

Byron 1

1Q/2006 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2005

Identified By: Self-Revealing

Item Type: FIN Finding

FAILURE OF THE NEWLY INSTALLED DIGITAL ELECTROHYDRAULIC SYSTEM TO RESPOND TO OPERATOR'S INPUT TO INITIATE A TURBINE RUNBACK

A finding having very low safety significance (Green) was self-revealed when the newly installed Digital Electrohydraulic System (DEH) failed to respond to operator input to initiate a turbine runback that subsequently resulted in a reactor trip. The inspectors determined that the algorithm required for turbine runback was deleted from the software database due to a compiler fault. Modification review and testing performed by the licensee failed to discover the software error. To correct the problem the licensee reinstalled the deleted software algorithm into the DEH system.

The finding was more than minor because it affected the design control attribute of the Initiating Events cornerstone objective. The attribute objective limits the likelihood of those events that upset plant stability and challenge critical safety functions during at-power operations. Specifically, the lack of turbine runback capability contributed to a reactor trip from a feedwater system transient. The finding was determined to be of very low safety significance (Green), since it only contributed to the likelihood of a reactor trip. No violation of NRC requirements occurred.

Inspection Report# : [2005011\(pdf\)](#)

Significance:  Jun 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Severe Weather Procedure Results in Less than Required Essential Service Water Basin Level

A finding of very low safety significance and associated Non-Cited Violation (NCV) of Technical Specification (TS) 5.4.1 regarding procedure adherence was self revealed, when during a tornado watch, operators failed to maintain both essential service water basin levels greater than 90 percent as specified in the associated abnormal operating procedure. Upon recognizing the low level condition, operators restored basin level to greater than 90 percent. The primary cause of this violation was related to the cross-cutting area of Human Performance (personnel) because the operators failed to maintain the required basin level even though adequate guidance for maintaining basin level was provided in the associated procedure.

This finding was more than minor because the operators allowed the level to drop below the operating limit; which is similar to the more than minor examples of Section 2 of Appendix E to Inspection Manual Chapter (IMC) 0612. The finding was determined to be of very low safety significance because the condition did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.

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

Mitigating Systems

Significance:  Mar 24, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Translate Design Basis Into Procedures for Service Water Flow to the CC Heat Exchangers

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance for the licensee's failure to correctly translate the design basis into procedures. Specifically, the licensee failed to update operator rounds to verify the revised design basis minimum value for essential service water flow to the component cooling water (CC) heat exchangers. In addition, because the operator rounds were not revised, the design basis minimum flow value was not bounded by the emergency operating procedure used for establishing initial cold leg recirculation in the event of a loss of coolant accident (LOCA). This issue was entered into the licensee's corrective action program to revise the operator rounds.

The issue was more than minor because it was associated with the Mitigating System cornerstone attribute of "Design Control," and affected the cornerstone objective of ensuring the capability of systems that respond to initiating events to prevent undesirable consequences.

Specifically, the failure to have operator rounds verify the design basis minimum service water flow or to have the emergency operating procedures ensure the minimum flow prior to establishing initial cold leg recirculation in the event of a LOCA could potentially have allowed the service water flow to be less than the required value to maintain the design heat load during post LOCA conditions. This finding was of very low safety significance because it screened out as Green using the SDP Phase 1 worksheet. Even though the licensee did not control their bounding design basis service water flow procedurally, the flow to the CC heat exchangers has historically been well above the bounding design basis flow.

Inspection Report# : [2006006\(pdf\)](#)

Significance:  Mar 24, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Reduction of Fire Suppression Capacity and Capability

The inspectors identified a Non-Cited Violation of 10 CFR 50.48(a)(1) having very low safety significance for the licensee's failure to provide fire fighting systems of appropriate capacity and capability to minimize the adverse effects of fires on structures, systems, and components important to safety. Specifically, the licensee abandoned standpipes and manual hose stations located near safety-related equipment (essential service water makeup pumps) which reduced the fire suppression capacity and capability to protect such equipment. In addition, the site relied on a local fire department instead of the site fire brigade to manually suppress a fire that could have affected safety-related equipment. This issue was entered into the licensee's corrective action program, and compensatory measures were taken to place dry chemical fire extinguishers in the vicinity of the fire area to take the place of the abandoned manual fire hose stations.

This finding was considered more than minor because it was associated with the Mitigating System cornerstone attribute of "Protection Against External Factors," and affected the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, removing the manual hose stations reduced the fire suppression capacity and capability for protecting the emergency service water cooling tower makeup pumps and their diesels in the event of a fire. This finding was determined to be of very low safety significance (Green) based on a Phase 3 SDP evaluation.

Inspection Report# : [2006006\(pdf\)](#)

Significance:  Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILED TO PERFORM VT-2 EXAMINATION AT NOMINAL OPERATING PRESSURE FOR SIX NEW RHR SYSTEM WELDS

The inspectors identified a finding involving a Non-Cited Violation (NCV) of 10 CFR Part 50.55a(g)(4)ii having very low safety significance for failure to perform a VT-2 examination at nominal operating pressure for six new residual heat removal system welds that were returned to service. This finding was entered into the licensee's corrective action program.

This finding was more than minor significance because the licensee returned these six welds to service without completing the required pressure test and VT-2 examination, which placed this system at increased risk for undetected leakage and component failure. Operation of this system with improperly tested piping affected the mitigating systems cornerstone objective of equipment reliability. This finding was of very low safety significance because the required test and VT-2 examination were subsequently completed and all welds passed. The finding was not suitable for a significance determination process evaluation. This finding has been reviewed by NRC Management and has been determined to be a Green finding of very low safety significance.

Inspection Report# : [2005011\(pdf\)](#)

Significance:  Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE CLEANING OF ESSENTIAL SERVICE WATER DIESEL FUEL OIL STORAGE TANKS.

A self-revealing NCV of Technical Specification 5.4.1a, "Procedures", was identified for Byron's inadequate cleaning procedure for the Essential Service Water (SX) make-up pump diesel fuel oil storage tanks. This resulted in each of the SX make-up pumps being inoperable for a period of approximately 60 days. Byron's inadequate SX fuel tank cleaning procedure is identified as a performance deficiency that is greater than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone to ensure the availability, reliability, and capability of systems to respond to an initiating event to prevent undesirable consequences. A contributing cause to the inadequate SX fuel tank cleaning is related to the Human Performance cross-cutting area. Procedures for diesel fuel oil tank cleaning and post maintenance testing lacked technical details to ensure that the SX make-up pumps were restored to an operable condition.

Inspection Report# : [2005009\(pdf\)](#)

Significance:  Jun 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Technical Specification 3.8.4.a.3 Violation for Untimely Verification of Battery Float Current Due to Improper Procedure Change

A finding of very low safety significance and associated NCV of TS 3.8.4.A.3 regarding DC electrical sources during operations was self-

revealed. Specifically, during a work window on the Unit 1 train A battery charge requiring the associated battery to be cross-connected to the Unit 2 train A battery charger, operators incorrectly directed the verifying of the battery float charge ampere to the Unit 2 battery. This resulted in the Unit 1 battery float current not being verified as acceptable in the time required by TS. The primary cause of this violation was related to the cross-cutting area of Human Performance (personnel) because the unit supervisor improperly changed the associated procedure thereby directing the operators to verify the float current on the wrong battery.

This finding was more than minor because it was similar to the more than minor examples of Section 3 of Appendix E of IMC 0612. The finding was determined to be of very low safety significance because there was no design deficiency, no actual loss of safety function, no single train loss of safety function for greater than the TS allowed outage time, and no risk due to external events.

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

Barrier Integrity

Significance:  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

DEGRADED INCORRECT PLANT BARRIER IMPAIRMENT EVALUATION RESULTED IN AN AUXILIARY BUILDING INTEGRITY

A finding of very low safety significance and associated Non-Cited Violation (NCV) of Technical Specification 5.4.1, regarding procedure adherence was inspector identified when the inspectors identified that ventilation barrier requirements were not being met during a routine assessment of work activities in the Unit 2 containment spray pump rooms. Upon identification, the licensee restored the barrier. The primary cause of this violation was related to the cross-cutting area of Human Performance.

This finding was more than minor because it affected the barrier integrity objective to provide reasonable assurance that the physical design barriers to protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance because the issue only represented a degradation of the radiological barrier function provided for the auxiliary building.

Inspection Report# : [2006002\(pdf\)](#)

Significance:  Mar 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURE RESULTED IN UNTIMELY COMPLETION OF OPERABILITY EVALUATION

A finding of very low safety significance and associated NCV of Technical Specifications 5.4.1, "Procedures," was self-revealed. Specifically, licensee personnel conducted unauthorized troubleshooting activities after an abnormal flow condition was encountered during Reactor Coolant System sampling activities and did not report the condition to shift operations promptly. These troubleshooting activities were not allowed by the chemistry sampling, procedures use and adherence, and corrective action program procedures. Shift operations learned about the condition 2 days later and subsequently declared the pressurizer liquid sample containment isolation valves inoperable and completed the required Technical Specification actions. The primary cause of this violation was related to the cross-cutting area of Human Performance.

This finding was more than minor because it affected the human performance attribute of the barrier integrity cornerstone to provide reasonable assurance that physical barriers, specifically the reactor containment, protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance because it did not represent an actual open pathway or involve an actual reduction in defense-in-depth for the pressure control or hydrogen control functions of the reactor containment.

Inspection Report# : [2006002\(pdf\)](#)

Significance:  Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FUEL HANDLING ERROR POTENTIALLY DAMAGES FUEL ASSEMBLY.

A Non-Cited Violation (NCV) of TS 5.4.1a, having very low safety significance was self-revealed. Specifically, a fuel handler moving new fuel in the spent fuel pool failed to unlatch the fuel assembly after being lowered into the designated storage position, potentially damaging the fuel assembly as the bridge crane was trolleyed with the fuel assembly partially inserted in its storage location. The inspectors determined that the failure to detach the fuel assembly from the fuel handling tool prior to raising the assembly approximately three feet and moving the spent fuel pool bridge crane hoist trolley was a performance deficiency. This performance deficiency warranted a significance evaluation in accordance with Inspection Manual Chapter (IMC) 0612 "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening." The inspectors determined that the finding was more than minor because it is related to the human performance attribute of the barrier integrity cornerstone to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. A contributing cause to the fuel handling procedure violation is related to the Human Performance cross-cutting area. The operators failed to follow the procedure specified in OU-BY-204, "Fuel Handling Procedures in the Spent Fuel Pool for Byron", Revision 2.

Inspection Report# : [2005009\(pdf\)](#)

G**Significance:** Jun 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Procedure During VCT Level Instrument Calibration Results in Work on Wrong Train and Unexpected Opening of the RWST Suction Valves to the Charging Pumps

A finding of very low safety significance and associated NCV of 10 CFR 50 Appendix B, Criterion V, "Instructions, Drawings and Procedures," was self-revealed. Specifically, during the calibration of a Unit 1 volume control tank level instrument, technicians incorrectly loosened the low sensor test tap cap for other level instrument. Although the technicians immediately realized their error and closed the low sensor test tap cap, the charging pump control circuitry responded to the two low level signals and unexpectedly opened the refueling water storage tank suction valves to the charging pumps. The primary cause of this violation was related to the cross-cutting area of Human Performance (personnel) because the technicians opened the wrong test tap due to inadequate self or peer checking.

This finding was more than minor because it affected the human performance attribute of the fuel barrier function of the barrier integrity cornerstone to provide reasonable assurance that physical barriers, specifically the fuel, protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance because the fuel cladding barrier was not degraded.

Inspection Report# : [2005004\(pdf\)](#)**Significance:** SL-III Jun 30, 2005

Identified By: NRC

Item Type: VIO Violation

Review of Missed Ventilation And Filtration System Technical Specification Surveillance Requirements

On January 13, 2005, during a Nuclear Oversight Audit, the licensee identified that 15 Technical Specifications required ventilation surveillance tests were not performed. The licensee's subsequent root cause evaluation and investigation determined that the missed surveillance tests were due to willful falsification of documents by a non-licensed employee. The licensee's associated extent of condition review identified 12 additional TS required ventilation surveillance tests that were also falsified. Upon performing the 27 falsified surveillance requirements, six failed. The NRC determined that this issue was a violation of Byron Station Technical Specifications. By providing false information regarding the surveillances, the non-licensed employee also caused the licensee to be in violation of 10 CFR 50.9, "Completeness and Accuracy of Information. In addition, the activities of the employee also placed himself in violation of 10 CFR 50.5, "Deliberate Misconduct." The enforcement aspects of this issue were described in the Notice of Violation EA-05-159, "Byron Station - Notice of Violation [NRC Office of Investigations Report No. 3-2005-008," from James L. Caldwell to Christopher M. Crane, dated October 27, 2005. This URI is closed.

Inspection Report# : [2005004\(pdf\)](#)Inspection Report# : [2005011\(pdf\)](#)

Emergency Preparedness

Significance: SL-IV Dec 31, 2005

Identified By: NRC

Item Type: VIO Violation

FAILURE TO OBTAIN PRIOR NRC APPROVAL FOR CHANGE TO AN EAL THAT DECREASED THE EFFECTIVENESS OF THE EMERGENCY PLAN

The inspectors identified that the licensee had changed its standard emergency action level (EAL) scheme by revising one EAL's criteria for an Unusual Event declaration that addressed an unplanned radiological release in excess of effluent radiation monitor readings unless the release could be determined to be below Offsite Dose Calculation Manual limits within 15 minutes for releases that could not be terminated in 60 minutes or less. The inspectors determined that this EAL change decreased the effectiveness of the emergency plan, and that the licensee did not obtain prior NRC approval for this change, contrary to the requirements of 10 CFR 50.54(q). The licensee is evaluating the options to correct the EAL.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process as specified in Section IV.A.3 of the Enforcement Policy. According to Supplement VIII of the Enforcement Policy, this finding was determined to be a Severity Level IV because it involved a failure to meet a requirement not directly related to assessment and notification. Further, this problem was isolated to one EAL and was not indicative of a functional problem with the EAL scheme. Additionally, because the violation was a Severity Level IV and the licensee entered this issue into its corrective action program this finding is being treated as a Severity Level IV Non-Cited Violation of 10 CFR 50.54(q).

Inspection Report# : [2005011\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Significance: N/A Jul 01, 2005

Identified By: NRC

Item Type: FIN Finding

PI&R INSPECTION SUMMARY

Overall, the team concluded that problems were being adequately identified, evaluated, and corrected. Issues captured in the corrective action program were appropriately screened and evaluated for root or apparent causes and workers generally expressed positive views about the program. However, the team identified two concerns that cut across all the functional areas (problem identification, evaluation and resolution) of the corrective actions program. Specifically, the team identified that plant staff were sometimes too focused on the specific process being implemented than on the overall program. There were several instances where issues were identified during cause or operability evaluations, but were not fed back into the corrective action program, because it was not a specific requirement of the evaluation process. The team also noted that industry experience, especially Braidwood station experience, was underutilized in identifying or evaluating issues. The Nuclear Oversight organization was considered intrusive and challenged corrective action program performance based on the numerous examples of assessment findings reviewed during the inspection. The team also observed that the station had reasonably addressed previously identified NRC issues, but noted that Nuclear Oversight had identified some concerns with the corrective actions for those issues identified during the 2003 NRC Problem Identification and Resolution inspection.

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

Last modified : May 25, 2006