



UNITED STATES  
**NUCLEAR REGULATORY COMMISSION**  
REGION IV  
1600 EAST LAMAR BLVD  
ARLINGTON, TEXAS 76011-4511

May 7, 2012

Rafael Flores, Senior Vice President  
and Chief Nuclear Officer  
Luminant Generation Company, LLC  
Comanche Peak Nuclear Power Plant  
P.O. Box 1002  
Glen Rose, TX 76043

Subject: COMANCHE PEAK NUCLEAR POWER PLANT - NRC INTEGRATED INSPECTION  
REPORT 05000445/2012002 AND 05000446/2012002

Dear Mr. Flores:

On March 27, 2012, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Comanche Peak Nuclear Power Plant. The enclosed integrated inspection report documents the inspection results which were discussed on April 3, 2012, with you and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Three NRC-identified findings of very low safety significance (Green) were identified during this inspection.

All of these findings were determined to involve violations of NRC requirements. Further, three licensee-identified violations which were determined to be of very low safety significance are listed in this report. The NRC is treating these findings as non-cited violations (NCVs), consistent with Section 2.3.2 of the Enforcement Policy.

If you contest these non-cited violations you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001, with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 1600 East Lamar Boulevard, Arlington, Texas, 76011-4511; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at the Comanche Peak Nuclear Power Plant.

Senior Vice President and  
Chief Nuclear Officer – Rafael Flores

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If you disagree with a cross-cutting aspect assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region IV, and the NRC Resident Inspector at the Comanche Peak Nuclear Power Plant.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

*/RA/*

Wayne C. Walker, Chief  
Project Branch A  
Division of Reactor Projects

Docket Nos: 05000445, 05000446  
License Nos: NPF-87, NPF-89

Enclosure: 05000445/2012002 and 05000446/2012002  
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U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket: 05000445, 05000446  
License: NPF-87, NPF-89  
Report: 05000445/2012002 and 05000446/2012002  
Licensee: Luminant Generation Company LLC  
Facility: Comanche Peak Nuclear Power Plant, Units 1 and 2  
Location: FM-56, Glen Rose, Texas  
Dates: January 1 through March 27, 2012  
Inspectors: J. Kramer, Senior Resident Inspector  
B. Tindell, Resident Inspector  
G. Apger, Operations Engineer  
Approved By: Wayne Walker, Chief, Project Branch A  
Division of Reactor Projects

## SUMMARY OF FINDINGS

IR 05000445/2012002, 05000446/2012002; 1/1/2012 - 3/27/2012; Comanche Peak Nuclear Power Plant, Units 1 and 2; Operability Evaluations

The report covered a 3-month period of inspection by resident inspectors and announced baseline inspections by region based inspectors. Three Green non-cited violations were identified. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using Inspection Manual Chapter 0609, "Significance Determination Process." Findings for which the significance determination process does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

### A. NRC-Identified Findings and Self-Revealing Findings

Cornerstone: Mitigating Systems

- Green. The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure to follow procedure and initiate a condition report for degradation of safety-related equipment. Specifically, the licensee failed to initiate a condition report for multiple small oil leaks on emergency core cooling system pumps and motors. As a result, the licensee failed to characterize the operability of the equipment and identify potential corrective actions. The licensee entered the finding into the corrective action program as Condition Report CR-2012-003390.

The licensee's failure to follow procedure and initiate a condition report for emergency core cooling system pump and motor oil leaks was a performance deficiency and resulted in the failure to characterize the operability of the equipment and the failure to initiate appropriate corrective actions. The finding was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, in that, the leaks could worsen before establishing corrective actions and cause inoperable safety-related equipment. Using NRC Manual Chapter 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance in the mitigating systems cornerstone because the equipment was able to perform its safety function and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding has a problem identification and resolution cross-cutting aspect associated with the corrective action program because the licensee did not use a low threshold for identifying issues [P.1a] (Section 1R15.1).

- Green. The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure to follow procedure and perform an adequate operability evaluation to determine if a condition would have made a system inoperable in the past. Specifically, the licensee failed to determine that the degraded thrust in the closing direction of a pressurizer power operated relief block valve would have made the valve inoperable in the past. The licensee failed to fully understand the technical specification safety function of the valve.

As a result of the inadequate past operability evaluation, the licensee incorrectly classified the significance of the condition report. The licensee entered the finding into the corrective action program as Condition Report CR-2011-010056.

The failure to follow procedure and perform an adequate past operability evaluation of a degraded pressurizer power operated relief block was a performance deficiency which resulted in the licensee misclassifying the significance of the condition report. The finding was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, in that, the licensee could fail to correct a condition commensurate with its safety significance. Using NRC Manual Chapter 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance in the mitigating systems cornerstone because it did not result in the equipment being unable to perform its safety function, did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event and the technical issue screened as Green as documented in report Section 4OA7. The finding has a human performance cross-cutting aspect associated with decision making because the licensee did not use conservative assumptions in decision making [H.1b] (Section 1R15.2).

- Green. The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure to follow procedure and perform an adequate past operability evaluation to determine if a condition would have made a system inoperable in the past. Specifically, the licensee failed to determine that when a diesel generator was paralleled to the grid with a high bus voltage condition, the diesel generator was inoperable. As a result of the inadequate past operability evaluation, the licensee incorrectly classified the significance of the condition report. The licensee entered the finding into the corrective action program as Condition Report CR-2011-006113.

The failure to follow procedure and perform an adequate past operability evaluation of the diesel generators was a performance deficiency which resulted in the licensee incorrectly classifying the significance of the condition report. The finding was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, in that, the licensee could fail to correct a condition commensurate with its safety significance. Using NRC Manual Chapter 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance in the mitigating systems cornerstone because it did not result in the equipment being unable to perform its safety function for greater than its technical specification allowed outage time, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding has a human performance cross-cutting aspect associated with work practices because the licensee failed to use error prevention techniques, such as pre-job briefings, that were commensurate with the risk of the assigned task and support human performance error prevention [H.4a] (Section 1R15.3).

**B. Licensee-Identified Violations**

Violations of very low safety significance or severity level IV that were identified by the licensee have been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. These violations and corrective action tracking numbers are listed in Section 4OA7 of this report.

## REPORT DETAILS

### Summary of Plant Status

Unit 1 began the inspection period at approximately 100 percent power and operated at approximately 100 percent power for the entire inspection period.

Unit 2 began the inspection period at approximately 100 percent power. On March 26, 2012, operators reduced power to approximately 97 percent as a result of the failure of a reheater drain tank level controller. On March 27, the unit returned to approximately 100 percent power and operated at approximately 100 percent power for the remainder of the inspection period.

### 1. REACTOR SAFETY

#### Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness

#### 1R01 Adverse Weather Protection (71111.01)

##### a. Inspection Scope

On January 25, 2012, the inspectors performed a walkdown of the plant during heavy rains to verify that no activities were in progress that would open the circulating water system below nominal reservoir level and cause an external flood hazard. The inspectors evaluated the design, material condition, and procedures for coping with the design basis probable maximum flood. The evaluation included a review to check for deviations from the descriptions provided in the Final Safety Analysis Report for features intended to mitigate the potential for flooding from external factors. The inspectors reviewed the abnormal operating procedure for mitigating the design basis flood to ensure it could be implemented as written.

These activities constitute completion of one external flooding sample as defined in Inspection Procedure 71111.01-05.

##### b. Findings

No findings were identified.

#### 1R04 Equipment Alignments (71111.04)

##### a. Inspection Scope

The inspectors performed partial system walkdowns of the following risk-significant systems:

- January 12, 2012, Unit 2, motor driven auxiliary feedwater pumps when the turbine driven auxiliary feedwater pump was unavailable for testing
- January 24, 2012, Unit 2, safety injection pump 2-02 when safety injection pump 2-01 was unavailable for maintenance

- February 29, 2012, Unit 2, diesel generator 2-02 when diesel generator 2-01 was unavailable for testing

The inspectors selected these systems based on their risk significance relative to the reactor safety cornerstones at the time they were inspected. The inspectors focused on discrepancies that could affect the function of the system and, therefore, potentially increase risk. The inspectors reviewed applicable operating procedures, system diagrams, Final Safety Analysis Report, technical specification requirements, outstanding work orders, condition reports, and the impact of ongoing work activities on redundant trains of equipment in order to identify conditions that could have rendered the systems incapable of performing their intended functions. The inspectors also walked down accessible portions of the systems to verify system components and support equipment were aligned correctly and operable. The inspectors examined the material condition of the components and observed operating parameters of equipment to verify that there were no obvious deficiencies. The inspectors also verified that the licensee had properly identified and resolved equipment alignment problems that could cause initiating events or impact the capability of mitigating systems or barriers and entered them into the corrective action program with the appropriate significance characterization.

These activities constitute completion of three partial system walkdown samples as defined in Inspection Procedure 71111.04-05.

b. Findings

No findings were identified.

**1R05 Fire Protection (71111.05AQ)**

a. Inspection Scope

The inspectors conducted fire protection walkdowns in the following risk-significant plant areas:

- January 17, 2012, fire zone AA99a, 810 foot fuel handling area
- February 7, 2012, Unit 1 fire zone 1SB4, 790 foot corridor
- February 7, 2012, Unit 2 fire zone 2SE18, 852 foot switchgear
- February 14, 2012, Unit 1 fire zone 1TB105D, turbine building 778 foot

The inspectors reviewed areas to assess if licensee personnel had implemented a fire protection program that adequately controlled combustibles and ignition sources within the plant; effectively maintained fire detection and suppression capability; maintained passive fire protection features in good material condition; and had implemented adequate compensatory measures for out of service, degraded or inoperable fire protection equipment, systems, or features, in accordance with the licensee's fire plan. The inspectors selected fire areas based on their overall contribution to internal fire risk as documented in the plant's individual plant examination of external events, their potential to affect equipment that could initiate or mitigate a plant transient, or their impact on the plant's ability to respond to a security event. The inspectors verified that fire hoses and extinguishers were in their designated locations and available for immediate use, that fire detectors and sprinklers were unobstructed, that transient material loading was within the analyzed limits, and fire doors, dampers, and penetration seals appeared to be in satisfactory condition.

These activities constitute completion of four quarterly fire protection inspection samples as defined in Inspection Procedure 71111.05-05.

b. Findings

No findings were identified.

**1R06 Flood Protection Measures (71111.06)**

a. Inspection Scope

On January 17, 2012, the inspectors observed the condition of Unit 2 service water train B cable vaults. The inspectors verified the power cables were not submerged. In addition, the inspectors observed the material condition of the cable supports. The inspectors reviewed the licensee's efforts to maintain the cables in a qualified environment. The inspectors reviewed the corrective action program to determine if licensee personnel identified and corrected flooding problems.

These activities constitute completion of one underground cable flood protection measures inspection sample as defined in Inspection Procedure 71111.06-05.

b. Findings

No findings were identified.

**1R11 Licensed Operator Requalification Program and Licensed Operator Performance (71111.11)**

.1 Quarterly Inspection of Licensed Operator Requalification Program (71111.11Q)

a. Inspection Scope

On February 13, 2012, the inspectors observed a crew of licensed operators in the plant's simulator during requalification training. The inspectors assessed the following areas:

- Licensed operator performance
- The ability of the licensee to administer the evaluations
- The modeling and performance of the control room simulator
- The quality of post-scenario critiques
- Follow-up actions taken by the licensee for identified discrepancies

These activities constitute completion of one quarterly inspection of licensed operator requalification program sample as defined in Inspection Procedure 71111.11.

b. Findings

No findings were identified.

.2 Quarterly Observation of Licensed Operator Performance (71111.11Q)

a. Inspection Scope

The inspectors observed the performance of on-shift licensed operators in the plant's main control room. At the time of the observations, the plant was in a period of heightened activity. The inspectors observed the operators' performance of the following activities:

- February 23, 2012, Unit 2, turbine driven auxiliary feedwater pump testing
- March 20, 2012, shift turnover
- March 26, 2012, Unit 2, manual control of reheater drain tank 2-B1

In addition, the inspectors assessed the operators' adherence to plant procedures and other operations department policies.

These activities constitute completion of one quarterly observation of licensed operator performance sample as defined in Inspection Procedure 71111.11.

b. Findings

No findings were identified.

.3 Annual Review of Licensed Operator Regualification Program (71111.11A)

The licensed operator regualification program involves two training cycles that are conducted over a 2-year period. In the first cycle, the annual cycle, the operators are administered an operating test consisting of job performance measures and simulator scenarios. In the second part of the training cycle, the biennial cycle, operators are administered an operating test and a comprehensive written examination. For this annual inspection requirement, the licensee was in the first part of the training cycle.

a. Inspection Scope

The inspectors reviewed the results of the operating tests to satisfy the annual inspection requirement. On January 4, 2012, the licensee informed the inspectors of the results for the annual operating tests that ended on December 15, 2011:

- 14 of 14 crews passed the simulator portion of the operating test
- 83 of 84 licensed operators passed the simulator portion of the operating test
- 82 of 84 licensed operators passed the job performance measure portion of the operating test

On February 3, 2012, the licensee informed the inspectors that individuals that failed the job performance measure portion of the operating test were remediated, retested, and passed their retake test. The delay in remediation was due to the holidays and medical issues which precluded immediate completion.

These activities constitute completion of one annual review of licensed operator regualification program sample as defined in Inspection Procedure 71111.11.

b. Findings

No findings were identified.

**1R12 Maintenance Effectiveness (71111.12)**

a. Inspection Scope

The inspectors evaluated the following risk significant systems, components, and degraded performance issues:

- Fire protection pumps
- Containment isolation

The inspectors reviewed events where ineffective equipment maintenance had resulted in failures and independently verified the licensee's actions to address system performance or condition problems in terms of the following:

- Implementing appropriate work practices
- Identifying and addressing common cause failures
- Scoping of systems in accordance with 10 CFR 50.65(b)
- Characterizing system reliability issues for performance
- Charging unavailability for performance
- Trending key parameters for condition monitoring
- Ensuring proper classification in accordance with 10 CFR 50.65(a)(1) or (a)(2)

The inspectors verified appropriate performance criteria for structures, systems, and components classified as having an adequate demonstration of performance through preventive maintenance, as described in 10 CFR 50.65(a)(2), or as requiring the establishment of appropriate and adequate goals and corrective actions for systems classified as not having adequate performance, as described in 10 CFR 50.65(a)(1). The inspectors assessed performance issues with respect to the reliability, availability, and condition monitoring of the system. In addition, the inspectors verified that maintenance effectiveness issues were entered into the corrective action program with the appropriate significance characterization. Specific documents reviewed during this inspection are listed in the attachment.

These activities constituted completion of two maintenance effectiveness samples as defined in Inspection Procedure 71111.12-05.

b. Findings

No findings were identified.

**1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13)**

a. Inspection Scope

The inspectors reviewed the licensee's evaluation and management of plant risk for the maintenance and emergent work activities affecting risk-significant and safety-related

equipment listed below to verify that the appropriate risk assessments were performed prior to removing equipment for work:

- January 26, 2012, switchyard and diesel generator walkdown while Unit 2 turbine driven auxiliary feedwater pump was out of service
- February 29, 2012, Unit 2, diesel generator 2-01 out of service
- March 7, 2012, Unit 1, diesel generator 1-02 testing and containment spray pump 1-04 outage
- March 8, 2012, Unit 2, residual heat removal pump 2-02 out of service

The inspectors selected these activities based on potential risk significance relative to the reactor safety cornerstones. As applicable for each activity, the inspectors verified that licensee personnel performed risk assessments as required by 10 CFR 50.65(a)(4) and that the assessments were accurate and complete. When licensee personnel performed emergent work, the inspectors verified that the licensee personnel promptly assessed and managed plant risk. The inspectors reviewed the scope of maintenance work, discussed the results of the assessment with the licensee's probabilistic risk analyst or shift technical advisor, and verified plant conditions were consistent with the risk assessment. The inspectors also reviewed the technical specification requirements and inspected portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met.

These activities constitute completion of four maintenance risk assessments and emergent work control inspection samples as defined in Inspection Procedure 71111.13-05.

b. Findings

No findings were identified.

**1R15 Operability Evaluations (71111.15)**

a. Inspection Scope

The inspectors reviewed the following issues:

- CR-2011-004136, Unit 2 pressurizer power operated relief valve block valve inadequate thrust
- CR-2011-006113, diesel generator paralleled to the grid during high grid voltage conditions
- CR-2011-008215, Unit 1 containment sump to containment spray pumps 1-01 and 1-03 suction valve failed to fully stroke
- CR-2011-010175, effect of plant ventilation on waste gas decay tank rupture
- CR-2011-010210, Unit 1 personnel airlock inner door seal unable to pressurize

- CR-2012-001473, residual heat removal motor oil leaks

The inspectors selected these potential operability issues based on the risk-significance of the associated components and systems. The inspectors evaluated the technical adequacy of the evaluations to ensure that technical specification operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred. The inspectors compared the operability and design criteria in the appropriate sections of the technical specifications and Final Safety Analysis Report to the licensee's evaluations, to determine whether the components or systems were operable. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled. The inspectors determined, where appropriate, compliance with bounding limitations associated with the evaluations. Additionally, the inspectors reviewed a sampling of corrective action documents to verify that the licensee was identifying and correcting any deficiencies associated with operability evaluations. Specific documents reviewed during this inspection are listed in the attachment.

These activities constitute completion of six operability evaluation inspection samples as defined in Inspection Procedure 71111.15-05.

b. Findings

1. Failure to Initiate Condition Report for Emergency Core Cooling Pump Oil Leaks

Introduction. The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure to follow procedure and initiate a condition report for degradation of safety-related equipment. Specifically, the licensee failed to initiate a condition report for multiple small oil leaks on emergency core cooling system pumps and motors. As a result, the licensee failed to characterize the operability of the equipment and identify potential corrective actions.

Description. The inspectors performed a walkdown of the safety injection pumps and motors. The inspectors identified that the equipment had evidence of small oil leaks. The inspectors determined that the licensee had not documented the oil leakage from all four safety injection pumps in condition reports. Subsequently, the licensee documented the oil leaks in the corrective action program and determined that the components would have adequate oil for their mission time and were always operable.

The inspectors also performed a walkdown of centrifugal charging pump 2-01 because the inspectors had reviewed condition reports that documented low oil levels in the inboard motor bearing. However, the inspectors noted that each condition report indicated there was no oil leakage. The inspectors determined a small measurable oil leak existed because oil additions were necessary to maintain the appropriate level in the bearing. The inspectors concluded that the licensee had failed to document the leak in a condition report. The licensee addressed the issue in a condition report and determined that the motor would have adequate oil for its mission time and was always operable.

The inspectors determined, through interviews, that the licensee was aware of the oil residue on the equipment, but considered the leaks insignificant.

Analysis. The licensee's failure to follow procedure and initiate a condition report for emergency core cooling system pump and motor oil leaks was a performance deficiency and resulted in the failure to characterize the operability of the equipment and the failure to initiate appropriate corrective actions. The finding was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, in that, the leaks could worsen before establishing corrective actions and cause inoperable safety-related equipment. Using NRC Manual Chapter 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance in the mitigating systems cornerstone because the equipment was able to perform its safety function and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding has a problem identification and resolution cross-cutting aspect associated with the corrective action program because the licensee did not use a low threshold for identifying issues [P.1a].

Enforcement. Title 10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions. Procedure STA-421, "Initiation of Condition Reports," Revision 18, Attachment 8.A, required, in part, that equipment malfunction, damage, or degradation, other than anticipated wear be documented in a condition report. Contrary to the above, as of February 26, 2012, the licensee had not documented equipment degradation other than anticipated wear in a condition report. Specifically, the centrifugal charging pump 2-01 motor oil leak and the safety injection pump oil leaks had not been documented on a condition report. Since the violation was of very low safety significance and was documented in the licensee's corrective action program as Condition Report CR-2012-003390, it is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy: NCV 05000445/2012002-01; 05000446/2012002-01, "Failure to Initiate Condition Report for Emergency Core Cooling System Pump Leaks."

## 2. Inadequate Past Operability Determination for Degraded Pressurizer Power Operated Relief Block Valve

Introduction. The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure to follow procedure and perform an adequate operability evaluation to determine if a condition would have made a system inoperable in the past. Specifically, the licensee failed to determine that the degraded thrust in the closing direction of a pressurizer power operated relief block valve would have made the valve inoperable in the past. The licensee failed to fully understand the technical specification safety function of the valve. As a result of the inadequate past operability evaluation, the licensee incorrectly classified the significance of the condition report.

Description. During Unit 2 Refueling Outage 12, the licensee performed inservice testing on valve 2-8000A, a pressurizer power operated relief block valve, and determined that it failed to generate the required thrust in the closing direction. The licensee documented the failure in Condition Report CR-2011-004136 and corrected the condition. The licensee performed an evaluation that determined the valve would have been capable of performing its design basis safety function for a steam generator tube rupture as described in the accident analysis. Therefore, the licensee concluded the

valve was always operable. The inspectors agreed with licensee's assessment that the valve was capable of meeting its accident analysis function.

The inspectors challenged the licensee's determination that the valve met all of its technical specification required safety functions. Specifically, the inspectors determined that one of the safety functions of the block valve included isolation of a stuck open power operated relief valve with the reactor coolant system at high pressure following a transient. The inspectors noted that Technical Specification 3.4.11, "Pressurizer Power Operated Relief Valves (PORVs)," Action C, "One block valve inoperable," required that the associated power operated relief valve be placed in manual. This action would prevent the relief valve from opening for an overpressure event and avoid the potential for a stuck open relief valve at a time that the block valve is inoperable. The inspectors concluded that the block valve was not capable of isolating a stuck-open power operated relief valve with the reactor coolant system at high pressure following a transient due to its degraded closing thrust and was therefore past inoperable.

The inspectors determined through document review and interviews that the licensee had applied information from the current licensing basis that supported its position on the safety function of the block valve instead of using conservative decision making.

The inspectors reviewed the technical aspects and safety significance of the failure of the block valve to develop the required thrust in the close direction. The inspectors documented this licensee-identified violation for "Inadequate Lubrication of a Pressurizer Power Operated Relief Block Valve" in Section 4OA7 of this report.

Analysis. The failure to follow procedure and perform an adequate past operability evaluation of a degraded pressurizer power operated relief block was a performance deficiency which resulted in the licensee misclassifying the significance of the condition report. The finding was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, in that, the licensee could fail to correct a condition commensurate with its safety significance. Using NRC Manual Chapter 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety significance in the mitigating systems cornerstone because it did not result in the equipment being unable to perform its safety function and the finding did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event, and the technical issue screened as Green as documented in report Section 4OA7. The finding has a human performance cross-cutting aspect associated with decision making because the licensee did not use conservative assumptions in decision making [H.1b].

Enforcement. Title 10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions. Procedure STA-422, "Processing Condition Reports," Revision 27, Attachment 8.D, "Operability Determination for Condition Reports (QTE Completion)," states, in part, that past operability evaluations should determine if the condition would have made the system inoperable in the past. Contrary to the above, from April 7, 2011, to February 21, 2012, the licensee failed to determine if a condition would have made a system inoperable in the past. Specifically, the licensee failed to determine that the degraded thrust of a pressurizer power operated relief block valve would have made the

valve inoperable in the past. Since the violation was of very low safety significance and was documented in the licensee's corrective action program as Condition Report CR-2011-010056, it is being treated as a non-cited violation, consistent with Section 2.3.2 of the NRC Enforcement Policy: NCV 05000446/2012002-02, "Inadequate Past Operability Determination for Degraded Pressurizer Power Operated Relief Block Valve."

### 3. Inadequate Past Operability Determination for the Diesel Generators

Introduction. The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure to follow procedure and perform an adequate past operability evaluation to determine if a condition would have made a system inoperable in the past. Specifically, the licensee failed to determine that when a diesel generator was paralleled to the grid with a high bus voltage condition, the diesel generator was inoperable. As a result of the inadequate past operability evaluation, the licensee incorrectly classified the significance of the condition report.

Description. On April 12, 2011, the licensee tested diesel generator 2-02 with a high bus voltage due to grid conditions. The K300 relay, operating as designed, sensed the high bus voltage and incorrectly assessed the condition as an automatic voltage regulator failure. As part of the testing, the licensee opened the normal bus feeder breaker to the 6.9 kV bus. When the feeder breaker was opened and with the diesel generator no longer paralleled to the grid, the K300 relay signal was no longer blocked. Therefore, the diesel generator tripped and the automatic voltage regulator transitioned to the magnetics mode of operation.

The licensee documented the event in a condition report and performed a past operability determination of the diesel generators. The licensee concluded that the diesel generators were always operable in the past. The inspectors reviewed the past operability evaluation and determined that the diesel generators were not operable when paralleled to the grid with a high bus voltage condition that caused the K300 relay to actuate. With the K300 relay actuated and opening of the offsite power feeder breaker, the diesel generator would trip and, if required, restart in an emergency mode. However, the automatic voltage regulator function would not be available and the voltage control would function in a magnetics mode of operation. The diesel generator would develop appropriate bus voltage and accept accident loads, but operators would not be able to adjust voltage and would not be able to parallel the diesel to offsite power. Without the ability to parallel the diesel generator to offsite power, the diesel generator is inoperable.

The inspectors determined through interviews that the licensee failed to use error prevention techniques, such as pre-job briefings, that were commensurate with the risk of the assigned task and support human performance error prevention when performing the past operability determination.

Analysis. The failure to follow procedure and perform an adequate past operability evaluation of the diesel generators was a performance deficiency which resulted in the licensee incorrectly classifying the significance of the condition report. The finding was more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern, in that, the licensee could fail to correct a condition commensurate with its safety significance. Using NRC Manual Chapter 0609, "Significance Determination Process," Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings," the finding was determined to be of very low safety

significance in the mitigating systems cornerstone because it did not result in the equipment being unable to perform its safety function for greater than its technical specification allowed outage time and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding has a human performance cross-cutting aspect associated with work practices because the licensee failed to use error prevention techniques, such as pre-job briefings, that were commensurate with the risk of the assigned task and support human performance error prevention [H.4a].

Enforcement. Title 10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions. Procedure STA-422, "Processing Condition Reports," Revision 27, Attachment 8.D, "Operability Determination for Condition Reports (QTE Completion)" states, in part, that past operability evaluations should determine if the condition would have made the system inoperable in the past. Contrary to the above, from April 12, 2011 to March 13, 2012, the licensee failed to determine if a condition would have made a system inoperable in the past. Specifically, the licensee failed to determine that when a diesel generator was paralleled to the grid with a high bus voltage, the diesel generator was inoperable in the past. Since the violation was of very low safety significance and was documented in the licensee's corrective action program as Condition Report CR-2011-006113, it is being treated as a non-cited violation, consistent with Section 2.3.2 of the NRC Enforcement Policy: NCV 05000445/2012002-03; 05000446/2012002-03, "Inadequate Past Operability Determination for the Diesel Generators."

## **1R18 Plant Modifications (71111.18)**

### **a. Inspection Scope**

The inspectors reviewed the permanent plant modification associated with the new storage facility for chemicals stored near the service water intake structure. The inspectors reviewed Condition Report CR-2010-009180 and the associated safety evaluation screenings against the system design bases documentation, including the Final Safety Analysis Report and the technical specifications, and verified that the modifications did not adversely affect control room habitability. The inspectors also verified that the installation and restoration were consistent with the modification documents and that configuration control was adequate. Additionally, the inspectors verified that the modifications were identified on control room drawings, appropriate tags were placed on the affected equipment, and licensee personnel evaluated the combined effects on mitigating systems.

These activities constitute completion of one permanent plant modification inspection sample as defined in Inspection Procedure 71111.18-05.

### **b. Findings**

No findings were identified.

## **1R19 Postmaintenance Testing (71111.19)**

### a. Inspection Scope

The inspectors reviewed the following postmaintenance activities to verify that procedures and test activities were adequate to ensure system operability and functional capability:

- January 12, 2012, Unit 1 turbine driven auxiliary feedwater pump flow control valve strokes and accumulator pressure drop testing following planned valve operator diaphragm replacement
- January 24, 2012, Unit 2 safety injection pump 2-01 suction valve stroke following major inspection
- February 9, 2012, Unit 1 centrifugal charging pump 1-02 run following oil change and oil cooler cleaning
- February 23, 2012, Unit 1 residual heat removal pump 1-01 testing following motor and pump oil change and pump discharge flow calibration
- March 7, 2012, Unit 1 containment spray pump 1-04 testing following repairs to the pump casing drain line

The inspectors selected these activities based upon the structure, system, or component's ability to affect risk. The inspectors evaluated the activities to ensure the testing was adequate for the maintenance performed, the acceptance criteria were clear, and the test ensured equipment operational readiness.

The inspectors evaluated the activities against technical specifications, the Final Safety Analysis Report, 10 CFR Part 50 requirements, licensee procedures, and various NRC generic communications to ensure that the test results adequately ensured that the equipment met the licensing basis and design requirements. In addition, the inspectors reviewed corrective action documents associated with postmaintenance tests to determine whether the licensee was identifying problems and entering them into the corrective action program and that the problems were being corrected commensurate with their importance to safety. Specific documents reviewed during this inspection are listed in the attachment.

These activities constitute completion of five postmaintenance testing inspection samples as defined in Inspection Procedure 71111.19-05.

### b. Findings

No findings were identified.

## **1R22 Surveillance Testing (71111.22)**

### a. Inspection Scope

The inspectors reviewed the Final Safety Analysis Report, procedure requirements, technical specifications, and corrective action documents to ensure that the surveillance

activities listed below demonstrated that the systems, structures, and components tested were capable of performing their intended safety functions:

Pump or Valve Inservice Test

- February 23, 2012, Unit 2 turbine driven auxiliary feedwater pump test in accordance with Procedure OPT-206B, "AFW System," Revision 20

Routine Surveillance Testing

- February 7, 2012, X-06 fire pump test in accordance with Procedure OPT-220, "Fire Suppression Water System Operability Test," Revision 11
- February 22, 2012, Unit 1 diesel generator 1-02 fast start test in accordance with Procedure OPT-214A, "Diesel Generator Operability Test," Revision 21
- March 21, 2012, seismic monitoring system test in accordance with Procedure INC-7694A, "Functional Test, Channel Operation test and Channel Calibration Seismic Monitoring System," Revision 3
- March 23, 2012, squaw creek reservoir outlet gate strokes in accordance with Procedure SOP-902, "Squaw Creek Reservoir Return and Service Outlet System," Revision 10

The inspectors either witnessed or reviewed test data to verify that the significant surveillance test attributes were adequate to address the following:

- Preconditioning
- Evaluation of testing impact on the plant
- Acceptance criteria
- Test equipment
- Procedures
- Jumper and lifted lead controls
- Test data
- Testing frequency and method demonstrated technical specification operability
- Test equipment removal
- Restoration of plant systems
- Fulfillment of ASME code requirements
- Updating of performance indicator data
- Reference setting data
- Annunciators and alarms setpoints

Specific documents reviewed during this inspection are listed in the attachment.

These activities constitute completion of five surveillance testing inspection samples (one pump or valve inservice test sample, and four routine surveillance testing samples) as defined in Inspection Procedure 71111.22-05.

b. Findings

No findings were identified.

## **1EP6 Drill Evaluation (71114.06)**

### a. Inspection Scope

On February 28, 2012, the inspectors evaluated the conduct of licensee emergency drills to identify any weaknesses and deficiencies in classification, notification, and protective action recommendation development activities. The inspectors observed emergency response operations in the simulator and the emergency operations facility to determine whether the event classification, notifications, and protective action recommendations were performed in accordance with procedures. The inspectors also compared any inspector-observed weakness with those identified by the licensee staff in order to evaluate the critique and to verify whether the licensee staff was properly identifying weaknesses and entering them into the corrective action program.

These activities constituted completion of one drill/training evolution sample as defined in Inspection Procedure 71114.06-05.

### b. Findings

No findings were identified.

## **4. OTHER ACTIVITIES**

### **4OA1 Performance Indicator Verification (71151)**

#### **.1 Data Submission Issue**

##### a. Inspection Scope

The inspectors performed a review of the data submitted by the licensee for the fourth quarter 2011 performance indicators for any obvious inconsistencies prior to its public release in accordance with NRC Inspection Manual Chapter 0608, "Performance Indicator Program."

This review was performed as part of the inspectors' normal plant status activities and, as such, did not constitute a separate inspection sample.

##### b. Findings

No findings were identified.

#### **.2 Unplanned Scrams per 7000 Critical Hours (IE01)**

##### a. Inspection Scope

The inspectors sampled licensee submittals for the unplanned scrams per 7000 critical hours performance indicator for Units 1 and 2 for the period from January through December 2011. To determine the accuracy of the performance indicator data reported during those periods, performance indicator definitions and guidance contained in Nuclear Energy Institute Document 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 6, was used. The inspectors reviewed the licensee's operator narrative logs, event reports and NRC integrated inspection reports to validate the accuracy of the submittals. The inspectors also reviewed the corrective action

database to determine if any problems had been identified with the performance indicator data collected or transmitted for this indicator and none were identified. Specific documents reviewed are described in the attachment to this report.

These activities constitute completion of two unplanned scrams per 7000 critical hours samples as defined in Inspection Procedure 71151.05.

b. Findings

No findings were identified.

.3 Unplanned Power Changes per 7000 Critical Hours (IE03)

a. Inspection Scope

The inspectors sampled licensee submittals for the unplanned power changes per 7000 critical hours performance indicator for Units 1 and 2 for the period from January through December 2011. To determine the accuracy of the performance indicator data reported during those periods, performance indicator definitions and guidance contained in Nuclear Energy Institute Document 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 6, was used. The inspectors reviewed the licensee's operator narrative logs, maintenance rule records, event reports and NRC integrated inspection reports to validate the accuracy of the submittals. The inspectors also reviewed the licensee's corrective action database to determine if any problems had been identified with the performance indicator data collected or transmitted for this indicator. Specific documents reviewed are described in the attachment to this report.

These activities constitute completion of two unplanned power changes per 7000 critical hours samples as defined in Inspection Procedure 71151.05.

b. Findings

No findings were identified.

.4 Unplanned Scrams with Complications (IE04)

a. Inspection Scope

The inspectors sampled licensee submittals for the unplanned scrams with complications performance indicator for Units 1 and 2 for the period from January through December 2011. To determine the accuracy of the performance indicator data reported during those periods, performance indicator definitions and guidance contained in Nuclear Energy Institute Document 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 6, was used. The inspectors reviewed the licensee's operator narrative logs, event reports and NRC integrated inspection reports to validate the accuracy of the submittals. The inspectors also reviewed the licensee's corrective action database to determine if any problems had been identified with the performance indicator data collected or transmitted for this indicator. Specific documents reviewed are described in the attachment to this report.

These activities constitute completion of two unplanned scrams with complications samples as defined in Inspection Procedure 71151.05.

b. Findings

No findings were identified.

**40A2 Identification and Resolution of Problems (71152)**

.1 Routine Review of Identification and Resolution of Problems

a. Inspection Scope

As part of the various baseline inspection procedures discussed in previous sections of this report, the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to verify that they were being entered into the licensee's corrective action program at an appropriate threshold, that adequate attention was being given to timely corrective actions, and that adverse trends were identified and addressed. The inspectors reviewed attributes that included: the complete and accurate identification of the problem; the timely correction, commensurate with the safety significance; the evaluation and disposition of performance issues, generic implications, common causes, contributing factors, root causes, extent of condition reviews, and previous occurrences reviews; and the classification, prioritization, focus, and timeliness of corrective actions. Minor issues entered into the licensee's corrective action program because of the inspectors' observations are included in the attached list of documents reviewed.

These routine reviews for the identification and resolution of problems did not constitute any additional inspection samples. Instead, by procedure, they were considered an integral part of the inspections performed during the quarter and documented in Section 1 of this report.

b. Findings

No findings were identified.

.2 Daily Corrective Action Program Reviews

a. Inspection Scope

In order to assist with the identification of repetitive equipment failures and specific human performance issues for follow-up, the inspectors performed a daily screening of items entered into the licensee's corrective action program. The inspectors accomplished this through review of the station's daily corrective action documents.

The inspectors performed these daily reviews as part of their daily plant status monitoring activities, so these reviews did not constitute any separate inspection samples.

b. Findings

No findings were identified.

**40A3 Event Followup (71153)**

The inspectors performed a review of licensee event reports and related documents to determine the accuracy of the licensee event reports, appropriateness of corrective actions, violations of requirements, and generic issues.

These activities constitute completion of two event followup samples as defined in Inspection Procedure 71153-05.

.1 (Closed) Licensee Event Report 05000445/2010-004-00, Component Cooling Water Train Inoperable Due to Inadequate Post Work Procedure

On July 4, 2010, the licensee identified during a surveillance test that the Unit 1 train B containment spray heat exchanger 1-02 component cooling water outlet valve was oscillating from 22 to 100 percent open. The licensee determined that the actuator rotor on the component cooling water outlet valve had been incorrectly set during the previous refueling outage on April 21, 2010. The licensee adjusted the incorrect actuator rotor and re-performed the surveillance test. The licensee initiated Condition Report CR-2010-006595 to address the issue. The licensee revised Procedure PPT-P1-6200, "CCW to RHR/CS HX Outlet Valve Flow Control Test," Revision 2, to ensure valve testing will properly verify the operability of the outlet valves. The enforcement aspects of this finding are discussed in Section 4OA7. This licensee event report is closed.

.2 (Closed) Licensee Event Report 05000445/2011-002-00, Unit 1 Containment Personnel Airlock Door Inoperable

On September 17, 2011, the licensee was unable to pressurize the Unit 1 containment personnel airlock inner door seal during testing. The licensee discovered a piece of tape that had inadvertently fallen across the sealing surface. The licensee initiated Condition Report CR-2011-010210 to document the condition. The licensee determined that the cause of the issue was insufficient controls in place to ensure the sealing surface remained free of debris while operating the door. The licensee removed the debris and revised the containment entry procedure to correct the condition. The enforcement aspects of this finding are discussed in Section 4OA7. This licensee event report is closed.

## **4OA6 Meetings**

### Exit Meeting Summary

On February 27, 2012, the inspectors conducted a telephonic exit meeting to present the results of the annual review of the licensed operator requalification program with Mr. A. Glass, Licensed Operator Requalification Supervisor. The licensee acknowledged the issues presented. The inspectors did not review any proprietary information during this inspection.

On April 3, 2012, the inspectors presented the resident inspection results to Mr. R. Flores, Senior Vice President and Chief Nuclear Officer, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors acknowledged review of proprietary material during the inspection. No proprietary information has been included in the report.

## 40A7 Licensee-Identified Violations

The following violations of very low safety significance (Green) or Severity Level IV were identified by the licensee and are violations of NRC requirements which meet the criteria of the NRC Enforcement Policy for being dispositioned as non-cited violations.

- .1 Title 10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality shall be prescribed by documented instructions of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions. Procedure PPT-P1-6200, "CCW to RHR/CS HX Outlet Valve Flow Control Test," Revision 2, provided instructions for testing the containment spray heat exchanger outlet valve. Contrary to the above, on April 22, 2010, the licensee performed a test of a containment spray heat exchanger outlet valve using an instruction of a type that was not appropriate to the circumstances. Specifically, Procedure PPT-P1-6200 did not provide adequate instructions for testing the containment spray heat exchanger outlet valve. As a result, the licensee failed to identify an incorrectly adjusted valve. The licensee documented the issue in Condition Report CR-2010-006595. The non-cited violation was determined to be of very low safety significance because it did not represent an actual loss of safety function of a single train of safety equipment. This non-cited violation addresses the enforcement aspect of the licensee event report documented in Section 40A3.1.
- .2 Technical Specification 5.4.1.a requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A. Regulatory Guide 1.33, Revision 2, Appendix A, Item 1.i, requires, in part, procedures for access to containment. Contrary to the above, as of September 17, 2011, the licensee failed to establish an adequate procedure to access containment. Specifically, STA-620, "Containment Entry," Revision 12, failed to include requirements to verify that the containment airlock sealing surfaces were free of debris when operating the door. The licensee documented the issue in Condition Report CR-2011-010210. This condition was not an actual open pathway in the containment barrier and determined to be of very low safety significance. This non-cited violation addresses the enforcement aspect of the licensee event report documented in Section 40A3.2.
- .3 Technical Specification 5.4.1.a requires, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A. Regulatory Guide 1.33, Revision 2, Appendix A, Item 9.a, requires, in part, that maintenance that can affect the performance of safety-related equipment should be performed in accordance with written procedures appropriate to the circumstances. Contrary to the above, as of April 1, 2011, the licensee failed to perform maintenance on safety-related equipment in accordance with written procedures appropriate to the circumstances. Specifically, the licensee failed to properly lubricate valve 2-8000A because procedure MSE-P0-8349, "Limitorque Actuator Periodic Electrical and Mechanical Inspection," Revision 9, failed to require lubrication of the portion of the stem in contact with the operator. The licensee documented the condition in Condition Report CR-2011-004136. The non-cited

violation was determined to be of very low safety significance by performing a Phase 3 evaluation in accordance with NRC Inspection Manual 0609 Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations."

## **SUPPLEMENTAL INFORMATION**

### **KEY POINTS OF CONTACT**

#### **Licensee Personnel**

R. Flores, Senior Vice President and Chief Nuclear Officer  
T. Gilder, Director, Performance Improvement  
D. Goodwin, Director, Engineering Support  
T. Hope, Manager, Nuclear Licensing  
B. Kidwell, Manager, Emergency Preparedness  
F. Madden, Director, Oversight and Regulatory Affairs  
M. Marler, Director, Organizational Effectiveness  
B. Mays, Vice President, Engineering and Support  
K. Nickerson, Director, Site Engineering  
B. Patrick, Director, Maintenance  
K. Peters, Site Vice President  
S. Sewell, Director, Operations  
S. Smith, Plant Manager  
K. Tate, Manager, Security  
D. Wilder, Director, Plant Support

### **LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED**

#### **Opened and Closed**

05000445/2012002-01	NCV	Failure to Initiate Condition Report for Emergency Core Cooling System Pump Leaks (Section 1R15.1)
05000446/2012002-01		
05000446/2012002-02	NCV	Inadequate Past Operability Determination for Degraded Pressurizer Power Operated Relief Block Valve (Section 1R15.2)
05000445/2012002-03	NCV	Inadequate Past Operability Determination for the Diesel Generators (Section 1R15.3)
05000446/2012002-03		

#### **Closed**

05000445/2010-004-00	LER	Component Cooling Water Train Inoperable Due to Inadequate Post Work Procedure (Section 4OA3.1)
05000445/2011-002-00	LER	Unit 1 Containment Personnel Airlock Door Inoperable (Section 4OA3.2)

## LIST OF DOCUMENTS REVIEWED

### Section 1R04: Equipment Alignments

#### CONDITION REPORTS

2012-000385                      2012-000387

#### PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
OPT-206B	AFW System	28

### Section 1R05: Fire Protection

#### PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
FPI-301A	Unit 1 and 2 Turbine Building Elevation 778'-0"	4
FPI-102B	Unit 2 Safeguards Building Elevation 790'-0"	2
FPI-107A	Unit 1 Safeguards Building, Elevation 852'-6"	4

### Section 1R11: Licensed Operator Requalification Program

#### MISCELLANEOUS DOCUMENTS

<u>TITLE</u>	<u>REVISION</u>
LO47.E11.CLS, Cycle 11-5 Evaluated Scenario	01/10/2012
OTDI-07, Requalification Simulator Exercise Conduct	09/23/2008
Operating Test Results	01/03/2012

### Section 1R12: Maintenance Effectiveness

#### CONDITION REPORTS

2011-007833                      2011-008375

### Section 1R15: Operability Evaluations

#### CONDITION REPORTS

2011-010612	2012-000298	2012-002191	2011-013202
2011-001731	2010-006590	2012-001903	2012-002085
2011-010056	2011-004169	2011-007636	2012-002404
2005-000021			

PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
RWS-201	Gaseous Waste Processing System	19
WCI-607	Fluid Leak Management Program	3
MSE-P0-8349	Limatorque Actuator Periodic Electrical and Mechanical Inspection	9

**Section 1R19: Postmaintenance Testing**

WORK ORDERS

4287812	4349152	4299999	4036107
4036991	4035962		

PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
OPT-603A	TDAFW Accumulator Check Valve Leak Test	6
OPT-201A	Charging System	14
INC-2027	Calibration of ITT Barton Differential Pressure Indicating Switches	6
MSM-G0-0101	Lubricant Sampling	3
MSE-P0-4312	RHR Pump Motor Inspection	6

**Section 1R22: Surveillance Testing**

CONDITION REPORTS

2012-002280	2012-003034	2011-002749
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WORK ORDERS

3793772

PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
FIR-PX-3803	Diesel Driven Fire Protection Pump CPX-FPAPFP-06 Operability Test	3

**Section 4OA3: Event Followup**

PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
PPT-S0-6004	Motor Operated Rising Stem Valve Risk-Informed IST Testing	5

PROCEDURES

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
PPT-S0-6004	Motor Operated Quarter Turn Valve Risk-Informed IST Testing	1
OPT-476A	Train B Safeguards Slave Relay K644 Actuation Test	4

MISCELLANEOUS DOCUMENTS

<u>NUMBER</u>	<u>TITLE</u>	<u>REVISION</u>
DBD-ME-304	Control Room Air Conditioning System	20
DBD-ME-229	Component Cooling Water System	36