Farley 2 3Q/2004 Plant Inspection Findings

Initiating Events

Significance:

Sep 25, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Backhoe Struck Support in High Voltage Switchyard

A self-revealing non-cited violation was identified for failure to follow procedure for control of switchyard activities in accordance with TS 5.4.1.a. which resulted in a backhoe striking and damaging a 500KV bus support in the high voltage switchyard.

This finding is more than minor because it adversely affected the protection against external factors attribute of the Initiating Event cornerstone for switchyard activities. The licensee considers activities in the high voltage switchyard as risk significant. The damage to the support occurred due to not following the procedural requirements in place to reduce the risk for work in the high voltage switchyard. This finding was determined to be of very low safety significance because it did not contribute to the likelihood of a reactor trip or the likelihood that mitigation equipment or functions would not be available. This finding involved the cross-cutting aspect of Human Performance.

Inspection Report# : 2004004(pdf)

Mitigating Systems

Significance: 6

ep 25, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Reactive Senior Reactor Operator License

A non-cited violation was identified for failure to follow the requirements of licensee procedures FNP-0-AP-16, Conduct of Operations - Operations Group, and FNP-0-TCP-17.5, License Administration, as required by Technical Specification 5.4.1.a. This resulted in the incorrect certification of the reactivation of two SRO licenses.

The inspectors determined that the finding is greater than minor because it involves the Mitigating System Cornerstone objective of the reliability and capability of operators to respond to initiating events to prevent undesirable consequences. The NRC considers the reactivation and proficiency of licensed operators an element of the human performance attribute which helps to minimize potential human errors. The finding was evaluated using the Operator Requalification Human Performance significance determination process and was determined to be a finding of very low safety significance because more than 20 percent of the reactivation records reviewed had deficiencies.

Inspection Report# : 2004004(pdf)

Significance:

Mar 27, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Required Repairs of Service Water System ASME Class 3 Piping

A Green NRC-identified NCV was identified for failure to meet the ASME Boiler and Pressure Vessel Code requirements of 10 CFR 50.55a section (a)(2) for systems and components of a pressurized water-cooled reactor or seek a proposed alternative as permitted by section (a)(3) for three through-wall leaks in ASME Code Class 3 piping of the Service Water (SW) system. The leaks, when identified, were not repaired to ASME code requirements or a proper evaluation performed for an alternative non-code repair as discussed in Generic Letter (GL) 90-05, Guidance for Performing Temporary Non-Code Repair of ASME Code Class 1,2, and 3 Piping.

This finding is more than minor because it adversely affected the equipment performance attribute of the mitigating system cornerstone because it had the potential to affect the reliability of the SW system. This finding was determined to be of very low safety significance because there was not a large leak or loss of SW system safety function.

Inspection Report# : 2004002(pdf)

Significance: 6

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:

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-ofcalibration 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)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:

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

Physical Protection information not publicly available.

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: December 29, 2004