Brunswick 2
2Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Engineering Change Procedure Resulting in Inoperable Reactor Core Isolation Cooling System
An NRC-identified non-cited violation was identified for failure to meet Technical Specification (TS) 5.4.1, Procedures. Specifically, the temporary modification process was not followed when implementing a temporary change to the Unit 2 reactor core isolation cooling keepfill system. As a result, appropriate reviews of the impact on reactor core isolation cooling system operability were not performed. This resulted in the Unit 2 reactor core isolation cooling system being inoperable due to the potential of voiding the reactor core isolation cooling pump discharge piping during certain scenarios.

This finding is more than minor because it is associated with operating equipment lineup and affected the Mitigating System Cornerstone objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance (Green) because it did not represent an actual loss of safety function for greater than the TS allowed outage time. The inspectors determined that the cause of this finding is a performance aspect of the human performance cross-cutting area, in that the cause was due to personnel failing to follow the temporary modification process (Section 1R04).

Inspection Report# : 2006003*(pdf)*

Significance: G Nov 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedural Controls for RHR System Venting
Green. A Green NRC identified, non-cited violation (NCV) of Technical Specification (TS) 5.4.1.a was identified for failure to establish written procedures to direct venting of the residual heat removal (RHR) system in response to increasing system pressure. Instead, system venting was directed through informal communications, such as e-mails and telephone calls. The licensee entered the deficiency associated with lack of procedural guidance into their Action Request Program for resolution.

This finding is more than minor because it affected the ability of the licensee to properly control the venting of the RHR system and was associated with the Mitigating Systems Cornerstone and the respective attribute of procedure quality. The finding is of very low safety significance because there was no actual loss of safety function. A contributing cause of the finding is related to the cross-cutting element of problem identification and resolution.
Inspection Report# : 2005007*(pdf)*

Significance: G Sep 30, 2005
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Properly Control the EDG Control Switch
Green. A self-revealing finding was identified for failure to properly control the emergency diesel generator control switch to assure reliability of the offsite power source to the plant's emergency buses. As a result, Brunswick Units 1 and 2 experienced a loss of power to emergency bus E-1 on May 12, 2005 when it's feeder breaker from the offsite power source opened following a voltage transient initiated by a fault on another emergency bus. The licensee entered this issue into the corrective action program.

This finding is greater than minor because it is associated with the operating equipment lineup attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective of ensuring the reliability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because it did not represent an actual loss of safety function of a single train for greater than the TS allowed outage time.
Inspection Report# : 2005004*(pdf)*

Significance: G Aug 12, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Generate an A/R for Abnormal Conditions Identified in Work Orders
A non-cited violation (NCV) of 10CFR50, Appendix B, Criterion XVI was identified because the licensee failed to promptly identify a condition adverse to quality in that licensee personnel failed to generate an Action Request (A/R) for abnormal conditions identified in the comment section of work orders associated with OPM-GEN005, "Diesel Generator Electrical Inspections."

This finding is greater than minor because it is associated with the reactor safety Mitigating System Cornerstone and affects the configuration control attribute of the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). A phase one evaluation determined that the performance deficiency was of very low safety significance because the abnormal conditions did not effect the operability of the affected components. This finding also involved the cross-cutting aspects of problem identification and resolution (PI&R) in that the licensee failed to properly identify or address these issues in the corrective action system. [An additional example of this NCV was identified in IR 05000325,324/2005004 with the additional title of Failure to Identify a Vulnerability to Spurious Tripping of EDG during the Start Sequence.]
Inspection Report# : 2005010*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Dec 16, 2005
Identified By: NRC
Item Type: FIN Finding
PROBLEM IDENTIFICATION AND RESOLUTION
The inspectors determined that the licensee was effective in identifying problems and entering them into the Corrective Action Program (CAP). One example was noted where new action requests/nuclear condition reports (ARs/NCRs) were not written for current failures, instead the issue was tracked with an old NCR. Problem evaluation and corrective action implementation were generally effective with deficiencies noted in corrective action timeliness and in the quality and timeliness of investigations. The inspectors noted several examples where significant adverse conditions had recurred, indicating that all root/contributing causes had not been determined or that corrective actions had not provided timely resolution. Significant investigations were ongoing and recent CAP process changes were initiated by management to address these issues. The inspectors did not identify any new CAP problems not already being addressed by the licensee. The inspectors determined that the site staff felt free to raise issues and that management wanted issues placed into the CAP for resolution. Some engineering department staffing and CAP workload distribution concerns were noted in the employee concerns program (ECP). The ECP coordinator and management were already addressing the underlying issues related to these concerns and their potential affect on plant equipment. The inspectors did not identify any reluctance to report safety concerns.
Inspection Report# : 2005011*(pdf)*

Last modified : August 25, 2006