

Browns Ferry 3

4Q/2007 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Work Instructions For Isolating Condensate Demineralizer System Causes a Unit 3 Reactor Scram (Section 4OA3.5)

Green. A Green self-revealing finding was identified for use of an inadequate work order instructions during an online modification of the Unit 3 Condensate Demineralizer System control logic that caused an inadvertent isolation of condensate flow which directly resulted in a reactor scram. Condensate Demineralizer System operating procedures were subsequently revised to clarify manual operation of system controllers. This finding was entered into the licensee's corrective action program as PER 119490.

This finding is greater than minor because it is associated with the Initiating Event Cornerstone attributes of Human Performance and Procedure Quality, and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during at-power operations. The finding was determined to be of very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment or functions were not available. The cause of this finding was directly related to the aspect of "complete and accurate work packages" in the area of Human Performance (Resources component) because the necessary work order instructions for ensuring the condensate demineralizer system controllers remained in manual were inaccurate and/or incomplete. (Section 4OA3.5)

Inspection Report# : [2007003](#) (*pdf*)

Mitigating Systems

Significance:  Dec 14, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform ASME Inspections of Safety-Related Piping.

The inspectors identified a Green non-cited violation of 10 CFR 50.55a(g)4 Codes and Standards. Specifically, the licensee failed to perform required code inspections of accessible portions of safety-related piping. The licensee entered this issue into their corrective action program.

This finding is more than minor because if left uncorrected it would become a more significant safety concern. The failure to perform required inspections of safetyrelated piping could have allowed undetected through-wall flaws to remain in-service. These undetected flaws could grow in size until leakage from the piping degrades system operation, or if sufficient general corrosion occurs, a gross rupture or collapse of the piping could occur. The finding is of very low safety significance because the finding did not represent a loss of safety function. The cause of the finding is related to the cross-cutting element of problem identification and resolution under the operating experience aspect of the corrective action component [P.2(b)].

[Section 1R21.4]

Inspection Report# : [2007007](#) (*pdf*)

Significance:  Dec 14, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Corrective Actions for Cable Submersion Were Not Effective.

The inspectors identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action. Specifically, the licensee failed to correct a cable submergence issue which resulted in the failure of a safety-related cable.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance because the finding was not a design or qualification deficiency, and did not represent a loss of safety function because the redundant train was available. The cause of the finding is related to the cross-cutting element of problem identification and resolution under the licensee thoroughly evaluates problems aspect of the corrective action component [P.1(c)].

Inspection Report# : [2007007](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Mar 31, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Properly Prepare a Radioactive Materials Package for Shipment

A Green self-revealing non-cited violation of 10 CFR 71.5 was identified for failure to properly package radiological material such that, under conditions normally incident to transportation, the radiation levels at the external surface of the package would not exceed applicable Department of Transportation (DOT) limits. When the two shipments arrived at a processing facility on April 21, 2005, the radiation dose rates measured on portions of the external surface of the packages were as high as 300 mrem/hr, which was in excess of the 200 mrem/hr limit specified by the regulation. The licensee established additional supervisory review and approval prior to shipping packages approaching DOT limits. This finding was entered into the licensee's corrective action program as PER 81364.

This finding is more than minor because it is associated with the Plant Facilities/ Equipment and Instrument attribute of the Public Radiation Safety cornerstone and adversely affected the cornerstone objective, in that, the improper transportation packaging resulted in a shipping container with external dose levels exceeding regulatory requirements. Using the Public Radiation Significance Determination Process, the finding was determined to be of very low safety significance because the areas on the packages with elevated radiation levels were inaccessible to the public and the radiation levels were less than two times the DOT limit.

Inspection Report# : [2007002](#) (*pdf*)

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Aug 24, 2007

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The licensee was effective in identifying problems at a low threshold and entering them into the CAP. Issues were typically properly characterized and evaluations such as root causes were sufficiently thorough and detailed. Strong management oversight of the CAP was evident. Initial prioritization of issues and corrective actions appeared to be appropriate to risk and program guidance; however, numerous delays in completion of corrective actions had led to increased backlogs in closure of Problem Evaluation Reports (PERs). Recent management attention had resulted in the backlogs beginning to decrease at the time of this inspection. In addition, the inspectors concluded that the licensee had been slow to effect significant improvement in equipment reliability based on the number of equipment problems and timeliness of corrective actions. Also, some repeat problems, such as, adequacy of corrective action implementation were noted; however, these problems were improved from previous inspections.

The licensee was effective in evaluating internal and external industry operating experience items for applicability and taking appropriate action.

Based on review of the licensee's Concerns Resolution Program (CRP), discussions conducted with plant employees from various departments, and review of many PERs, the inspectors did not identify any reluctance to report safety concerns. The inspectors concluded that licensee management routinely emphasized the need for all employees to identify and report problems using the appropriate methods established within the administrative programs.

Inspection Report# : [2007008](#) (*pdf*)

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Work Hours for I&C Mechanics Exceeded Overtime Limits Without Prior Authorization

The inspectors identified a Green non-cited violation of Technical Specification 5.2.2.d due to inadequate management oversight and awareness of the administrative requirements for controlling overtime which resulted in multiple instances of Instrumentation and Control personnel exceeding overtime limits without prior authorization and documentation. Management immediately changed work schedules to comply with the Technical Specification requirements and entered the issue into their corrective action program as PER 119016.

This finding was greater than minor because if left uncorrected it could become a more significant safety concern due to excessive fatigue by key maintenance personnel performing safety-related activities. An NRC management review determined that the finding was of very low safety significance because no specific performance deficiencies were identified for the individuals during the time they exceeded the established overtime limits

Inspection Report# : [2007002](#) (*pdf*)

Last modified : February 04, 2008