containment." Specifically, the inspectors determined that the licensee brought loose debris items into Unit 2 containment prior to Mode 5 and did not perform an engineering evaluation required by procedure. The licensee entered this issue into the CAP as IR 1058304 and completed an evaluation to verify that the containment sump was not adversely affected.

The finding is more than minor because, if left uncorrected, the issue could have become a more significant safety concern. The inspectors evaluated the finding using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Finding," dated January 10, 2008, for the Mitigating Systems Cornerstone. Since this finding was not a design or qualification deficiency, did not result in loss of system or train safety function, and was not safety significant due to external events, this issue is screened as very low safety significance. This finding is related to the Work Control component of the Human Performance cross cutting area for the licensee's failure to coordinate work activities and the need for work groups to coordinate with each other. (H.3 (b)) (Section 1R20.b)

Inspection Report# : [2010003](#) (pdf)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO APPROPRIATELY ANALYZE THE DEGRADED VOLTAGE TIMER SETTINGS

A finding of very low safety significance and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, Design Control, was identified by the inspectors for the licensee's failure to have an appropriate analysis for the second level undervoltage (degraded voltage) relay timer settings. Specifically, Byron's analysis EC 377631, "Evaluation and Technical Basis for the AP System Second Level Undervoltage (Degraded Voltage) Time Delay Settings," dated February 3, 2010, failed to demonstrate the ability of the permanently connected safety-related loads to continue to operate for 5 minutes and 40 seconds without sustaining damage during a worst case, non-accident degraded voltage condition. The licensee entered this issue into their corrective action program as IR 1071667. The performance deficiency was determined to be more than minor because the finding affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, there was reasonable doubt as to whether the permanently connected safety-related loads would remain operable during a worst case, non-accident degraded voltage condition for the duration of the time delay chosen. This finding is of very low safety significance (Green), because the design deficiency was confirmed not to result in loss of operability or functionality. After consulting with the Office of Nuclear Reactor Regulation (NRR), the inspectors identified a cross-cutting aspect associated with this finding in the area of human performance, decision making because the licensee did not use conservative assumptions based on NRC approved changes to the licensing basis in choosing the worst case degraded voltage condition in their February 2010 analysis. Specifically, in their February 2010 analysis, the licensee chose 75 percent of nominal voltage as their lower limit of degraded voltage (based on a not formally approved manual action), opposed to the worst possible degraded voltage of approximately 66 percent of nominal (first level undervoltage setpoint). (IMC 0310, Section 06.01.a. (2))

Inspection Report# : [2010003](#) (pdf)

Significance:  Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

0B FIRE PUMP DISCHARGE VALVE DISCOVERED CLOSED (SECTION 1R12)

A self-revealed finding of very low safety significance and associated Non-Cited Violation of Byron Operating License Condition 2.C(6) for Unit 1 and 2.E for Unit 2 for the licensees failure to identify the separation of the 0B Fire Pump discharge valve, 0FP018B, valve stem and valve disk. As a result, the mitigating functions associated with the 0B Diesel driven fire pump would not be assured. The licensee entered this issue into the Corrective Action Program (CAP) as Issue Report (IR) 1063395 and repaired the valve.

The issue is more than minor because it affected the Mitigating Systems Cornerstone attribute of Protecting Against

External Events and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Based on a Phase 3 significance evaluation, the finding is determined to be of very low safety significance. The primary cause for this finding was related to the cross-cutting area of Problem Identification and Resolution and its associated component for Corrective Action Program (P.1(c)) because licensee personnel failed to identify the discharge valve's functionality was impacted by its degraded state. (Section 1R12.b)

Inspection Report# : [2010003](#) (pdf)

Significance: SL-IV Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO REPORT AN AUTOMATIC RPS AND AUXILIARY FEEDWATER ACTUATION WHILE SHUTDOWN THUS IMPACTING THE REGULATORY PROCESS.

A Severity Level IV, NCV of 10 CFR 50.72(b)(3)(iv)(A) was identified by the inspectors for the licensee's failure to recognize that a valid Unit 2 automatic Reactor Protection System (RPS) and Auxiliary Feedwater (AF) actuation while shutdown were reportable conditions. Consequently, the licensee failed to make an eight hour report as required by 10 CFR 50.72. This issue was documented in the licensee's Corrective Action Program as IR 1060177 and the licensee subsequently reported the event.

This finding was evaluated under Traditional Enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. However, this violation was of very low safety significance because immediate NRC follow-up action was not required. The NRC has characterized this violation as a Severity Level IV NCV in accordance with Section IV.A.3 and Supplement 1 of the NRC Enforcement Policy. The cause of this finding was directly related to the cross-cutting area of Problem Identification and Resolution (P.1(c)) because the licensee did not thoroughly evaluate and classify a condition adverse to quality for reportability. (Section 4OA3).

The performance deficiency associated with this traditional enforcement case is item 2010-003-07.

Inspection Report# : [2010003](#) (pdf)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO REPORT AN AUTOMATIC RPS AND AUXILIARY FEEDWATER ACTUATION WHILE SHUTDOWN .

A Green Finding and associated NCV of 10 CFR 50.72(b)(3)(iv)(A) was identified by the inspectors for the licensee's failure to recognize that a valid Unit 2 automatic Reactor Protection System (RPS) and Auxiliary Feedwater (AF) actuation while shut down were reportable conditions. Consequently, the licensee failed to make an 8 hour report as required by 10 CFR 50.72. This issue was documented in the licensee's CAP as IR 1060177 and the licensee subsequently reported the event.

This finding was of very low safety significance (Green) because immediate NRC follow-up action was not required. The cause of this finding was directly related to the cross-cutting area of Problem Identification and Resolution (P.1 (c)) because the licensee did not thoroughly evaluate and classify a condition adverse to quality for reportability. (Section 4OA3).

The traditional enforcement issue associated with this finding is tracked as item 2010-003-06.

Inspection Report# : [2010003](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH 10 CFR PART 26.203(b)(2)

The inspectors identified a finding of very low safety significance and the associated NCV of 10 CFR Part 26.203(b) (2), "Procedures," for the licensee's failure to adhere to work hour rule procedures. Specifically, a licensed reactor operator who was working an outage work hour schedule on Unit 1 was assigned as the online unit, Unit 2, Assist

Operator without meeting the online work hour requirements. Subsequently, the licensee clarified the requirements for scheduling personnel and entered this issue into their corrective action (CAP) program as Issue Report (IR) 882727.

The finding was more than minor because the finding could lead to a more significant safety concern. The finding is of very low safety significance because there were additional operators in the control room that satisfied the work hours requirements and the operators were required to perform peer check before any control room equipment manipulation were taken. This finding has a cross-cutting aspect in the area of Human Performance, Resources Component (H.2(b)), because there were insufficient qualified personnel to maintain work hours within the working hours guidelines.

Inspection Report# : [2009005](#) (*pdf*)

Barrier Integrity

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM ADEQUATE EVALUATION FOR CRANE UPGRADE

A finding of very low safety significance and an associated Non-Cited Violation (NCV) of Title 10 Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion III, "Design Control" was identified by the inspectors for the licensee's failure to perform adequate evaluations to upgrade the single failure proof crane. Specifically, the inspectors identified six examples where the licensee failed to perform adequate evaluations in accordance with American Society of Mechanical Engineers (ASME) NOG-1-2004, requirements. The licensee documented the conditions in Issue Report (IR) 1099897, and IR 1100062 and initiated actions for calculation revisions and field modifications.

The Fuel Handling Building (FHB) crane is designed to Seismic Category I requirements and the licensee used compliance with ASME NOG-1-2004, as the design basis for their crane upgrade to a single failure proof crane. The inspectors determined that the failure to perform adequate evaluations was contrary to ASME NOG-1-2004 requirements and was a performance deficiency. The finding was more than minor as it was associated with the Barrier Integrity cornerstone, because a fuel handling building crane heavy load drop can damage the Spent Fuel Pool (SFP) Cooling System or spent fuel cladding. The inspectors evaluated the finding using Inspection Manual Chapter (IMC) 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," and based on a "No" answer to all of the questions in the Barrier Integrity column of Table 4a, determined the finding to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Human Performance, Resources because the licensee did not provide adequate oversight of work activities, including contractors, such that design documentation was accurate to support nuclear safety. H.2(c) (Section 4OA5)

Inspection Report# : [2010004](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH 10 CFR PART 20 APPENDIX G

The inspectors identified a finding of very low safety significance and the associated NCV of 10 CFR Part 20, Appendix G, Section III.A.3. Specifically, the licensee did not establish a Quality Assurance Program sufficiently to assure conformance with 10 CFR 61.55, in that, the program was not adequate to identify incorrect waste stream data was used to determine the concentrations of radionuclides, and ultimately ensure waste was properly classified, in accordance with 10 CFR 61.55. The licensee entered the deficiency into its CAP (IR 950082) and re-evaluated these shipments using the appropriate waste stream radionuclide distribution and correctly determined that the waste classification remained Class C.

The failure to establish an adequate 10 CFR Part 61 Quality Assurance Program, to assure conformance with 10 CFR 61.55, is a performance deficiency that was reasonably within the licensee's ability to foresee and correct, which should have been prevented. The finding is more than minor because, if left uncorrected the performance deficiency could have the potential to lead to a more significant safety concern. This finding was determined to be of very low safety-significance because no radiation limits were exceeded, there was no breach of packaging, there was no package certificate of compliance finding, there was no low level burial ground non-conformance, and no failure to make notifications or provide emergency information. The cause of this finding was related to the cross-cutting area of Human Performance, Resources (H.2(b)) due to inadequate training and insufficient qualified personnel.

Inspection Report# : [2009005](#) (*pdf*)

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

Last modified : November 29, 2010