Farley 2
4Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Oct 03, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Adequately Evaluate and Correct a Recurring Auxiliary Feedwater Pump Bearing Oil Out-of-Specification Condition
Green: A Green NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for failure to utilize the corrective action program for repetitive problems with Motor Driven Auxiliary Feedwater Pump (MDAFWP) bearing oil which did not meet acceptance criteria.

This finding is associated with the Mitigating Systems cornerstone and affected the objective of equipment reliability. This finding is of very low safety significance because it did not result in actual inoperability of the MDAFWP.
Inspection Report# : 2003007*(pdf)*

Significance: G Oct 03, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Promptly Identify and Correct Multiple Loss of Off-site Power Sequencer Relay Out of Calibration Conditions
A Green NCV of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for failure to take timely corrective action for repetitive out-of-calibration conditions on safety-related relays associated with Loss of Off-Site Power (LOSP) sequencers.

This finding is associated with the Mitigating Systems cornerstone and affected the objective of equipment reliability. This finding is of very low safety significance because the system was not inoperable for greater that the time allowed by plant Technical Specifications.
Inspection Report# : 2003007*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Maintenance Risk Assessment Requirements
The inspectors identified a non-cited violation of 10 CFR 50.65 a(4) because the licensee failed to properly assess the risk associated with planned maintenance on the 2B residual heat removal (RHR) pump with concurrent work in the

high voltage switch yard.

This finding is greater than minor because it resulted in an increased risk threshold ("green" to "yellow"). The failure to properly manage the increase in risk during maintenance has a credible impact on the configuration control attribute of the mitigating systems cornerstone. Accurate maintenance risk assessments are necessary to trigger management controls that ensure sufficient operating equipment remains available to respond to an initiating event. This finding is of very low safety significance because of the short duration of the increased risk condition, no other equipment was removed from service, and the RHR Technical Specification (TS) requirements were met.
Inspection Report# : 2003003*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: G Dec 27, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Adequate QA Procedures for Monitoring Particulate Effluents from the Unit 2 Plant Vent
An NRC-identified non-cited violation of Technical Specification 5.4.1(b) was identified in that the Unit 2 Plant Vent air sampler was not taking an isokinetic sample of the Plant Vent airstream.

This finding is greater than minor because it adversely affects the Effluent Monitoring attribute of the Public Radiation Safety cornerstone. The finding is of very low safety significance because there was no failure to assess dose to the public.

Inspection Report# : 2003005*(pdf)*

Physical Protection

Miscellaneous

Significance: N/A Oct 03, 2003
Identified By: NRC
Item Type: FIN Finding
Biennial Problem Identification and Resolution Inspection Results
The licensee was generally effective at identifying problems at a low threshold and entering them into the corrective action program. One exception was noted regarding the failure to utilize the corrective action program (CAP) for a repetitive problem involving Motor Driven Auxiliary Feedwater Pumps (MDAFWPs) lubricating oil which did not meet requirements. The licensee properly prioritized issues and routinely performed adequate evaluations that were technically accurate and of sufficient depth. Formal root cause evaluations for significant conditions adverse to quality were normally thorough and detailed although the CAP program as written allowed a less than formal disciplined process to be utilized for root cause evaluations. Historically, corrective actions developed and implemented for problems had not always been timely and effective, however, this inspection showed marked improvement in this area, with one exception involving untimely corrective action for safety-related Loss of Off-Site Power relays. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. Based on discussions conducted with plant employees from various departments the inspectors did not identify any reluctance to report safety concerns.
Inspection Report# : 2003007*(pdf)*

Last modified : March 02, 2004