

Farley 2

4Q/2012 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to implement design control measures to verify the adequacy of CST design

The inspectors identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to implement design control measures to verify the adequacy of design inputs, assumptions, or limiting plant conditions which were relied upon in the design basis analyses used to demonstrate the adequacy of condensate storage tank (CST) design. The licensee entered these issues into their corrective action program as condition reports 351170, 353599, and 355457. The licensee performed operability evaluations in support of current operability and implemented additional compensatory measures to ensure that CST level would be maintained above the condenser hotwell make-up elevation pending completion of proposed long term corrective actions. These proposed corrective actions included the more detailed design basis analysis required to support a license amendment request to increase the minimum volume of water specified by the limiting condition for operation in Technical Specification 3.7.6.

The failure to utilize conservative design inputs, assumptions, or limiting plant conditions when implementing design control measures to verify the adequacy of CST design was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the mitigating systems cornerstone attribute of design control and adversely affected 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 0609.04, "Initial Screening and Characterization of Findings," the inspectors used the mitigating systems column to perform a phase 1 significance determination process screening, and determined the finding to be of very low safety significance (Green). This determination was based on the fact that the performance deficiency was not a design issue resulting in loss of function, did not represent an actual loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not affect external event mitigation. A cross-cutting aspect was not identified because the design basis calculation associated with the performance deficiency was last approved on March 25, 1999, and therefore, did not represent current licensee performance. (Section 1R21.1)

Inspection Report# : [2012003](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: G Jun 30, 2012

Identified By: NRC

Item Type: FIN Finding

Failure to monitor for auxiliary building airborne radioactivity levels as described in the FSAR

The inspectors identified a Green finding for failure to meet the FSAR continuous online radiation monitor design bases as described in FSAR Section 12.2.4, Airborne Radioactivity Monitoring. Specifically, six of the nine continuous online radiation monitors, R-30 series, provided to monitor airborne radiation concentrations within select Unit 1 and Unit 2 Auxiliary Building locations have been out of service (OOS) for extended periods of time over the past two and half years. Further, no reviews were completed to evaluate the significance of the OOS monitors nor were compensatory sampling activities performed during the extended OOS periods. The licensee entered this issue into their corrective action program as Condition Report (CR) 44407, and CR 463051, and implemented compensatory activities.

The inspectors determined that the failure to monitor airborne radioactivity levels as described in FSAR Section 12.2.4 was a performance deficiency. The finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of Plant Facilities/Equipment and Instrumentation and adversely affects the cornerstone objective of ensuring the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Inadequate monitoring of areas with the potential for airborne radioactivity could lead to worker contamination and increased exposure. The finding was assessed using the Occupational Radiation Safety Significance Determination Process (SDP). Based on the facts that this was not an ALARA planning issue, there were no overexposures nor substantial potential for overexposures, and the licensee's ability to assess worker dose was not compromised, the finding was determined to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Human Performance [H.2(d)] because the licensee did not ensure that equipment was adequate and available to assure nuclear safety. (Section 2RS5)

Inspection Report# : [2012003](#) (*pdf*)

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

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