

## Comanche Peak 1 1Q/2014 Plant Inspection Findings

---

### Initiating Events

**Significance:**  Jun 26, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Procedure Results in Water Hammer**

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a for the failure to follow an auxiliary feedwater system operating procedure. As a result, a water hammer occurred on the condensate storage tank makeup reject line. The licensee entered the finding into the corrective action program as Condition Report CR-2012-012539.

The finding was more than minor because it was associated with the human performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective, in that, it increased the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, it resulted in a system water hammer. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the finding was determined to be of very low safety significance because the finding did not cause a reactor trip and the loss of mitigation equipment. The finding had a human performance cross-cutting aspect associated with resources, in that, the licensee failed to ensure that personnel were adequately trained to perform the activity. [H.2(b)]

Inspection Report# : [2013003](#) (*pdf*)

---

### Mitigating Systems

**Significance:**  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Instructions for Containment Sump Inspection Results in Debris Left in the Sump**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to follow instructions and maintain appropriate housekeeping and cleanliness controls when performing an inspection on the containment emergency sump. As a result, the four sections of tape that were attached to the wheels of the robot, used to perform the inspection, fell off and remained in the sump for an operating cycle. The licensee entered the finding into the corrective action program as Condition Report CR-2013 -005097.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee did not follow documented instructions and ensure no foreign material remained in the sump after the inspection. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At Power," the finding was determined to be of very low safety significance (Green) because the finding was not a design or qualification deficiency; did not represent an actual loss of safety function of a system or train; and did not result in the loss of one or more trains of non technical specification trains of equipment. The finding has a human performance cross-cutting

aspect associated with resources, in that, the licensee failed to ensure an adequate work instruction for the inspection activity [H.2(c)].

Inspection Report# : [2013005](#) (*pdf*)

**Significance:**  Dec 31, 2013

Identified By: NRC

Item Type: FIN Finding

**Cutting Incorrect Cable Results in an Inoperable Offsite Power Source**

The inspectors reviewed a self-revealing finding for the failure of maintenance personnel to follow work instructions. Specifically, maintenance personnel failed to follow instructions and cut the wrong cable during a transformer modification. As a result, one offsite power source to both units was unavailable during the repair of the damaged cable. The licensee entered the finding into the corrective action program as Condition Report CR-2013-011124.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At Power,” the finding was determined to be of very low safety significance (Green) because the finding was not a design or qualification deficiency; did not represent an actual loss of safety function of a system or train; and did not result in the loss of one or more trains of non-technical specification trains of equipment. The finding has a human performance cross-cutting aspect associated with work practices in that the licensee personnel failed to use human performance error prevention techniques such as self and peer checking when cutting cables [H.4(a)].

Inspection Report# : [2013005](#) (*pdf*)

**Significance:**  Nov 20, 2013

Identified By: NRC

Item Type: FIN Finding

**Failure to Perform Cause Evaluations for Maintenance Preventable Functional Failures**

The team identified a Green finding for a failure to follow procedures that required the licensee to perform cause evaluations for maintenance preventable functional failures (MPFFs). Two MPFFs were not evaluated for their causes because a condition report was not generated to perform the evaluation. After identification of this performance deficiency, the licensee generated condition reports to evaluate the two MPFFs for causes.

The licensee’s failure to ensure that cause evaluations were performed for MPFFs as required by procedure was a performance deficiency. This constituted a programmatic weakness in the licensee’s maintenance rule program and corrective action program and resulted in MPFFs not being prioritized and evaluated appropriately for corrective action, which could result in recurring failures. The affected systems crossed the Initiating Events, Mitigating Systems, and Emergency Preparedness cornerstones, but because the performance deficiency was associated with a programmatic weakness of the maintenance rule program, the inspectors determined that the Mitigating Systems cornerstone was the most affected. The finding was more than minor because it adversely affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At Power,” the finding was determined to be of very low safety significance (Green) because the finding was not a deficiency affecting the design or qualification of a mitigating SSC, and did not represent a loss of system or function. The finding has a human performance cross-cutting aspect associated with work practices in that licensee supervision failed to define expectations regarding compliance with the maintenance rule and corrective action program procedures (H.4(b)).

Inspection Report# : [2013008](#) (pdf)

**Significance:**  Nov 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Provide Adequate Acceptance Criteria**

• The team identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the licensee’s failure to provide adequate acceptance criteria for bearing oil level in its residual heat removal pump motors. The team identified two examples of this violation, one of which resulted in pump bearing oil being low-out-of-specification. After identification of this performance deficiency, operations management issued an Operations Shift Order to ensure equipment operators appropriately verified bearing oil levels.

The failure to provide adequate acceptance criteria for an activity affecting quality was a performance deficiency. The performance deficiency was more than minor because it adversely affected the human performance attribute of the mitigating systems cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events. Using Inspection Manual Chapter 0609, Appendix A, the team determined that the finding was of very low safety significance because it did not result in the loss of operability or functionality of a safety-related system or train. The finding had a cross-cutting aspect in the corrective action program component of the problem identification and resolution cross-cutting area because the licensee had failed to implement a corrective action program with a low threshold for identifying issues to ensure that an issue potentially affecting nuclear safety was promptly identified and fully evaluated (P.1(a)).

Inspection Report# : [2013008](#) (pdf)

**Significance:**  Nov 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Components of Indeterminate Quality Installed in Safety-Related Applications**

The team identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion III, “Design Control,” for the licensee’s failure to control deviations from quality standards. After identifying that maintenance personnel had failed to ensure that subcomponents of 480-volt switchgear were properly identified and controlled during refurbishment, the licensee failed to document or evaluate where subcomponents of an indeterminate pedigree had been installed in safety-related applications. The licensee took immediate action to confirm the operability of the installed trip units and to determine the scope of the problem.

The failure to control deviations from quality standards as required by 10 CFR 50, Appendix B, Criterion III was a performance deficiency. This performance deficiency was more than minor because it affected the design control attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of components that respond to initiating events. Using Inspection Manual Chapter 0609, Appendix A, the team determined that the finding was of very low safety significance because it did not result in the loss of operability or functionality of a safety-related system or train. The finding had a cross-cutting aspect in the corrective action program component of the problem identification and resolution cross-cutting area because the licensee had failed to implement a corrective action program with a low threshold for identifying issues to ensure that an issue potentially affecting nuclear safety was promptly identified and fully evaluated (P.1(a)).

Inspection Report# : [2013008](#) (pdf)

**Significance:**  Sep 25, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Remove Cable Material from Inside Containment**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to follow instructions and remove cables from containment as part of a modification. As a result, portions of 12 cables totaling approximately 100 feet in length wrapped with tape on the ends remained in containment and could have been transported to the emergency sumps during an accident. The licensee entered the finding into the corrective action program as Condition Report CR-2013-009443. The finding was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of the emergency sumps. Using NRC Manual Chapter 0609, "Significance Determination Process," Appendix G, "Shutdown Operations Significance Determination Process," Attachment 1, Checklist 2, the finding was determined to be of very low safety significance because the licensee maintained adequate mitigation capability for the current plant state and the finding was not characterized as a loss of control event. The finding has a human performance cross-cutting aspect associated with work practices in that the maintenance personnel did not involve supervision when they had questions concerning the removal of the cables and proceeded in the face of uncertainty [H.4(a)].

Inspection Report# : [2013004](#) (*pdf*)

**Significance:**  Sep 25, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Establish Goals and Monitor the Performance of the Auxiliary Feedwater System**

The inspectors identified a non-cited violation of 10 CFR 50.65(a)(1) for the licensee's failure to establish performance goals and perform monitoring to ensure the Unit 1 auxiliary feedwater system was capable of performing its intended function. The licensee entered the finding into the corrective action program as Condition Report CR-2013-010024. This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the finding was determined to be of very low safety significance (Green) because the finding was not a design or qualification deficiency; did not represent an actual loss of safety function of a system or train; and did not represent an actual loss of a technical specification train for greater than its allowed outage time. The finding had a human performance cross-cutting aspect associated with decision-making, in that, the licensee failed to demonstrate that nuclear safety is the overriding priority by not obtaining adequate interdisciplinary input when determining the auxiliary feedwater maintenance rule status [H.1(a)].

Inspection Report# : [2013004](#) (*pdf*)

**Significance:**  Sep 25, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Initiate a Condition Report for a Degraded Under Frequency Relay**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to follow procedures that require initiating a condition report for degradation to safety-related equipment. During a surveillance activity, maintenance personnel discovered that a reactor coolant pump under frequency relay was outside the as-found setpoint tolerance for pick-up frequency and failed to enter the condition into the corrective action program. As a result, the cause and effect of the degraded condition was not evaluated and the relay again drifted outside the setpoint tolerance. The licensee entered the finding into the corrective action program as Condition Report CR-2013-010078.

The finding was more than minor because if the licensee continues to fail to document degraded safety-related

equipment in the corrective action database, there is a potential that this could lead to a more significant safety concern, in that the cause of the degradation will not be evaluated and corrected. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” the finding was determined to be of very low safety significance (Green) because the finding was not a design or qualification deficiency; did not represent an actual loss of safety function of a system or train; and did not represent an actual loss of a technical specification train for greater than its allowed outage time. The finding has a human performance cross-cutting aspect associated with resources in that the licensee failed to provide adequate training to personnel performing maintenance [H.2(b)].

Inspection Report# : [2013004](#) (*pdf*)

**Significance:**  Jun 26, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Procedure for Testing Main Steam Safety Valves**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure of the licensee to have documented instructions of a type appropriate to the circumstances for testing the main steam safety valves. Specifically, the procedure for testing the main steam safety valves did not provide direction to declare the valves inoperable when applying pressure to the lifting device. As a result, the licensee failed to declare the main steam safety valves inoperable during testing. The licensee entered the finding in the corrective action program as Condition Report CR-2013-002947.

The finding was more than minor because it was associated with the procedure quality attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the procedure did not provide guidance to declare a main steam safety valve inoperable with the test rig installed. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” the finding was determined to be of very low safety significance because the finding was not a design or qualification deficiency; did not represent an actual loss of safety function of a system or train; and did not result in the loss of one or more trains of non-technical specification trains of equipment. The inspectors determined that the finding was not representative of current licensee performance and no cross-cutting aspect was assigned.

Inspection Report# : [2013003](#) (*pdf*)

**Significance:**  Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Calculations and Procedures for Offsite Power Availability**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” that states, in part, “applicable regulatory requirements and design basis are correctly translated into specifications, drawings, procedures, and instructions.” Specifically, prior to June 5, 2013, the licensee did not establish that the minimum switchyard voltages established in station procedures were adequate to prevent undesired actuation of the undervoltage protection scheme. This condition resulted from an inadequate analysis of undervoltage relay setpoints in design calculations, and the failure to provide acceptance criteria for undervoltage relay reset setpoints in relay calibration procedures. The finding was entered into the licensee’s corrective action program as Condition Report CR-2013-006176.

The inspectors determined that the failure to properly analyze minimum switchyard voltage requirements, and control relay setpoints necessary to maintain the availability of offsite power was a performance deficiency. The performance deficiency is more-than-minor because it was associated with Reactor Safety, Mitigating Systems Cornerstone, Design Control attribute and adversely affected the cornerstone objective to ensure the availability, reliability, and

capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, at the minimum switchyard voltages established in station procedures, actuation of the undervoltage protection scheme could have occurred and removed the reliable offsite power sources during an accident. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was not a design deficiency and did not result in the loss of operability or functionality. The finding had a cross-cutting aspect in the Area of Problem Identification and Resolution, associated with the Operating Experience Component, since the issues noted in this finding were discussed in Regulatory Issue Summary (RIS) 2011-12, “Adequacy of Station Electric Distribution System Voltages,” and RIS 2011-12 was reviewed by the licensee as part of the self assessment conducted in February 2013. [P.2(b)]

Inspection Report# : [2013007](#) (pdf)

**Significance:** G Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Voltage Calculations for the 125 VDC and 120 VAC Buses**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” that states, in part, “applicable regulatory requirements and design basis are correctly translated into specifications, drawings, procedures, and instructions.” Specifically, prior to June 20, 2013, the 125 VDC calculation did not take into account the maximum inrush currents and actual accident loading, and the 120 VAC calculation did not properly account for low voltage when the buses are supplied from their alternate source. The finding was entered into the licensee’s corrective action program as Condition Report CR-2013-006273 and CR-2013- 006396.

The inspectors determined that the failure to perform accurate voltage calculations for the 125 VDC system and 120 VAC bus was a performance deficiency. The performance deficiency is more-than-minor because it was associated with the Reactor Safety, Mitigating Systems Cornerstone, Design Control attribute and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the 125 VDC calculation did not take into account the maximum inrush currents and actual accident loading, and the 120 VAC calculation did not properly account for low voltage when the buses are supplied from their alternate source. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013007](#) (pdf)

**Significance:** G Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure To Establish 10 CFR 50.65(a)(1) Performance Goals for the APDG'S**

The inspectors identified a Green, non-cited violation of 10 CFR 50.65(a)(1), “Requirements for monitoring the effectiveness of maintenance at nuclear power plants,” that states, in part, that the licensee “shall monitor the performance or condition of structures, systems, or components, against licensee established goals, in a manner sufficient to provide reasonable assurance that these structures, systems, and components are capable of fulfilling their intended functions.” Specifically, on July 26, 2012, the licensee failed to establish goals and monitor the performance of the alternate power diesel generator system to ensure the system is capable of providing the necessary electric

power onto the emergency buses. The finding was entered into the licensee's corrective action program as Condition Report CR-2013-006521.

The inspectors determined that the failure to follow procedure to establish performance goals while performing Maintenance Rule (a)(1) monitoring to ensure the APDG system is capable and tested to meet the design basis requirements, was a performance deficiency. The performance deficiency is more-than-minor because it was associated with the Reactor Safety, Mitigating Systems Cornerstone, Equipment Performance attribute and adversely affected the cornerstone objective to ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the procedure directs the licensee to establish performance goals on activities that address conditions which were determined to be classified as (a)(1). In accordance with Inspection Manual Chapter (IMC) 0609, Attachment 4, "Initial Characterization of Findings," the inspectors determined that the finding affected the Mitigating System Cornerstone. Using IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding had a cross-cutting aspect in the area of human performance associated with the resources component because the licensee failed to ensure that emergency equipment is adequate and available to assure nuclear safety. [H.2(d)]

Inspection Report# : [2013007](#) (pdf)

**Significance:**  Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Analyze Effect of System Harmonics on Degraded Voltage Relays**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," that states, in part, "measures 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 May 20, 2013, the licensee failed to assess the adverse effects of 6.9kV and 480V system harmonics on the degraded voltage relays. The finding was entered into the licensee's corrective action program as Condition Report CR-2013-006230.

The inspectors determined that the failure to analyze the effect of electrical system harmonics on the degraded voltage relays was a performance deficiency. The performance deficiency is more-than-minor because it was associated with the Reactor Safety, Mitigating Systems Cornerstone, Design Control attribute and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, failure to analyze the effect of electrical system harmonics on the degraded voltage relays could cause the relays to fail to actuate at the setpoint specified in Technical Specifications. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was a deficiency affecting the design or qualification that did not result in the safety-related equipment losing operability or functionality. This finding did not have a cross-cutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013007](#) (pdf)

**Significance:**  Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Perform Adequate Operability Assessments**

The inspectors identified a Green, non-cited violation, with three examples, of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," that states, in part, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings and shall be accomplished in accordance with these instructions, procedures, or drawings." Specifically, for example 1 on February 28, 2013, for example 2 on June 5, 2013 and for example 3 on June 8, 2013, the licensee failed to follow procedure STI 442.01, "Operability Determination and Functionality Assessment Program," Revision 1, Attachment 8.B page 3 of 5 which states, in part, "Identify the topics that are applicable to the quick technical evaluation and include information for applicable topics within the evaluation such as: for example 1, The effect or potential effect of the degraded or nonconforming condition on the affected SSC's ability to perform its specified safety function, or for example 2, Compensatory Measures are recommended, or for example 3, Whether there is reasonable expectation of operability, including the basis for the determination." The finding was entered into the licensee's corrective action program as Condition Report CR-2013-006599.

The inspectors determined that the failure to perform adequate operability assessments was a performance deficiency. The performance deficiency is more-than-minor because:

Example 1: It was associated with the Reactor Safety, Barrier Integrity Cornerstone, Configuration Control attribute and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (containment) protect the public from radionuclide releases caused by accidents or events. Specifically, shutting off of the containment spray pumps during a large break LOCA inside containment would allow containment pressure to increase. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 3, the inspectors determined the finding was of very low (Green) safety significance because it did not represent an actual open pathway in the physical integrity of reactor containment (valves, airlocks, etc.), containment isolation system (logic and instrumentation), and heat removal components or actual reduction in function of hydrogen igniters in the reactor containment.

Example 2: It was associated with the Reactor Safety, Mitigating Systems Cornerstone, Equipment Performance attribute and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the compensatory measures established in the first operability assessment did not ensure that offsite power would be maintained at minimum grid voltage.

Example 3: It was associated with the Reactor Safety, Mitigating Systems Cornerstone, Design Control attribute and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the operability assessment initially credited the use of the battery chargers after the emergency diesel generators restored power to the bus, without evaluating design basis for the battery chargers.

For examples 2 and 3, the inspectors used Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because these examples were a deficiency affecting the design or qualification that did not result in losing operability or functionality.

This finding had a cross-cutting aspect in the area of human performance associated with the decision making component because the licensee failed in all three examples to conduct an effectiveness review of a safety-significant decision to verify the validity of the underlying assumptions to identify possible unintended consequences during the original operability assessments. [H.1(b)]

Inspection Report# : [2013007](#) (pdf)

**Significance:** G Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Provide Appropriate Acceptance Criteria and Testing Procedure Instructions**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," that states, in part, "A test 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 the requirements and acceptance limits contained in applicable design documents." Specifically, since 2001, the licensee failed to provide appropriate acceptance criteria and testing procedure instructions during modified performance tests involving Class 1E batteries for the 1-minute critical period testing data which incorporated the requirements of IEEE Standard 450-1995 to ensure the battery would meet the required design voltage for the duty cycle. The finding was entered into the licensee's corrective action program as Condition Report CR-2013-005673.

The inspectors determined that the failure to provide appropriate acceptance criteria and testing procedure instructions involving Class 1E batteries for the 1-minute critical period testing data during modified performance tests was a performance deficiency. The performance deficiency is more-than-minor because it was associated with the Reactor Safety, Mitigating Systems Cornerstone, Procedure Quality attribute and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, Procedure MSE-S0-5715 does not direct the technicians to record and evaluate the voltage at the end of the 1-minute critical period to ensure it does not drop below the designed minimum voltage, which would indicate the battery would not be capable of meeting the required design function. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because Calculation EE-CA-0000-5121 was implemented in 2001 and did not reflect current licensee performance.

Inspection Report# : [2013007](#) (*pdf*)

**Significance:** G Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Provide Appropriate Acceptance Criteria for the Safety Chill Water Pumps**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," that states, in part, "A test 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 the requirements and acceptance limits contained in applicable design documents." Specifically, since 1994, the licensee failed to recognize that if the safety-related chilled water pumps were degraded to 90 percent of their reference value, as permitted by IST Procedures OPT 209A/B, the system may not be able to achieve the required design flowrates as stated in Calculation 1-EB-311-8. This finding was entered into the licensee's corrective action program as Condition Report CR-2013-006252.

The inspectors determined that the failure to ensure appropriate acceptance criteria were incorporated into test procedures for the safety chill water pumps was a performance deficiency. The performance deficiency is more-than-minor because it was associated with the Reactor Safety, Mitigating Systems Cornerstone, Design Control attribute and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed to recognize that if the safety-related chilled water pumps were degraded to 90 percent of their reference value, as permitted by IST Procedures OPT-209A/B, the system may not be able to achieve the required design flowrates as stated in Calculation

1-EB-311-8. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because Calculation 1-EB-311-8 was updated in 1994 to incorporate the uninterruptible power system fan coil units and did not reflect current licensee performance.

Inspection Report# : [2013007](#) (*pdf*)

**Significance:** G Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Identify Fouling on the Emergency Diesel Generator Building Exhaust Ventilation Screens**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” that states, in part, “measures shall be established to assure that conditions adverse to quality are promptly identified and corrected.” Specifically, prior to June 17, 2013, the licensee failed to establish an activity to identify fouling of the Unit 1 emergency diesel generator building exhaust ventilation screens. The finding was entered into the licensee's corrective action program as Condition Report CR-2013-006540.

The inspectors determined that the failure to identify fouling on the Unit 1 emergency diesel generator building exhaust ventilation screens was a performance deficiency. The performance deficiency is more-than-minor because it had the potential to lead to a more significant safety concern. Specifically, the Unit 1 emergency diesel generator rooms could have insufficient exhaust flow to meet design basis temperature requirements if left uncorrected. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was not a design deficiency and did not result in the emergency diesel generators losing operability or functionality. This finding did not have a crosscutting aspect because the most significant contributor to the performance deficiency did not reflect current licensee performance.

Inspection Report# : [2013007](#) (*pdf*)

**Significance:** G Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Incorporate the Refueling Water Storage Tank Vortexing Design Calculation Into the Emergency Operating Procedures for Containment Spray Pump Operation**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” states, in part, “measures shall be establish to assure that the design basis for systems, structures, and components are correctly translated into specifications, drawings, procedures and instructions.” Specifically, since 2006 and 2007, the licensee failed to appropriately incorporate the RWST vortexing design calculation’s 6 percent indicated level into the emergency operating procedures for switching containment spray pump suction from the RWST to the containment sump to prevent damage to the pumps. The finding was entered into the licensee’s corrective action program as Condition Report CR-2013-005739.

The inspectors determined that the failure to appropriately incorporate the RWST vortexing design calculation’s 6 percent indicated level into the emergency operating procedures for switching containment spray pump suction from the RWST to the containment sump to prevent damage to the pumps was a performance deficiency. The performance deficiency is more-than-minor because it was associated with the Reactor Safety, Mitigating Systems Cornerstone, Procedure Quality attribute and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, Emergency

Operating Procedure EOS 1.3A/B allowed the operators the ability to delay transfer of containment spray pump suction source which could have caused damage to the pumps due to vortexing. Using Inspection Manual Chapter 0609 Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was not a design deficiency and did not result in the loss of operability or functionality. This finding did not have a cross-cutting aspect because the change to the procedure due to the addition of the sump strainers occurred in 2006 and 2007, and did not reflect current licensee performance.

Inspection Report# : [2013007](#) (pdf)

**Significance:**  Jun 20, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Correct Design Calculations to Incorporate Technical Specification Allowed Frequency Range for the Emergency Diesel Generator in a Timely Manner**

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” states, in part, “measures shall be established to assure that conditions adverse to quality are promptly identified and corrected.” Specifically, since May 2010, the licensee failed to correct a condition adverse to quality in a timely manner that involved updating design basis calculations for safety-related equipment to include the allowed technical specification frequency range of  $\pm 2$  percent for the emergency diesel generators. The finding was entered into the licensee's corrective action program as Condition Report CR-2013-006604.

The inspectors determined that the failure to correct a condition adverse to quality in a timely manner that involved updating design basis calculations for safety-related equipment to include the allowed technical specification frequency range of  $\pm 2$  percent for the emergency diesel generators was a performance deficiency. The performance deficiency is more-than-minor because it was associated with the Reactor Safety, Mitigating Systems Cornerstone, Design Control attribute and adversely affected the cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the calculations to support safety-related equipment did not include allowed technical specification frequency range for the emergency diesel generators to ensure the equipment would be capable of performing their safety-related functions. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, the inspectors determined the finding was of very low (Green) safety significance because the finding was a deficiency affecting the design or qualification that did not result in the safety-related equipment losing operability or functionality. This finding had a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component because the licensee failed to take appropriate corrective actions to address updating design basis calculations to include technical specification allowed emergency diesel generator frequency range in a timely manner, commensurate with their safety significance. [P.1(d)]

Inspection Report# : [2013007](#) (pdf)

## Barrier Integrity

**Significance:**  Mar 27, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to Follow Procedure for Operation of the Containment Emergency Air Lock Doors**

The inspectors reviewed a self-revealing non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure to follow procedure for performing surveillance testing of the containment emergency air locks. Specifically, licensee personnel failed to fully close the Unit 1 containment emergency airlock exterior door and equalizing valve after performance of a door seal leak surveillance test. As a result, the containment emergency air lock exterior door was inoperable. Upon discovery, the licensee properly closed the containment emergency airlock door. The licensee entered the finding into the corrective action program as Condition Report CR 2013 000264.

The finding was more than minor because it was associated with the human performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that containment physical design barriers protect the public from radionuclide releases caused by accidents or events. Using Inspection Manual Chapter 0609, Attachment 04, “Initial Characterization of Findings,” and Appendix A, Exhibit 3, “Barrier Integrity Screening Questions,” the finding was determined to be of very low safety significance (Green) because the finding did not represent an actual open pathway in the physical integrity of reactor containment. The finding has a human performance cross-cutting aspect associated with resources, in that, the licensee failed to ensure that equipment and procedures were adequate to support nuclear safety [H.1].

Inspection Report# : [2014002](#) (*pdf*)

---

## Emergency Preparedness

---

## Occupational Radiation Safety

---

## 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

Last modified : May 30, 2014