Farley 1
1Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Mar 31, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Promptly Identify and Correct Conditions Resulting in the Unrecognized Inoperability of the 1-2A Emergency Diesel Generator
A Green, NRC-identified, non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XIV, Corrective Actions, was identified for failure to promptly identify and correct a failure of the 1F (Unit 1 Train A Engineered Safety Feature) 4-kV bus synchroscope resulting in the unrecognized inoperability of the 1-2A Emergency Diesel Generator (EDG) set.

This finding is more than minor because it is associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and because it affects the associated cornerstone objective. Specifically, the Mitigating System Cornerstone objective is to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences in the future. This finding is of very low safety significance (Green) because there was no complete loss of system safety function and no direct effect on initial accident response or system mission time. This finding involved the cross-cutting aspect of Identification within the area of Problem Identification and Resolution due to cognitive personnel error and knowledge deficiency, in that, it was unclear to the operating crew that loss of the voltmeter indicated that the synchroscope might also be inoperable.

Inspection Report# : 2006002*(pdf)*

Significance: G Jun 30, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Loss of Spent Fuel Pool Cooling
A self-revealing non-cited violation (NCV) was identified for failure to follow procedure in accordance with Technical Specification 5.4.1.a, which resulted in a loss of both trains of Unit 1 spent fuel pool (SFP) cooling for nine hours and a 12 degree Fahrenheit rise in SFP temperature.

This finding is more than minor because it adversely impacted the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events. The finding was determined to be of low safety significance because the SFP temperature was below Updated Final Safety Analysis Report limits, peak temperature only reached 100 degrees and water level in the fuel pool was normal. This finding also involved the cross-cutting aspects of human performance in that the operators failed to properly follow the procedure requirement to successfully swap pumps in operation.
Inspection Report# : 2005003*(pdf)*

Significance: G Jun 30, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Follow TS for Inoperable Train of SSPS Logic
A self-revealing NCV was identified for failure to implement the proper Limiting Condition of Operation (LCO) associated with Technical Specifications (TS) 3.3.2, Engineered Safety Feature Actuation System Instrumentation when one train was inoperable. The licensee initially entered a LCO for failed channel (TS 3.3.2.D), but later determined that a logic card failed that impacted the Unit 1 A train of solid state protection system (SSPS) and subsequently entered TS LCO 3.3.2.C.

This finding is more [than] minor because it affects the Mitigating Systems Cornerstone attribute of equipment performance and adversely impacted the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events. Unit 1 A train of the SSPS logic initiation was unavailable for a time that exceeded the allowed time permitted by TS. This finding is of very low safety significance because the B train of SSPS logic initiation was maintained operable at all times.

Inspection Report# : 2005003*(pdf)*

Barrier Integrity

Significance: G 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)*

Significance: G Aug 26, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Identify 1A Containment Spray Pump Room Cooler Degraded Time Delay Relay
A self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, was identified for failure to identify a significant condition adverse to quality. Specifically, following the July 15, 2003, trip of the 1A containment spray pump room cooler, the licensee failed to identify an existing degraded time delay relay. Consequently, for the period between July 15, 2003, until corrected on May 1, 2004, the degraded condition of the 1A containment spray pump room cooler rendered it vulnerable to "run/stop/hot restart" scenarios that could be encountered during the response to a large break loss of coolant accident (LOCA).

This finding is more than minor because it affects the Barrier Integrity Cornerstone attribute of Barrier Performance and impacted the cornerstone objective in that tripping of the room cooler could result in loss of the 1A containment spray pump safety function due to overheating. This finding is of very low safety significance (Green) because the 1B containment spray pump and room cooler and all containment coolers were available to ensure containment barrier integrity would be maintained in the event of a large break LOCA or containment over pressure challenge. This finding has the cross-cutting aspect of Problem Identification and Resolution - Identification.
Inspection Report# : 2005008*(pdf)*

Emergency Preparedness

Significance: G 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 1of 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

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