

Waterford 3

1Q/2012 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Implement a Reactor Coolant System Drain Down Procedure

The inspectors documented a self-revealing non-cited violation of Technical Specification 6.8.1.a because the licensee did not adequately implement Operating Procedure OP-001-003, "Reactor Coolant System Drain Down," during the installation of the incore instrumentation flanges. Specifically, the licensee did not establish a reactor coolant system vent path while maintaining reactor coolant level below 26 feet for the assembly of the incore instrumentation flanges as required by OP-001-003. As a result, the licensee experienced a loss of reactor coolant inventory from three unassembled incore instrumentation flanges, which spilled onto the reactor vessel head insulation and filled the upper annulus cavity of the reactor vessel. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2011-3163 and CR-WF3-2011-3636. The immediate corrective actions included opening the pressurizer spray line vent valve (RC-309) to establish a reactor coolant system vent path.

The finding is more than minor because it is associated with the configuration control attribute of the Initiating Events cornerstone and affects 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 inspectors performed the initial significance determination for the failure to adequately implement operating procedures using NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The Initial screening directed the inspectors to use Attachment 1 of Appendix G, "Shutdown Operations Significance Determination Process," based on the conditions of the plant at the time of the event. The inspectors evaluated the significance of the finding and determined that it did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the inspectors determined that the finding is of very low safety significance (Green). This finding has a cross-cutting aspect in the work control component of the human performance area because the licensee did not appropriately coordinate work activities in incorporating actions to address the impact of the need to keep personnel apprised of work status, the operational impact of work activities, and plant conditions that may affect work activities [H.3(b)]. (Section 1R20.1)

Inspection Report# : [2011004](#) (*pdf*)

Significance: G Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Testing for a Shutdown Cooling Heat Exchanger Outlet Stop Check Valve

The inspectors documented a self-revealing non-cited violation of 10 CFR 50.55a, "Codes and Standards," because the licensee did not establish and maintain an adequate testing program for a shutdown cooling heat exchanger outlet stop check valve (CS-117A) in accordance with Mandatory Appendix II, "Check Valve Condition Monitoring Program," of the American Society of Mechanical Engineers Operation and Maintenance Code 2001 through 2003. Specifically, the licensee did not provide adequate inservice testing to detect degradation of seat leakage on the stop check valve CS-117A. As a result, the operating train of shutdown cooling experienced a flow diversion when the licensee opened the upstream containment spray isolation header valve to fill the containment spray riser. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2011-3350 and CR-WF3-2011-5841. The immediate corrective action included the closure of the upstream isolation valve and the initiation of a work order to address seat leakage on the stop check valve CS-117. The planned corrective action includes the development of an augmented test to determine appropriate seat leakage criteria for the stop check valve.

The finding is more than minor because it is associated with the equipment performance attribute of the Initiating Events cornerstone and affects 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 inspectors performed the initial significance determination using NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The initial screening directed the inspectors to use Attachment 1 of Appendix G, "Shutdown Operations Significance Determination Process," since the degraded stop check valve upsets plant stability and challenge critical safety functions during shutdown conditions. The inspectors evaluated the significance of the finding and determined that it did not require a quantitative assessment because adequate mitigating equipment remained available and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the inspectors determined that the finding is of very low safety significance (Green). This finding did not have a cross-cutting aspect associated with it because the licensee established the check valve condition monitoring program prior to the past three years. Therefore it is not reflective of current plant performance. (Section 1R20.2)

Inspection Report# : [2011004](#) (pdf)

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: FIN Finding

Failure to Follow Apparent Cause Evaluation Process Procedure

The inspectors identified a finding because the licensee did not implement procedure EN-LI-119, "Apparent Cause Evaluation Process." Specifically, the licensee did not follow the requirements provided in procedure EN-LI-119, Section 5.3.3 (k), to complete corrective actions in a timely manner for the intersystem leakage in the gas waste management system. As a result, no corrective action implementation occurred prior to additional equipment failures for the system. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2011-0934. The immediate corrective action included the reevaluation of the causal determination and development of an implementation plan to complete the corrective actions in a timely manner.

The finding is more than minor because it is associated with the protection against external factors attribute of the Initiating Events cornerstone and affects 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 intersystem leakage of the gas decay tanks increase the likelihood of a potential explosive mixture and continued to challenge technical specification oxygen concentration limits. The inspectors performed the initial significance determination using NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The Initial screening directed the inspectors to use Appendix F, "Fire Protection Significance Determination Process," because the finding is a contributor to a fire initiation event. The inspectors assigned a degradation rating of low to the finding since the oxygen concentration levels in the gas decay tanks were below the limit of an explosive mixture. The inspectors determined that the finding is of very low safety significance (Green) because the finding minimally impacted the fire protection capabilities of the fire area. This finding has a cross-cutting aspect in the resources component of the human performance area in that the licensee did not minimize long-standing equipment issues and maintenance deferrals [H.2(a)]. (Section 4OA2.3(2))

Inspection Report# : [2011004](#) (pdf)

Significance: SL-IV Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Update the FSAR following Modifications to the Reactor Coolant Pump Vapor Seals.

The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.71(e) because the licensee did not revise the final safety analysis report (FSAR) as updated with information consistent with plant conditions. Specifically, the licensee did not update Section 5.4.1.3 of the FSAR for Waterford Steam Electric Station, Unit 3 following modifications to the reactor coolant pump vapor seals in 2007 and 2009, respectively. As a result, the licensee did not promptly identify and correct FSAR noncompliance. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2010-7421. The planned corrective actions include revising the FSAR as updated and replacing the degraded reactor coolant pump seals during the next two refueling outages.

The inspectors considered this issue to be within the traditional enforcement process because it has the potential to impede or impact the NRC's ability to perform its regulatory function. The inspectors used the NRC Enforcement Policy to evaluate the significance of this violation. The inspectors concluded that the violation is more than minor because the longstanding and incorrect information in the FSAR as updated had a material impact on safety and licensed activities. The material impact is that the modifications created a reactor coolant pump seal loss of coolant accident likelihood inside containment, which could have potentially impacted licensed activities. The inspectors determined the violation is a Severity Level IV (very low safety significance) since the erroneous information not updated in the FSAR was not used to make an unacceptable change to the facility nor impacted a licensing or safety decision by the NRC. The inspectors determined there is a cross-cutting aspect in the corrective action component of the problem identification and resolution area. Specifically, the licensee did not thoroughly evaluate and take adequate actions in a timely manner to update the FSAR to be consistent with plant conditions [P.1.c of IMC 0310] (Section 1R18).

Inspection Report# : [2011003](#) (*pdf*)

Significance:  Jun 30, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Implement Work Order Instructions to Restore a Feedwater Heater Drain Valve.

A self-revealing finding occurred because maintenance personnel did not follow written procedures during the calibration of a level switch that controls feedwater heater drain valve FHD703A. Specifically, the licensee did not perform concurrent verification checks as required by documented work order instructions (WO-00180716) to ensure that personnel restore manipulate components to the correct position following maintenance. As a result, the feedwater heater drain valve remained in a closed manipulate state, which caused a spurious isolation of a string of feedwater heaters. The isolation of the feedwater heaters caused operators to down power the reactor to approximately 72 percent. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2009-7420. The immediate corrective actions included restoring the feedwater heater drain valve to its proper position.

The finding is more than minor because it is associated with the human performance attribute of the Initiating Events cornerstone and affects 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. Specifically, the human error caused an event that upset plant stability during power operation. The inspectors evaluated this finding using IMC 0609 Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined that the finding is of very low safety significance (Green) because it does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. The finding has a cross-cutting aspect in the work practices component of the human performance area because the licensee's personnel proceed in the face of uncertainty or unexpected circumstances [H.4.a of IMC 0310] (Section 4OA2.3).

Inspection Report# : [2011003](#) (*pdf*)

Mitigating Systems

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Develop Preventive Maintenance Tasks for Critical Limit Switches on Component Cooling Water Inlet Isolation Valves

A Green self-revealing non-cited violation of Waterford Steam Electric Station, Unit 3 Technical Specification 6.8.1.a occurred because the licensee did not establish procedures for performing preventive maintenance tasks on the dry cooling tower (DCT) component cooling water inlet isolation valves A and B (CC-135) limit switches. Specifically, the licensee did not develop preventive maintenance tasks to lubricate or replace critical limit switches that provide a permissive for the operation of the DCT fans. As a result, on February 4, 2011, the limit switch on valve CC-135A failed to operate as designed and rendered an entire train of DCT fans inoperable. The licensee entered this condition

into their corrective action program as CR-WF3-2011-0679 for resolution. The immediate corrective action included the lubrication of the limit switch and the manual stroking of the valve to obtain free and smooth movement of the degraded equipment. The planned corrective actions include the development of a preventive maintenance task to lubricate and replace the limit switches on a scheduled frequency.

The failure to establish procedures for performing preventive maintenance tasks on the dry cooling tower (DCT) component cooling water inlet isolation valves A and B (CC-135) limit switches is a performance deficiency. The performance deficiency is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, since there is no preventive maintenance task for lubrication and replacement of the equipment, the limit switches can become stuck and render an entire train of DCT fans inoperable. The inspectors evaluated the significance determination using the NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined that the finding is of very low safety significance (Green) because it is not a design or qualification deficiency, did not represent a loss of a safety function of a system or a single train for greater than its technical specification completion time, and did not screen as potentially risk-significant due to an external initiating events. The inspectors also concluded that no cross-cutting aspect is applicable to this finding because the performance deficiency is not reflective of current performance.

Inspection Report# : [2012002](#) (pdf)

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Perform Testing to Demonstrate Performance of Safety-Related Valves

The inspectors identified a Green non-cited violation of 10CFR50, Appendix B, Criterion XI because the licensee did not identify and perform testing on a safety-related component to demonstrate that it would perform satisfactory in service in accordance with requirements contained in applicable design documents. Specifically, the licensee did not identify and perform proper testing for the Essential Chiller Hot Gas Bypass Valves (RFR-106A, B, and C). As a result, the licensee could not demonstrate that the safety-related valves would perform satisfactory in service without performing a test and operability evaluation. The licensee entered this condition into the corrective action program as CR-WF3-2012-0632 and CR-WF3-2012-0659. The immediate corrective action included testing the Hot Gas Bypass Valves (HGBVs) to demonstrate the proper performance of their safety function.

The failure to identify and perform testing to demonstrate that a safety-related component would perform satisfactory in service in accordance with requirements contained in applicable design documents is a performance deficiency. The performance deficiency is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the hot gas bypass valve closure is required for essential chiller operation to maintain the reactor in a safe shutdown condition. The inspectors evaluated the significance determination using the NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined that the finding is of very low safety significance (Green) because it is not a design or qualification deficiency, did not represent a loss of a safety function of a system or a single train for greater than its technical specification completion time, and did not screen as potentially risk-significant due to an external initiating events. This finding has a cross-cutting aspect in the resources component of the human performance area in that the licensee did not ensure that complete, accurate, and up-to-date test procedures were available to demonstrate that equipment performance is adequate to assure nuclear safety.

Inspection Report# : [2012002](#) (pdf)

Significance:  Feb 17, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Evaluate the Impact of Fire Damage on the Dry Cooling Tower Fans

The team identified a non-cited violation of License Condition 2.C.9 and Appendix R, Section III.G for the failure to adequately evaluate the impact of fire damage on the dry cooling tower fans. Specifically, the failure to adequately evaluate fire damage to the dry cooling tower fans did not ensure one train remained available to achieve and maintain hot shutdown conditions from the alternate shutdown panel. The licensee documented this deficiency in Condition Report 2012-00837.

The failure to adequately evaluate the impact of fire damage on the dry cooling tower fans was a performance deficiency. The performance deficiency was more than minor because it was associated with the protection against external events (fire) attribute of the Mitigating Systems Cornerstone and it adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated this deficiency using Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process." The performance deficiency affected the fire protection defense-in depth strategies involving post-fire safe shutdown systems. Since this finding involved a control room abandonment issue, a senior reactor analyst performed a Phase 3 significance determination. The senior reactor analyst determined this finding had very low risk significance based upon a bounding analysis (Green). The dominant core damage sequences involved a fire initiating event, failure of both the component cooling water and auxiliary component cooling water systems, as well as an independent failure of the turbine driven auxiliary feedwater pump. Equipment that helped to mitigate the significance included the unaffected offsite power system, the viable steam generators and the safety related auxiliary feedwater system. Because the original failure to evaluate the impact of fire damage on the dry cooling tower fans had occurred longer than three years prior to this inspection, this finding did not reflect current licensee performance.

Inspection Report# : [2012007](#) (pdf)

Significance:  Feb 17, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Calculate Adequate Cooling Provided to Diesel Generator B within Required Time

The team identified a non-cited violation of License Condition 2.C.9 and the fire protection program for the failure to perform a post-fire safe shutdown analysis design calculation. Specifically, the team determined that the licensee had not calculated the time available to establish component cooling water to prevent damaging the emergency diesel generator when providing power to post fire safe shutdown components. The licensee documented this deficiency in Condition Report 2012 00818.

The failure to perform a design calculation evaluating the ability to remove heat based upon emergency diesel generator loading following a control room fire was a performance deficiency. The performance deficiency was more than minor because it was associated with the protection against external events (fire) attribute of the Mitigating Systems Cornerstone and it adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the significance of this finding using Manual Chapter 0609, Appendix F. The performance deficiency affected the fire protection defense-in depth strategies involving post-fire safe shutdown systems. Using Appendix F, the team assigned this finding a low degradation rating because the system was expected to display nearly the same level of effectiveness and reliability as it would had the degradation not been present. Specifically, the component cooling water system could accommodate the heat in the jacket water system of a lightly loaded diesel generator. This finding screened as very low safety significance (Green) in the Phase 1 evaluation. Because the original failure to perform a design calculation had occurred longer than three years prior to this inspection, this finding did not reflect current licensee performance.

Inspection Report# : [2012007](#) (pdf)

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Correct a Condition Adverse to Quality Associated with the Main Feedwater Isolation

Valves

Green. The inspectors identified a non-cited violation of 10CFR50, Appendix B, Criterion XVI because the licensee failed to identify and correct a condition adverse to quality associated with the main feedwater isolation valve. Specifically, the licensee did not identify that varnish deposits were causing the main feedwater isolation valve to fail its inservice testing. As a result, corrective actions that were implemented did not address the adverse condition, leading to a subsequent test failure. The licensee entered this issue into their corrective action program as CRWF3-2011-2005 and CR-WF3-2011-8140. The corrective actions included the replacement of the actuator, a shortening of the replacement frequency of the fourway hydraulic valves to a 36 month interval, and an evaluation of the current methods of gathering and implementing operating experience. The performance deficiency is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the main feedwater isolation valve is credited for closure during a main feedwater line break. The inspectors performed the initial significance determination using the NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding screened to a Phase 2 significance determination because it involved a loss of one train of safety related equipment for longer than the technical specification allowed outage time. A Region IV senior reactor analyst performed a Phase 2 significance determination and used the pre-solved worksheet from the "Risk Informed Inspection Notebook for the Waterford-3 Nuclear Power Plant," Revision 2.01a. However, the main feedwater isolation valves were not included in the pre-solved worksheet and the valves did not appear as components in the Phase 2 significance determination worksheets. The senior reactor analyst performed a Phase 3 significance determination for this issue. The analyst noted that the main feed isolation valves were not a significant contributor to core damage frequency and were not included in the NRC's SPAR model. These valves close to mitigate core overcooling events or to isolate feedwater flow to a ruptured feedwater line inside containment. Overcooling events do not lead to core damage. A ruptured feedwater line could challenge containment integrity, but without core damage there would be no potential for a large early release. If a valve failed to close on demand, the licensee had other means to isolate feedwater flow to a steam generator or into containment. Operators could secure feedwater pumps, close a block valve, or close the main feedwater flow control valves. Accordingly, the contribution to core damage was much less than E-6. Therefore, the inspectors determined that this finding had very low safety significance (Green). This finding has a cross-cutting aspect in the operating experience component of the problem identification and resolution area in that the licensee did not collect and evaluate relevant external operating experience to identify that other sites experienced similar failures of feedwater isolation valves due to varnish deposits on the interior surface.

Inspection Report# : [2011005](#) (pdf)

G

Significance: Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Translate Tornado Impact on the Ultimate Heat Sink During a Refueling Outage

The inspectors identified a non-cited violation of 10CFR50, Appendix B, Criterion III because the licensee did not translate applicable regulatory requirements and the design basis into specifications and instructions. Specifically, the licensee did not translate the design basis tornado event into a design calculation. This outage-specific calculation was referenced by operations as the basis to ensure that the number of dry cooling tower fans needed for decay heat removal remained available. As a result, additional analysis needed to be performed to verify that the ultimate heat sink would have been able to perform its design function had a design basis tornado occurred during refueling outage RF-17. The licensee entered this issue into their corrective action program as CRWF3-2011-6480. The immediate corrective actions taken to restore compliance included analysis of the condition and actions to ensure that future outage specific calculations include the tornado design basis event.

The performance deficiency is more than minor because it challenges the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Since the calculation was used

when the plant was shutdown, the inspectors used Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process," and Appendix G, Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists." The issue was determined to have a very low safety significance (Green) because it did not require a quantitative assessment. Through calculation review, the inspectors concluded that this failure resulted in the potential to enter an unanalyzed condition. This finding had a crosscutting aspect in the resources component of the human performance area in that the licensee failed to incorporate accurate design information into instructions. Inspection Report# : [2011005](#) (pdf)

Significance: G Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Work Order Instructions to Install a Swagelok Fitting on a Main Feedwater Isolation Valve Tube Connection

The inspectors identified a non-cited violation of Technical Specification 6.8.1.a because the licensee did not follow work order instructions to install a pressure gage in an air line used to measure and maintain pressure for the hydraulic accumulators that close the main feedwater isolation valve. Specifically, the licensee did not follow the instructions to assemble and tighten a Swagelok fitting according to the work order. As a result, the fitting failed, preventing the valve from being able to perform its safety-related function. The licensee entered this issue into their corrective action program as CR-WF3-2010-1166 and CRWF3-2011-7469. The immediate corrective actions included repairing the Swagelok fitting and completing an apparent cause evaluation to determine the nature of the fitting failure and failure to follow procedure.

The performance deficiency is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

The inspector performed the initial significance determination using NRC Inspection Manual 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding screened to a Phase 2 significance determination because it involved a potential loss of one train of safety related equipment for longer than the technical specification allowed outage time. A Region IV senior reactor analyst performed a Phase 2 significance determination and used the pre-solved worksheet from the "Risk Informed Inspection Notebook for the Waterford-3 Nuclear Power Plant," Revision 2.01a. However, the main feedwater isolation valves were not included in the pre-solved worksheet and the valves did not appear as components in the Phase 2 significance determination worksheets. The senior reactor analyst performed a Phase 3 significance determination for this issue. The analyst noted that the main feed isolation valves were not a significant contributor to core damage frequency and were not included in the NRC's SPAR model. These valves close to mitigate core overcooling events or to isolate feedwater flow to a ruptured feedwater line inside containment. Overcooling events do not lead to core damage. A ruptured feedwater line could challenge containment integrity, but without core damage there would be no potential for a large early release. If a valve failed to close on demand, the licensee had other means to isolate feedwater flow to a steam generator or into containment. Operators could secure feedwater pumps, close a block valve, or close the main feedwater flow control valves. Accordingly, the contribution to core damage was much less than E-6. As a result, this finding had a very low safety significance (Green). This finding does not have a crosscutting aspect since it is not indicative of current plant performance.

Inspection Report# : [2011005](#) (pdf)

Significance: G Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Assure Design Basis Input was Correctly Translated into Design Basis Calculations

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states, in part, that "measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, prior to September 28, 2011, the licensee failed to assure that design basis information associated with loading the auxiliary component cooling water pumps on the Class 1E Bus was correctly translated in various design basis calculations. This finding was entered into the licensee's corrective action program as Condition Reports CR-WF3-2011-06737 and CR-WF3-2011-06808.

The team determined that the failure to verify the adequacy of the design for loading the auxiliary component cooling water pumps on the Class 1E Bus in various design basis calculations was a performance deficiency. This finding was more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the inadequate design calculations could have prevented continued operation of the emergency diesel generator under degraded voltage, short circuit, and increased fuel oil consumption conditions. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the issue was determined to have very low safety significance (Green) because it was a design deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee revised the associated calculations to include the required 295 brake horsepower value and reanalyzed for verification of operability. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance.

Inspection Report# : [2011007](#) (pdf)

Significance: G Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish an Adequate Containment Spray Pump Design Basis Verification Surveillance Test

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," which states, in part, "A program shall be established to assure that all testing required to demonstrate that structures, systems, and components will perform satisfactorily in service is identified and performed in accordance with written test procedures which incorporate acceptance limits contained in applicable documents." Specifically, as of October 4, 2011, the licensee did not have an adequate test procedure to verify containment spray pump design basis accident performance requirements. This finding was entered into the licensee's corrective action program as Condition Report CR-WF3-2011-06852.

The team determined that the failure to either have a stand-alone design basis accident containment spray pump verification test or to have it adequately incorporated into the in-service testing requirements was a performance deficiency. This finding was more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, neither the design basis analysis nor related in-service test surveillances, accounted for the inherent uncertainty of the flow element in the overall instrument uncertainty evaluation. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the issue was determined to have very low safety significance (Green) because it was not a design or qualification deficiency, did not represent a loss of system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance.

Inspection Report# : [2011007](#) (pdf)

Significance: **G** Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide an Adequate Basis for Extrapolation of Vendor Supplied Pump Net Positive Suction Head Values

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states, in part, that "measures shall be established to assure that applicable regulatory requirements and the design bases are correctly translated into specifications, drawings, procedures, and instructions." Specifically, as of October 4, 2011, the licensee extrapolated the values for required pump net positive suction head beyond those provided in vendor certified curves without adequate analysis or justification. Consequently, the licensee, per the station-approved net positive suction head analysis, could have operated the safety-related pumps in beyond-analyzed or vendor-approved flow regimes. This finding was entered into the licensee's corrective action program as Condition Report CR-WF3-2011-06870.

The team determined that the failure to provide adequate justification for extrapolation of net positive suction head values beyond those provided in the certified pump vendor data was a performance deficiency. This finding was more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, potential pump cavitation at higher than analyzed or vendor-approved operation, could have rendered mitigating equipment (i.e., pumps) to fail. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the issue was determined to have very low safety significance (Green) because it was a design deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee performed additional analyses to assure that the pumps could safely operate in the required flow regimes. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance.

Inspection Report# : [2011007](#) (*pdf*)

Significance: **G** Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Preventive Maintenance Procedures for Aluminum/Copper Electrical Connections to the Ultimate Heat Sink Transformers

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," which states, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Instructions, procedures, or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished." Specifically, as of October 7, 2011, when developing and implementing preventive maintenance procedures and work orders for transformers and electrical connections, the licensee failed to provide specific acceptance criteria and instructions addressing the potential vulnerability of these connections to degradation from galvanic reaction or differential thermal expansion, particularly in a high humidity outdoor environment. This finding was entered into the licensee's corrective action program as Condition Report CR-WF3-2011-06832.

The team determined that the failure to provide suitable acceptance criteria and instructions in preventive maintenance procedures and work orders applicable to the aluminum/copper electrical connections to the transformers was a performance deficiency. This finding was more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, inadequate preventive maintenance of the aluminum/copper connections could lead to degradation of the electrical connections to the station service transformer and loss of the ultimate heat sink. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the issue was determined to have very low safety significance (Green) because it was not a design or qualification deficiency, did not represent a loss of system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding did not have a crosscutting aspect because the most

significant contributor did not reflect current licensee performance.

Inspection Report# : [2011007](#) (pdf)

Significance:  Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish an Analysis to Support the Adequacy of the Four Inch Bulkhead Drain to Protect the Ultimate Heat Sink During Flood Events

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” which states, in part, that “measures shall be established to assure that applicable regulatory requirements and the design bases are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program.” Specifically, prior to October 7, 2011, the licensee failed to establish and maintain an analysis supporting the adequacy of a single four-inch overflow (bulkhead) drain for protecting the ultimate heat sink motor control center from flooding during a design basis probable maximum precipitation event. Failure of the motor control center as a result of flooding from the probable maximum precipitation event could result in the loss of the associated ultimate heat sink because the motor control center serves both the dry cooling tower and wet cooling tower fan motors. This finding was entered into the licensee’s corrective action program as Condition Report CR-WF3-2011-06701.

The team determined that the failure to establish and maintain an analysis supporting the adequacy of a single four-inch overflow (bulkhead) drain for protecting the ultimate heat sink motor control center from flooding during a design basis probable maximum precipitation event was a performance deficiency. This finding was more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the design basis analysis for the four-inch bulkhead drain did not ensure that the motor control center would be adequately protected during a probable maximum precipitation event. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, “Phase 1 – Initial Screening and Characterization of Findings,” the issue was determined to have very low safety significance (Green) because it was a design or qualification deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee performed calculations to justify the adequacy of the installed bulkhead drain for the probable maximum precipitation event. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance.

Inspection Report# : [2011007](#) (pdf)

Significance:  Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish an Analysis of the Effects of Reverse Rotation of Dry Cooling Tower Fan Motors Resulting from a Tornado Event

The team identified a Green violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” which states, in part, that “measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions. The design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program.” Specifically, prior to October 7, 2011, the licensee failed to analyze the dry cooling tower fan motors for premature trip as a result of reverse rotation caused by a tornado event that could result in the loss of the dry cooling tower heat removal capability. This finding was entered into the licensee’s corrective action program as Condition Report CR-WF3-2011-06850.

The team determined that the failure to establish and maintain an analysis supporting the ability of the dry cooling tower fan motors to operate successfully during and following a design basis tornado event was a performance deficiency. This finding was more than minor because it was associated with the design control attribute of the

Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the design basis analysis did not ensure that the dry cooling tower fan motors would perform as required under reverse rotation conditions, without premature trip, during a design basis tornado. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the issue was determined to have very low safety significance (Green) because it was a design or qualification deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee prepared an evaluation of the effect on fan motor starting current and duration for reverse rotation conditions. For reverse rotation conditions that would extend the locked rotor current time by a factor of two, the licensee's analysis showed ample margin for the instantaneous trip settings from the magnetic-only breaker and the thermal overload protection, such that premature trip would be precluded. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance.

Inspection Report# : [2011007](#) (pdf)

Significance:  Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide an Adequate Basis for Temperature Limits of Auxiliary Component Cooling Water Pump Motor Bearings

The team identified a Green noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states, in part, that "measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions." Specifically, prior to October 7, 2011, the licensee did not have an adequate technical basis for increasing the auxiliary component cooling water pump motor bearing temperature alarm setpoints or establishing an upper limit on motor bearing temperature, which directed operators to secure the pump. This finding was entered into the licensee's corrective action program as Condition Report CR-WF3-2011-06573.

The team determined that the failure to provide an adequate basis for increasing the high bearing temperature alarm setpoints and establishing a high temperature motor trip criterion was a performance deficiency. This finding was more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the issue was determined to have very low safety significance (Green) because it was a design or qualification deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee performed an engineering justification for the bearing temperatures based on industry guidance. This finding was determined to have a cross-cutting aspect in the area of human performance associated with the decision making component because the licensee did not use conservative assumptions in decision making and adopt a requirement to demonstrate that the proposed action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action [H.1(b)].

Inspection Report# : [2011007](#) (pdf)

Significance:  Oct 07, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Manage the Risk Involved with a Maintenance Window for the Turbine Driven Essential Feedwater Pump

The team identified a Green noncited violation of 10 CFR 50.65(a)(4), which states, in part, that "the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activities." Specifically, on October 28, 2010 the turbine driven essential feedwater pump was out of service for maintenance for approximately 12 hours. During this time the licensee unknowingly entered the Orange risk window (crossed a risk threshold) due to a faulty assumption in the probabilistic risk assessment model. This finding was entered into the licensee's corrective action program as Condition Report CR-WF3-2011-06653.

The team determined that the failure to perform adequate risk assessments is a performance deficiency. This finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems Cornerstone, adversely affecting the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the issue was identified as requiring a Phase 2 evaluation. A Region IV Senior Reactor Analyst performed a Phase 2 significance determination using NRC Inspection Manual Chapter 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process." In accordance with Appendix K:

$$\text{Delta-CDF} = [\text{CCDP}_{\text{Actual}} - \text{CCDP}_{\text{flawed}}] * \text{duration} / 8760$$

The licensee bounded the duration of the turbine driven essential feedwater pump maintenance at 8 hours in a year. The flawed ICDP was $3.1\text{E-}5$, the actual ICDP was $3.1\text{E-}5 + 1.9\text{E-}5 = 5.0\text{E-}5$. The difference was $1.9\text{E-}5$.

$$\text{Delta-CDF} = 1.9\text{E-}5 * 12/8760 = 2.6\text{E-}8$$

Therefore, the issue was determined to have very low safety significance (Green). This finding was determined to have a cross-cutting aspect in the area of problem identification and resolution associated with the self and independent assessments component because the licensee performed a probabilistic risk assessment model update in April 2009, which failed to identify the faulty assumption [P.3(a)].

Inspection Report# : [2011007](#) (pdf)

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate and Adequately Perform Preventive Maintenance Activities Associated with the Dry Cooling Tower Process Analog Control Cards

The inspectors identified a non-cited violation of 10 CFR 50.65 (a)(3) because the licensee did not adequately evaluate and take into account, where practical, industry operating experience related to preventive maintenance activities for the dry cooling tower process analog control cards. Specifically, internal and industry-wide operating experience documented previous failures of process analog control cards due to age-related degradation after about 15 years of services. The vendor and industry performed a benchmark in 2003, and noted that the average service life is about 12 to 15 years. The licensee initially provided a preventive maintenance activity to replace the cards on a 20 year interval. However, the licensee deleted the preventive maintenance activities in March of 2009. The licensee determined that the cards were non-critical and had no justification of deleting the preventive maintenance activities. The inspectors noted that after the deletion of the preventive maintenance activities and prior to the 15 year service interval, the licensee experienced additional unplanned failures of several process analog control cards that challenged dry cooling tower reliability. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2011-1356. The immediate corrective action includes the evaluation of the preventive maintenance activity for the dry cooling tower process analog control cards. The planned corrective action includes the reinstatement of the preventive maintenance activity that aligns with industry operating experience.

The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The process analog control card failures challenged the system availability and reliability. The inspectors performed the initial significance determination using NRC Inspection Manual Chapter 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined that the finding is of very low safety significance (Green) because the condition is not a design or qualification deficiency, did not represent the loss of a system safety function, did not represent an actual loss of a single train of equipment for more than its Technical Specification completion time, and did not screen as potentially risk-significant due to an external initiating event. This finding has a cross-cutting aspect in the operating experience component of the problem identification and resolution area in that the licensee did not implement and institutionalizes operating experience through change to station processes, procedures, equipment, and training programs [P.2(b)]. (Section 1R12)

Inspection Report# : [2011004](#) (pdf)

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify and Correct Work Order Instructions used for Technical Specification Surveillance Procedures

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," because the licensee did not promptly identify and correct work order instructions used to perform technical specification surveillance requirements. Specifically, the licensee did not provide adequate work order instructions or acceptance criteria to perform technical specification surveillance requirements associated with safety-related dry cooling tower fans and control room air handling units. The inspectors initially identified the issue of concern with the control room air handling units in December 2010. However, the licensee did not perform an adequate extent of condition review to determine if other work order instructions used to perform technical specification surveillance requirements contained adequate instructions and acceptance criteria. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2010-7223 and CR-WF3-2011-6254. The immediate corrective actions include revisions to the work order instructions in order to provide appropriate quantitative and qualitative acceptance criteria.

The finding is more than minor because it is associated with the procedure quality attribute of the Mitigating Systems cornerstone and affects 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 inspectors concluded that without appropriate quantitative and qualitative acceptance criteria this would affect the availability, reliability, and capability of the dry cooling tower fans and control room air handling units. The inspectors evaluated this finding using NRC Inspection Manual Chapter 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined that the finding was of very low safety significance (Green) because the finding was not a design or qualification deficiency, did not represent a loss of a safety function of a system or a single train for greater than its technical specification completion time, and did not screen potentially risk significant due to external events. The finding has a cross-cutting aspect in corrective action program component of the problem identification and resolution area because the licensee did not thoroughly evaluate problems such that the resolutions address causes and extent of conditions, as necessary [P.1(c)]. (Section 1R22.1)

Inspection Report# : [2011004](#) (pdf)

Significance:  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Comply with Technical Specification Surveillance Requirement 4.0.3 and the Limiting Conditions for Operation for Technical Specifications 3.0.3

The inspectors identified a non-cited violation of Technical Specification (TS) because the licensee did not enter or comply with the technical specification action requirements. Specifically, the licensee did not enter or comply with Technical Specification Surveillance Requirement 4.0.3 upon discovery of a never performed surveillance related to a safety-related relay contact for the Essential Chilled Water system. The licensee discovered the issue on July 27, 2011. However, the licensee did not enter TS 4.0.3 until August 12, 2011. Subsequently, when the licensee entered TS 4.0.3, the licensee did not perform a risk evaluation within 24 hours, as directed by the technical specification surveillance requirement. The licensee, per Technical Specification 4.0.3, has up to 24 hours to perform a risk evaluation or enter the applicable technical specification limiting condition for operation immediately. The inspectors determined that the licensee exceeded the allowed 24 hours and then did not enter the limiting condition for operation for Technical Specification 3.0.3 once the requirements for Technical Specification 4.0.3 and other applicable technical specifications had not been met. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2011-5779. The immediate corrective action included the performance of a special test instruction to demonstrate operability of the safety-related relay.

The finding is more than minor because it is associated with the human performance attribute of the Mitigating

Systems cornerstone and affects 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 inspectors concluded that a failure to comply with TS 4.0.3 and 3.0.3 affects the availability and reliability of the Essential Chill Water system. The inspectors evaluated this finding using NRC Inspection Manual Chapter 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined that the finding was of very low safety significance (Green) because the finding was not a design or qualification deficiency, did not represent a loss of a safety function of a system or a single train for greater than its technical specification completion time, and did not screen potentially risk significant due to external events. The finding has a cross-cutting aspect in decision-making component of the human performance area because the licensee did not make a safety-significant or risk-significant decision using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained [H.1(a)]. (Section 1R22.2)

Inspection Report# : [2011004](#) (*pdf*)

Significance: G Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely Actions to Correct Repetitive Dry Cooling Tower Fan Failures

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," because the licensee did not promptly correct a condition adverse to quality related to repetitive failures of the dry cooling tower fans to start and run in fast speed. Specifically, the licensee did not perform corrective actions to resolve the failure mechanism of the fast speed breaker relay in a timely manner. As a result, additional failures occurred over a period of several years prior to the implementation of corrective action in March 2011. The licensee entered this issue into their corrective action program for resolution as CR-WF3- 2011-2546. The corrective action includes a plan to replace the affected components inside the dry cooling tower fan breakers with a new design.

The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems 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 inspectors concluded that the reoccurrence of the problem challenged the reliability, and capability of the dry cooling tower fans. The inspectors performed the initial significance determination for the failure to start the dry cooling tower fans in fast speed using NRC Inspection Manual Chapter 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The Initial screening directed the inspectors to use Attachment 1 of Appendix G, "Shutdown Operations Significance Determination Process," based on fact that the failures of the breaker relay to start in fast speed occurred during refueling outages. The inspectors determined that the finding was of very low safety significance (Green) because it did not require a quantitative assessment since adequate mitigating equipment remained available and it did not constitute a loss of control, as defined in Appendix G. This finding has a cross-cutting aspect in the resource component of the human performance area in that the licensee did not minimize long-standing equipment issues and maintenance deferrals [H.2(a)]. (Section 4OA2.3(1))

Inspection Report# : [2011004](#) (*pdf*)

Significance: SL-IV Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit an LER within 60 days after Discovery of an Event

The inspectors identified a non-cited violation of 10 CFR 50.73(a)(1) because the licensee did not submit required Licensee Event Reports (LERs) within 60 days after discovery of conditions that required a report. Specifically, the inspectors identified three instances of untimely LERs submittals for conditions related to an inoperable emergency feedwater pump, a single point vulnerability of spent fuel pool pumps, and a degraded fuel oil supply line for the Train A emergency diesel generator. The licensee submitted the reports at 332, 163, and 101 days after discovery of the conditions, respectively. As a result, the licensee exceeded the 60 days for each condition that required a report. The inspectors noted that this is also contrary to the licensee's reportability procedure UNT-006-010, Event Notification and Reporting. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2010-5923. The immediate corrective actions include the performance of a human performance error review.

The inspectors considered this issue to be within the traditional enforcement process because it has the potential to impede or impact the NRC's ability to perform its regulatory function. The inspectors used the NRC Enforcement Policy to evaluate the significance of this violation. The inspectors concluded that the violation is more than minor because it occurred repeatedly within a two year period and the licensee missed opportunities to identify the issue. The NRC relies on the licensee to identify and report conditions or events meeting the criteria specified in regulations in order to perform its regulatory function, and when this is not done, this impacts the NRC's ability to carry out its statutory mission. The finding has a cross-cutting aspect in the work practices component of the human performance area because the licensee did not define and effectively communicate expectations regarding procedural compliance [H.4.(b)]. (Section 4OA3.4)

Inspection Report# : [2011004](#) (pdf)

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate and Adequately Monitor Activities Associated with the Internal Conditions of the Condensate and Refueling Water Storage Pool Structures.

The inspectors identified a non-cited violation of 10 CFR 50.65(a)(3) because the licensee did not evaluate or adequately monitor activities associated with the condition of the condensate and refueling water storage pools structures. Specifically, the licensee did not evaluate the internal condition of the storage pools through the performance of appropriate preventive maintenance activities and did not evaluate these activities at least every refueling cycle, where practical, for industry-wide operating experience. As a result, there is no preventive maintenance developed for this activity when previous industry-wide operating experience documented previous issues of concrete deterioration due to contact with boric acid over a long period of time. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2011-1168. The planned corrective actions include the development of appropriate preventive maintenance activities to examine the internal conditions of the storage pool structures during the refuel outages.

The finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affects 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, with no preventive maintenance to monitor the internal conditions of the storage pools, this would impact the reliability of the structures. The inspectors evaluated this finding using IMC 0609 Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings." The inspectors determined that the finding is of very low safety significance (Green) because the finding is not a design or qualification deficiency, did not represent a loss of a safety function of a system or a single train greater than its technical specification completion time, and did not screen potentially risk significant due to external events. The finding has a cross-cutting aspect in the operating experience component of the problem identification and resolution area because the licensee did not implement and institutionalize operating experience through changes to station processes, procedures, equipment, and training programs [P.2.b of IMC 0310] (Section 1R12).

Inspection Report# : [2011003](#) (pdf)

Significance:  Jun 30, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Implement Written Procedures for Restoring a Time Delay Relay Associated with the 'A' Emergency Diesel Generator Output Breaker.

A self-revealing non-cited violation of Technical Specification 6.8.1.a occurred because the licensee did not implement written procedures and instructions. Specifically, maintenance personnel did not follow procedure ME-007-005, "Time Delay Relay Setting Check, Adjustment, and Functional Test", during the lifting leads process for restoration of a time delay relay (EG EREL2327-C) associated with the 'A' emergency diesel generator (EDG) maintenance activity. As a result, the 'A' EDG output breaker did not automatically close during technical specification surveillance testing because the leads on the relay were wired incorrectly. The licensee entered this issue into their corrective action program for resolution as CR-WF3-2011-3190. The immediate corrective action included

the re-wiring of the relay.

The finding is more than minor because it is associated with the human and equipment performance attributes of the Mitigating Systems Cornerstone and affects 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 licensee did not ensure the availability, reliability and capability of the 'A' EDG through human error prevention techniques. The senior resident inspector performed the initial significance determination for the diesel generator output breaker failure. The inspector used the NRC IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." The finding screened to a Phase 2 significance determination because it involved a potential loss of one train of safety related equipment for longer than the technical specification allowed outage time. A Region IV senior reactor analyst performed a Phase 2 significance determination and used the pre-solved worksheet from the "Risk Informed Inspection Notebook for the Waterford-3 Nuclear Power Plant," Revision 2.01a. The senior reactor analyst considered the output breaker a part of the emergency diesel generator component boundary. Assuming a one year exposure period, the finding was potentially Yellow, which warranted further review. Therefore, the senior reactor analyst performed a bounding Phase 3 significance determination. The analyst determined that the finding was of very low safety significance (Green). The bounding change to the core damage frequency was approximately 5.4E-7/year. The dominant core damage sequences included loss of offsite power events, failure of the output breaker recovery action, independent failure of the other emergency diesel generator and failure to recover offsite power in 4 hours. Equipment that helped mitigate the risk included the ability of an operator to recover the output breaker. The finding has a cross-cutting aspect in the work practices component of the human performance area because the licensee did not communicate human performance error prevention techniques, such as self and peer checking, and proper documentation of activities [H.4.a of IMC 0310] (Section 1R19).

Inspection Report# : [2011003](#) (pdf)

Barrier Integrity

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inoperable Train of Containment Cooling System

Green. The inspectors identified a non-cited violation of Technical Specification Limiting Condition for Operation 3.6.2.2, "Containment Cooling System", which requires in Modes 1, 2, 3, and 4 that "Two independent trains of containment cooling shall be OPERABLE with one fan cooler to each train. The Technical Specification Action statement requires that "With one train of containment cooling inoperable, restore the inoperable train to OPERABLE status within 72 hours or be in at least HOT STANDBY within the next 6 hours; restore the inoperable containment cooling train to OPERABLE status within the next 48 hours or be in COLD SHUTDOWN within the next 30 hours. Specifically, from July 11, 2009, to July 19, 2009, the licensee failed to declare train B of the containment cooling system inoperable, and restore it to operable status within 72 hours or place the unit in hot standby in 6 hours. This finding has been entered into the licensee's corrective action program as Condition Reports CR-WF3-2011-08150.

The inspectors determined that the failure to meet Technical Specification Limiting Condition for Operation 3.6.2.2 was a performance deficiency. The finding was more than minor because it adversely affected the structures, systems, and components and barrier performance attribute of the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers (containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the component cooling water flow for containment cooling system train B decreased below the minimum flow limits of Technical Specification Surveillance Requirement 4.6.2.2. In accordance with NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," the issue was determined to have very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment and heat removal components, and did not involve an actual reduction in the function of hydrogen igniters in the reactor containment. This finding was determined to have a crosscutting aspect in the area of human performance associated with the decision making component because the licensee did not use conservative assumptions in decision making and adopt a requirement to demonstrate that the proposed

action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action.

Inspection Report# : [2011005](#) (pdf)

Emergency Preparedness

Occupational Radiation Safety

Significance: **W** Aug 10, 2011

Identified By: NRC

Item Type: FIN Finding

Failure To Use Effective Engineering Controls As Part Of Pre-Job Planning To Reduce Contamination And Subsequent Exposure

The inspectors identified an apparent White finding because the licensee failed to use effective engineering controls as part of pre-job planning to reduce contamination and subsequent exposure. The primary reason for the dose overage was the licensee's failure to prevent radioactive water from leaking into work areas and raising radiation dose rates. As corrective action, the licensee installed a trough system to collect and route the radioactive water away from the work area and to the reactor containment floor drain system. This issue was placed in the corrective action program as Condition Report CR-WF3-2011-05672.

The failure to use effective engineering controls as part of pre-job planning to reduce contamination and subsequent exposure is a performance deficiency. The finding is more than minor because it was similar to (the more than minor) Example 6.i in Inspection Manual Chapter 0612, Appendix E, "Example of Minor Issues," in that the actual collective dose exceeded 5 person-rem and exceeded the planned, intended dose by more than 50 percent. Additionally, the finding is associated with the program and process attribute of the Occupational Radiation Safety cornerstone and affected the cornerstone objective in that it increased collective radiation dose. The inspectors used Inspection Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," to analyze the significance of the finding. The finding was preliminarily determined to be White (low to moderate safety significance) because it involved ALARA planning or work controls; the average collective dose at the time the finding was identified was greater than 135 person-rem; and the actual dose associated with a work activity was greater than 25 person-rem. Alternately, there were greater than four occurrences in which the actual collective dose exceeded 5 person-rem and the estimated/planned dose by more than 50 percent. The final significance of this finding is to be determined. The finding had a crosscutting aspect in the area of problem identification and resolution, associated with the operating experience component, because the licensee did not institutionalize operating experience concerning the effects of reactor coolant pump leakage on work area dose rates [P2.(b)] (Section 2RS02).

Inspection Report# : [2011009](#) (pdf)

Public Radiation Safety

Significance: **SL-IV** Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Periodically Update the Updated Final Safety Analysis Report

The inspectors identified a Severity Level IV non-cited violation of 10 CFR Part 50.71, "Maintenance of Records," because the licensee failed to update its Updated Final Safety Analysis Report (UFSAR) with submittals that include the effects of a change made to the facility. This finding was determined to be of very low safety significance.

While inspecting the licensee's activities related to solid radwaste management and storage, the inspectors identified that the low level radwaste storage facility was not adequately described in Chapters 11 and 12 of the UFSAR. The licensee built the low level radwaste storage facility on the owner controlled area, outside of the protected area, for interim radwaste storage of dry active waste and solidified radioactive waste. Currently, the UFSAR, Chapters 11 and 12, Sections 11.4, "Solid Waste Management", and 12.2.1, "Contained Radiation Sources," describe facilities for the storage of radioactive material, such as the dry active waste handling and spent resin handling system. Section 12.2.1.7 of the UFSAR also describes principal sources of radioactivity not enclosed by plant structures. This section included maximum activity inventory of different waste management system components, including the laundry tank, waste condensate tank, and spent resin tank. The low level radwaste storage facility was not described in the UFSAR in adequate detail. The licensee is committed to Regulatory Guide 1.70, "Standard, Format, and Content of a Safety Analysis Report," Revision 2, dated September 1975, which describes the content of Chapter 11, Section 11.4, "Solid Waste Management System." Regulatory Guide 1.70 states that this section should describe the capabilities of the plant to control,

collect, handle, process, package, and temporarily store prior to shipment of solid radioactive waste generated as a result of normal operation, including anticipated operational occurrences. Regulatory Guide 1.70 also describes Chapter 12 of a safety analysis report and states, in part, that it should provide information on methods for radiation protection, estimated occupational radiation exposures to personnel during normal operation and anticipated operational occurrences, including radioactive material handling, processing, use, storage, and disposal. Section 12.2.1, "Radiation Contained

Sources," is the basis for the radiation protection design that should be described in the manner needed as input to the shield design calculations. Those sources that are contained in equipment like the radioactive waste management systems should be described. The source location in the plant should be specified so that all important sources of radioactivity can be located on plant layout drawings. Also, the UFSAR should provide a listing of isotope, quantity, form, and use of all sources that exceed 100 millicuries.

The low level radwaste storage facility has been in use since 1995 and contains a mixture of dry active waste and spent resin materials in separate storage compartments. The 50.59 screening performed for this facility stated that the low level radwaste storage facility will have onsite storage space for a total of five years based on estimates of waste generation. This storage facility has been in operation for approximately 16 years. The storage facility currently contains a significant source of radioactivity, 689.52 curies in total, which is not adequately described in the licensee's UFSAR.

The performance deficiency associated with this finding was failure of the licensee to update the UFSAR to reflect changes made to the facility. This issue was dispositioned using traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. The finding is more than minor because it has a material impact on licensed activities in that stored radwaste materials with a significant radioactive source term has been relocated from the plant radiologically controlled area to the owner controlled area. In addition, the radwaste management program has been affected because the licensee was not originally licensed to act as a low level waste facility. However, the termination of the Barnwell Low Level Radioactive Waste Management facility has forced the licensee to build such a storage area and make changes to the facility, significantly increasing the onsite storage capacity. The inspectors determined that this finding did not reflect present performance because it is an issue with changes made to the facility more than 15 years previously. Therefore, there was no cross-cutting aspect associated with this finding.

Inspection Report# : [2011005](#) (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 : May 29, 2012