

Farley 1

2Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

Improper Scheduling of Pump Motor Overhaul

Improper scheduling of vendor recommend 10 year overhaul of 1C Service Water pump motor. A self-revealing finding was identified for the 1C Service Water pump motor failure. This finding is greater than minor significance because it adversely impacted the ultimate heat sink reliability and effected the mitigating systems cornerstone objective. Because there was no loss of system function, this finding is of very low safety significance.

Inspection Report# : [2002005\(pdf\)](#)

Significance:  Sep 13, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Obtain NRC Approval Prior to Implementing Changes to the Approved Fire Protection Program

Green. A Severity Level IV NCV of Farley Unit 1 Operating License Condition 2.C.(4) and Farley Unit 2 Operating License Condition 2.C.(6) was identified for the licensee making a change to the approved fire protection program (FPP) without prior Commission approval. On January 20, 1992, and February 20, 1998, the licensee inappropriately used the 10 CFR 50.59 change process to revise the FPP to accept five fire areas (Fire Areas 51, 1-004, 1-042, 2-004, and 2-043) that did not satisfy the fire detection and suppression requirements of 10 CFR 50, Appendix R, Section III.G.3. These five fire areas contained unprotected, redundant electrical cables for both main control room (MCR) air conditioning (A/C) units. On Unit 1, the change decreased the effectiveness of the program in the event of a fire, while on Unit 2 the change adversely affected the ability to achieve and maintain safe shutdown (SSD) in the event of a fire. The team concluded that the finding had a credible impact on safety because the licensee's failure to properly evaluate changes to the FPP could adversely affect or degrade the reliability of SSD capability from the MCR. However, the team determined that this finding was of very low significance because the overall SSD capabilities in the affected fire areas and related FPP features were still adequate to ensure SSD capability. Therefore, this finding is characterized as Green.

Inspection Report# : [2002006\(pdf\)](#)

Significance:  Sep 13, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Revise Procedure AOP-29.0 Promptly

Green. An NCV of 10 CFR Part 50, Appendix B, Criterion XVI was identified for the licensee's failure to revise promptly plant procedure AOP-29.0, Plant Fire, to incorporate the use of alternative shutdown (ASD) procedures for Fire Areas 51, 1-004, 2-004, and 2-043, as specified in Production Change Notice (PCN) No. B-90-0-7074 dated January 20, 1992. This finding was more than minor since it affected the Reactor Safety Cornerstone objective to ensure the availability, reliability, and capability of SSD systems relied upon to respond to a fire initiating event and to prevent undesirable consequences. Required operator actions may not have been accomplished in a timely manner because an approved plant procedure was not promptly revised for mitigating a fire in four fire areas. This finding is characterized as having very low safety significance (Green) because it did not affect detection, manual suppression capability, automatic suppression capability, fire barriers, or 20-foot separation. Further, upon the MCR becoming uninhabitable during a fire, it would likely have been evacuated and ASD procedures used to mitigate the effects of the fire

Inspection Report# : [2002006\(pdf\)](#)

Significance:  Sep 13, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain and Implement Fire Protection Program Transformer Fluid Confinement Features Required by the Listing Agency

Green. An NCV of 10 CFR 50.48 and Farley Unit 1 Operating License Condition 2.C.(4) was identified for the licensee's failure to provide fluid confinement protection features, as required by the listing agency (Factory Mutual Data Sheet 5-4/14-8), in Train A load center (LC) Room 335 (Fire Area 1-041.) After replacing an Askarel-type insulating fluid with a silicone-type insulating fluid in two separate 600V transformers in Train A LC Room 335, the licensee failed to provide physical fire area boundary spill confinement protection features (curbs or ramps) at Doors No. 324 and 321, to prevent the spread of fluid fire resulting from a faulted transformer to adjacent fire areas. This finding was determined to be more than minor because it can be viewed as a precursor to a significant event where a combustible liquid fire in one fire area could potentially cause damage to the redundant train of SSD cables in an adjacent fire area. However, based on the self-extinguishment properties of the silicon-type insulating fluid, a fire in LC Room 335 involving the 600V transformer fluid would most likely extinguish prior to spreading into the adjacent fire area and hence, any damage would be confined to a single division (Train A) of SSD equipment. Thus, the finding did not affect the 3-hour rated fire barrier separating redundant SSD functions. Accordingly, this finding is of very low safety significance.

Inspection Report# : [2002006\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: SL-IV Sep 29, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Falsification of Security Round Logs

A Severity Level IV, non-cited violation of Section 8.3 of the Physical Security Plan and 10 CFR 50.9 was identified in that on February 19, 2002, a security officer failed to perform certain required recurring compensatory patrols of specified areas, but willfully documented that the patrols had in fact been performed. Because this issue involved willfulness on the part of a licensee employee and inaccurate information which impacts the regulatory process, it was not subject to the provisions of the Reactor Oversight Process, and was dispositioned in accordance with traditional enforcement. It was greater than minor because it involved willfulness and the loss of one barrier in the physical protection system. (Section 4OA5)

Inspection Report# : [2002004\(pdf\)](#)

Miscellaneous

Last modified : September 04, 2003