South Texas 1
1Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Jul 04, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Follow Hurricane Plan Procedure to Secure Missile Hazards During Tropical Storm Bill
Inspectors identified a non-cited violation of Technical Specification 6.8.1.a for failure to follow Procedure 0PGP03-ZV-0002, "Hurricane Plan," Revision 7. Specifically, on June 15 through 16, 2015, the licensee failed to remove loose trash and materials inside the protected area to protect against potential missile hazards in accordance with Data Sheet 3 of Procedure 0PGP03-ZV-0002 in preparation for Tropical Storm Bill. The licensee has entered this issue into the corrective action program as Condition Report 15-17110.

The failure of the licensee to address and control potential missile hazards on site, on the Unit 1 mechanical auxiliary building roof, turbine deck, and around standby transformer 1 was a performance deficiency. Specifically, on June 16, 2015, the licensee failed to follow Data Sheet 3 of Procedure 0PGP03-ZV-0002, "Hurricane Plan," Revision 7, to adequately secure potential missile hazards in preparation for Tropical Storm Bill. The performance deficiency was determined to be more than minor because it was associated with the protection against external factor attribute and adversely affected the Initiating Event Cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. Using NRC Inspection Manual 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," the inspectors determined the finding was of very low safety significance (Green) because it did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The inspectors determined the finding had a cross cutting aspect in the area of problem identification and resolution associated with resolution. Specifically, the licensee failed to take effective corrective action from previous NRC-identified instances in the past where the licensee had loose material and debris that could become a missile hazards during a severe weather event [P.3].

Inspection Report# : 2015002 *(pdf)*

Mitigating Systems

Significance: G Mar 31, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Identify and Correct Faulty NI-36 Channel
Inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the licensee's failure to identify a condition adverse to quality. Specifically, the licensee failed to identify that a faulty logarithmic amplifier was producing inaccurate intermediate range nuclear instrument channel NI-36 indications. This resulted in multiple instances of delays in the change of state of reactor trip instrumentation permissive P-6 when shutting down the reactor. The licensee replaced NI-136's log current amplifier using approved procedures and returned the channel to service. This issue was entered into the corrective action program as Condition Report 16-1227.

The licensee's failure to identify a condition adverse to quality regarding intermediate range nuclear instrument channel NI-36 was a performance deficiency. Specifically, the licensee failed to identify a faulty log current amplifier in intermediate range nuclear instrument channel NI-36, which led to multiple instances of inaccurate indication and delays in the change of state of reactor trip instrumentation permissive P-6, when shutting down the reactor that required operator action and unplanned technical specification entries. This performance deficiency is more than minor and, therefore, a finding because it impacts the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors screened this finding using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) For Findings At-Power," dated June 19, 2012. The finding screened as Green per Section A of Exhibit 2, "Mitigating Systems Screening Questions," because the finding did not affect the design or qualification of a mitigating structure, system, or component; the finding did not represent a loss of the system and/or function; the finding did not represent an actual loss of function of at least a single train for greater than its Technical Specification allowed outage time; and the finding did not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule for more than 24 hours. Inspectors determined the finding had a cross-cutting aspect of conservative bias in the human performance area because leaders did not take a conservative approach to decision making, particularly when information is incomplete or conditions are unusual. Specifically, the licensee made the decision not to enter their procedure for preventing recurring equipment problems process, even though entry criteria to do so was met, because of a false confidence that the correct cause had already been identified [H.14].
Inspection Report# : 2016001 *(pdf)*

Significance: G Dec 31, 2015
Identified By: NRC
Item Type: FIN Finding
Failure to Track and Incorporate Actual Plant Data into Simulator Operability Testing
The inspectors identified a finding, associated with simulator operability testing, for the failure of the licensee to track and incorporate actual plant data into their cyclic operability tests, as required by American National Standards Institute-3.5-2009, "Nuclear Power Plant Simulators for Use in Operator Training and Examination." With the exception of one transient, the licensee exclusively used engineering analysis from the RETRAN code as baseline data without reference to plant events that may have been related to the required transient tests. This issue was entered into the licensee's corrective action program as Condition Report 15-21463.

The failure to track and incorporate plant events into baseline data for simulator operability testing is a performance deficiency. It is more than minor and, therefore, a finding because it is associated with the human performance attribute of the Mitigating Systems Cornerstone and negatively affected the objective to ensure the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, if simulator performance is not being compared to the most relevant baseline data from the plant, the reliability of the simulator performance is reduced. Using Inspection Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheets, and the corresponding Appendix I, "Licensed Operator Requalification SDP" (block 14), the finding was determined to have very low safety significance (Green) because it is a "Simulator testing, maintenance, or modification deficiency." This finding has a cross-cutting aspect in the procedure adherence component of the human performance cross-cutting area because the licensee failed to ensure that individuals follow processes, procedures, and work instructions in that the American National Standards Institute-3.5-2009 guidance for selecting baseline data for simulator testing was not followed [H.8].
Inspection Report# : 2015004 *(pdf)*

Significance: G Jul 04, 2015

Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Failure to Properly Check Design and Test Chiller Purge Check Valves
The inspectors documented a self-revealing, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to have adequate measures for the selection and review for suitability of application of parts that are essential to the safety related functions of structures, systems and components. Specifically, the licensee failed to properly inspect and test essential chiller condenser purge check valves during the station's commercial dedication process to ensure proper function in their safety-related application. The licensee has entered the issue into the corrective action program as Condition Report 15-4990 and has implemented corrective actions to the technical evaluation that will adequately measure and test the purge check valve in the future.

The failure to properly inspect and test essential chiller condenser check valves during the station's commercial dedication process to ensure proper function in the safety-related application was a performance deficiency. This performance deficiency is 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 to prevent undesirable consequences. Specifically, on January 18, 2015, March 5, 2015, and March 21, 2015, the inadequately dedicated purge check valves resulted in a trip of the essential chiller, rendering the train inoperable and challenging plant operations. Using NRC Inspection Manual 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined the finding was of very low safety significance (Green) because it did not affect the design or qualification of the system, did not result in a loss of system function, did not represent a loss of function of a single train for greater than its technical specifications allowed outage time, and did not cause the loss of function of one or more non-technical specification trains of equipment designated as high safety-significance. The inspectors determined that the finding did not have a cross-cutting aspect because the main contributor to the cause of the performance deficiency occurred in 1993.

Inspection Report# : 2015002 *(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: G Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Maintain the Emergency Plan Up to Date With the Safety Evaluation Report
The inspectors identified a non-cited violation of 10 CFR 50.54(q)(2) for failure to maintain the emergency plan in accordance with the approved safety evaluation report. Specifically, the licensee failed to meet 10 CFR 50.47(b)(2) requirements for timely augmentation of response capabilities, in accordance with the approved safety evaluation report. Following an update to the safety evaluation report in 1993, the licensee failed to update the emergency response organization staff augmentation time requirements to commence at the time of an emergency declaration vice from the time of an emergency notification. To restore compliance, the licensee updated the emergency plan in accordance with the current safety evaluation report.

Failure to maintain the site emergency plan in accordance with the approved safety evaluation report, dated May 20, 1993, was a performance deficiency. Specifically, the licensee failed to update the ERO staff augmentation time

requirements to commence at the time of an emergency declaration, as required by the NRC safety evaluation report. This performance deficiency is more than minor because it is associated with the procedure quality attribute of the Emergency Preparedness Cornerstone and adversely affected the cornerstone objective to ensure that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. This finding was evaluated using Inspection Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process (SDP)," dated September 22, 2015, and was determined to be of very low safety significance (Green) per Table 5.2-1, "Significance Examples 50.47(b)(2)," because the staffing processes do not meet the threshold of "routinely not capable of ensuring timely augmentation of the on shift emergency response staff to the extent that more than one required ERO functional area (in accordance with E-plan commitments) would not be filled." No cross-cutting aspect is assigned because the performance deficiency is not indicative of present performance.
Inspection Report# : 2015004 *(pdf)*

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

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