

Farley 2

1Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Perform Risk Assessment

A Green, self-revealing non-cited violation (NCV) of 10 CFR 50.65(a)(4) was identified when the licensee failed to perform a required risk assessment following alignment of the 1-2K and 1-2L 600V load centers to their emergency power (Unit 1) supplies. This resulted in the risk being elevated from a Yellow to an Orange status without senior management concurrence and no additional compensatory actions.

This finding is more than minor because it impacted the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the cornerstone objective in that the licensee failed to perform a risk assessment following a change in actual plant configuration and did not establish compensatory measures consistent with the elevated outage risk. Based on an Incremental Core Damage Probability Deficit (ICDPD) of less than 1E-6, this finding is of very low safety significance (Green). This finding involved the cross cutting aspect of Human Performance [text removed] for failure to follow procedure FNP-0-ACP-52.3.

Inspection Report# : [2005005\(pdf\)](#)

Significance:  Dec 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Provide Adequate Procedural Controls

A Green, self-revealing NCV of Technical Specification (TS) 5.4.1.a was identified for inadequate procedural controls to maintain reactor coolant system (RCS) water level instruments operable. The lack of adequate procedural controls resulted in one of the required water level instruments being isolated prior to lowering RCS water level.

This finding is greater than minor because it affected the procedure quality attribute and the Mitigating Systems Cornerstone objective, in that, procedural controls for operability of RCS level instrument were not appropriate to the circumstances. This finding was determined to be of very low safety significance because actual water level was at the level planned for the drain down. This finding involved the cross cutting aspect of Human Performance [text removed] in that procedural controls were not adequate.

Inspection Report# : [2005005\(pdf\)](#)

Significance:  Aug 26, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Action Results in Recurrence of a SSPS/7300 Troubleshooting-Related Event

An NRC-identified non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, was identified for failure to take corrective actions to preclude repetition of a significant condition adverse to quality. Specifically, corrective actions taken to develop a solid state protection system (SSPS)/7300 troubleshooting guideline following a Unit 2 SSPS/7300 troubleshooting-related reactor trip on April 12, 2004, was inadequate to preclude the recurrence of another SSPS/7300 troubleshooting-related event on April 28, 2005.

This finding is more than minor because it affects the Mitigating Systems Cornerstone attribute of equipment performance and adversely impacted the cornerstone objective in that the SSPS/7300 troubleshooting guidance did not provide the necessary steps to facilitate timely (i.e., within the TS LCO) determination of a SSPS/7300 process channel failure. This finding is of very low safety significance because the "B" train of SSPS was maintained operable at all times. This finding has the cross-cutting aspect of Problem Identification and Resolution - Corrective Actions.

Inspection Report# : [2005008\(pdf\)](#)

Significance:  May 23, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Unapproved Local Manual Operator Actions for Post-Fire Safe Shutdown

The team identified a non-cited violation of 10 CFR 50, Appendix R, Section III.G.2, for failure to physically protect or separate cables from fire damage and instead relying on unapproved local manual operator actions. The operator actions were to be accomplished outside the main control room (MCR) and were relied on to achieve and maintain a safe shutdown from the MCR during a fire in the Unit 2 Train B 4 kV Switchgear Room and the Diesel Building Train B Switchgear Room.

This finding is greater than minor because it degraded the defense in depth for fire protection. It is associated with the protection against external factors attribute and degraded the reactor safety mitigating systems cornerstone objective. The finding adversely affected the reliability and capability of equipment required to achieve and maintain a safe shutdown condition following a fire. Because the operator actions were feasible and could reasonably be accomplished, the finding was determined to have very low safety significance.

Inspection Report# : [2005006\(pdf\)](#)

Barrier Integrity

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Significance: Aug 26, 2005

Identified By: NRC

Item Type: FIN Finding

Untimely Resolution of Flow Problems on Radiation Monitor R-11

An NRC-identified finding was identified for untimely resolution of excessive air flow problems on the Unit 1 and Unit 2 Containment Air Particulate Radiation Monitors (R-11). Excessive air flow through the moving filter paper caused the monitor to become inoperable on numerous occasions since 1990. When R-11 was out of service, the ability to detect low-level reactor coolant system (RCS) leakage was degraded.

This finding is more than minor because it is associated with the RCS Equipment and Barrier Performance Attribute of the Barrier Integrity Cornerstone and adversely affects the cornerstone objective in that the ability to detect low-level RCS leakage that may indicate pressure boundary degradation was reduced. This finding could not be evaluated using the Significance Determination Process (SDP) in accordance with IMC 0609 because the SDP for the RCS barrier only applied to a degraded barrier; not the ability to detect a degraded barrier. Therefore, this finding was reviewed by regional management and determined to be of very low safety significance (Green) because alternate methods of detecting low-level RCS leakage were available whenever R-11 was out of service. This finding has the cross-cutting aspect of Problem Identification and Resolution [in the area of Evaluation].

Inspection Report# : [2005008\(pdf\)](#)

Emergency Preparedness

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Significance: Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Respiratory Protection Equipment for Emergency Response

An NRC-identified non-cited violation of 10 CFR 50.47(b)(10) was identified for the failure to provide adequate respiratory protection equipment for emergency response, compromising the protective actions developed for the plume exposure pathway for emergency workers. A large respirator mask was not available in the control room for a licensed plant operator that was fit-tested with a large respirator mask.

This finding is greater than minor because it is associated with the Emergency Preparedness cornerstone attribute of Response Organization Performance and adversely affects the cornerstone objective of ensuring the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The finding was evaluated using Sheet 1 of the Emergency Preparedness SDP. The issue described was a failure to comply that was a planning standard problem, was not a risk-significant planning standard problem, and did not involve a planning standard function failure. Therefore, the finding is of very low safety significance.

Inspection Report# : [2005004\(pdf\)](#)

Occupational Radiation Safety

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Significance: Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Test Unit 2 Service Air Header for to Ensure Breathing Air Quality

An NRC-identified, non-cited violation of 10 CFR 20.1703(g) was identified for failing to ensure that atmosphere supplying-respirators were supplied with respirable air of grade 'D' quality or better.

This finding is greater than minor because it is associated with the Occupational Radiation Safety cornerstone attribute of Plant Equipment and Instrumentation and adversely affects the cornerstone objective in that if the breathing air quality was unacceptable, the workers would have removed their respiratory protection equipment, potentially resulting in the inhalation of contaminated material. If breathing air is not checked on a periodic basis for a system that is not routinely used, the licensee cannot ensure that the air quality standards of 10 CFR Part 20.1703(g) are met. The finding was evaluated using the Occupational Radiation Safety SDP. This finding was not related to ALARA planning, did not involve an overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. For these reasons, the inspectors concluded that the finding is of very low safety significance.

Inspection Report# : [2005004\(pdf\)](#)

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Aug 26, 2005

Identified By: NRC

Item Type: FIN Finding

PI&R Assessment

The team determined that the licensee was generally effective in identifying problems and entering them into the corrective action program (CAP). The threshold for problem identification was determined to be low. CAP-related audits were effective in identifying deficiencies for resolution. Condition Report trending under the CAP has had success in bringing about corrective actions for identified adverse trends. The team determined that the licensee properly prioritized issues entered into the CAP. Generally, the licensee performed adequate evaluations that were technically accurate and sufficiently detailed. Corrective actions developed and implemented for problems were generally timely, effective, and appropriate to the problem. One Green finding for failure to correct a long-standing condition adverse to quality and two Green non-cited violations for a failure to promptly identify a condition adverse to quality and inadequate corrective actions to preclude recurrence were identified. In addition, several examples of minor problems were identified including equipment failures that were inappropriately classified as not being functional failures, industry operating experience that was ineffectively evaluated, and past operability determinations that lacked proper documentation. Management emphasized the need for staff to identify and resolve issues using the CAP. A safety conscious work environment was evident.

Inspection Report# : [2005008\(pdf\)](#)

Last modified : May 25, 2006