



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
612 EAST LAMAR BLVD, SUITE 400
ARLINGTON, TEXAS 76011-4125

November 5, 2008

Mike Blevins, Executive Vice President
and Chief Nuclear Officer
Luminant Generation Company, LLC
ATTN: Regulatory Affairs
Comanche Peak Steam Electric Station
P.O. Box 1002
Glen Rose, TX 76043

SUBJECT: COMANCHE PEAK STEAM ELECTRIC STATION - NRC INTEGRATED
INSPECTION REPORT 05000445/2008004 AND 05000446/2008004

Dear Mr. Blevins:

On September 21, 2008, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Comanche Peak Steam Electric Station, Units 1 and 2, facility. The enclosed integrated inspection report documents the inspection findings which were discussed on September 17, 2008, with Mr. D. Kross, Plant Manager, 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.

Based on the results of this inspection, four findings of very low significance were identified. All of these findings involved violations of NRC requirements; three of the findings were NRC identified and one was self-revealing. However, because of the very low safety significance, and because they are entered into your corrective action program, the NRC is treating these findings as noncited violations in accordance with Section VI.A.1 of the NRC Enforcement Policy.

If you contest the noncited violations in this report, 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, DC 20555-0001, with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission - Region IV, 612 East Lamar Blvd, Suite 400, Arlington, TX 76011-4125; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Comanche Peak Steam Electric Station.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and its enclosure, 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/

Claude E. Johnson, Chief
Project Branch A
Division of Reactor Projects

Dockets: 50-445; 50-446
Licenses: NPF-87; NPF-89

Enclosure:
NRC Inspection Report 05000445/2008004 and 05000446/2008004
w/Attachment: Supplemental Information

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SRI:DRP/A-CP	RI:DRP/A-CP	C:DRS/EB1	C:DRS/EB2
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RELantz	MPShannon	GWerner	CEJohnson
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U. S. NUCLEAR REGULATORY COMMISSION
REGION IV

Dockets: 50-445, 50-446

Licenses: NPF-87, NPF-89

Report : 05000445/2008004 and 05000446/2008004

Licensee: Luminant Generation Company LLC

Facility: Comanche Peak Steam Electric Station, Units 1 and 2

Location: FM-56, Glen Rose, Texas

Dates: June 23 through September 21, 2008

Inspectors: J. Kramer, Senior Resident Inspector
B. Tindell, Resident Inspector
G. Tutak, Reactor Inspector, Engineering Branch 2
P. Elkmann, Senior Emergency Preparedness Inspector, PS Branch 1
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Accompanied by:
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Approved by: C. Johnson, Chief, Project Branch A
Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000445/2008004, 05000446/2008004; 06/23/2008-09/21/2008; Comanche Peak Steam Electric Station, Units 1 and 2: Integrated Resident and Regional Report; Fire Protection, Operability Evaluations, Plant Modifications, and Other Activities.

This report covers a 3-month period of inspection by resident inspectors and announced baseline inspections by regional based inspectors. Four Green noncited 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 and Self-Revealing Findings

Cornerstone: Initiating Events

- Green. The inspectors identified a noncited violation of Technical Specification 5.4.1.d for the licensee's failure to obtain an approved transient combustible permit before introducing transient combustibles into plant areas. As a result, the licensee placed undocumented and unanalyzed transient combustibles in the plant without compensatory measures on five different occasions. The licensee entered the finding into their corrective action program for resolution.

This finding was more than minor because it affected the protection against external factors attribute of the initiating events cornerstone, and it directly affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using NRC Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the condition represented a low degradation of fire prevention and administrative controls and the amount of combustibles was within the combustible loading calculations. The cause of the finding was related to the Human Performance crosscutting component of Work Practices, in that, the licensee failed to effectively communicate expectations, and that personnel failed to follow procedures [H4.b] (Section 1R05).

Cornerstone: Mitigating Systems

- Green. A self-revealing noncited violation of Technical Specification 5.4.1.a was reviewed for the failure of the licensee to follow the procedure for testing the emergency diesel generator. As a result, a cylinder indicator cock was left open and cylinder performance was affected. The licensee entered the finding into their corrective action program for resolution.

The finding was more than minor because it was associated with the availability/reliability of equipment performance attribute of the mitigating systems cornerstone, and it directly affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Characterization and Screening of Findings," the finding screened as having very low safety significance because it resulted in a minimal degradation of a diesel generator cylinder. The cause of this finding was related to the Human Performance crosscutting component of resources, in that, the licensee failed to provide adequate equipment to close the indicator cock [H2.d] (Section 1R15).

- Green. The inspectors identified a noncited violation of License Condition 2.G because the licensee failed to ensure that two fire-rated roll-up doors complied with the mounting requirements in National Fire Protection Association (NFPA) 80-1977. Specifically, during original construction, the licensee used bolts with a diameter less than the required 3/8-inch. The licensee entered this finding into their corrective action program for resolution as Smartform SMF-2008-001637.

Failure to meet the mounting requirements of NFPA 80-1977 for fire-rated roll-up doors is a performance deficiency. The inspectors determined this deficiency was more than minor because it was similar to the more than minor description in Manual Chapter 0612, Appendix E, Example 3.g. This finding affected the mitigating systems cornerstone. This fire confinement finding was assigned a Moderate A degradation rating because the fire-rated roll-up door had improperly installed fire door hardware. Using NRC Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1, Step 1.3.2, Question 5, the exposed fire area contained no potential damage targets closer than 20 feet (i.e., passive barrier) to the exposing fire area that would result in a demand for safe shutdown and the fire barrier would remain functional for at least 20 minutes. Therefore, the degraded fire-rated roll-up doors had very low risk significance (Section 4OA5).

Cornerstone: Barrier Integrity

- Green. The inspectors identified a noncited violation of Technical Specification 5.4.1.a for the licensee's failure to control a fire hose that was used to redirect the discharge of a vent chill water relief valve, which is also a containment isolation valve. As a result, a hose was left on the discharge piping at various times for approximately 10 years without documentation or evaluation. The hose affected the relief valve, in that, operators could not directly observe leakage from the valve. In addition, the hose created a backpressure on the valve that increased its lift setpoint, therefore, potentially affecting the containment penetration integrity. The licensee entered the finding into their corrective action program for resolution.

This finding was greater than minor because it was similar to NRC Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues," Example 4.a, and met the "not minor if" criteria because the licensee routinely failed to perform evaluations on this issue, and the inspectors determined that the safety-related equipment was adversely affected. Using NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Characterization and Screening of Findings," the inspectors determined that the issue was of very low safety significance because the finding did not result in an actual open pathway of the reactor containment. The cause of this finding was related to the Human Performance crosscutting component of Work Practices, in that, the licensee failed to define and effectively communicate expectations regarding procedural compliance and personnel failed to follow procedures [H4.b] (Section 1R18).

B. Licensee-Identified Violations

None.

REPORT DETAILS

Summary of Plant Status

Comanche Peak Steam Electric Station Unit 1 began the reporting period at 100 percent power. On September 18, 2008, the unit initiated a coastdown to Refueling Outage 1RF13 and ended the inspection period at approximately 96 percent power.

Comanche Peak Steam Electric Station Unit 2 began the reporting period at 100 percent power and operated at essentially 100 percent power for the entire reporting period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R01 Adverse Weather Protection (71111.01)

Readiness For Impending Adverse Weather Condition – Hurricane Ike

a. Inspection Scope

On September 12, 2008, the inspectors reviewed the licensee's overall preparations for expected weather conditions since high winds and heavy rains from Hurricane Ike were forecast in the vicinity of the facility the following day. The inspectors performed a walk down of the licensee's emergency diesel generators, because their safety-related functions could be affected or required as a result of high winds or wind-generated missiles or the loss of offsite power. The inspectors evaluated the licensee staff's preparations against the site's procedures and determined that the staff's actions were adequate. During the inspection, the inspectors focused on plant specific design features and the licensee's procedures used to respond to specified adverse weather conditions. The inspectors also toured the plant grounds to look for any loose debris that could become missiles during a tornado. The inspectors evaluated operator staffing and accessibility of controls and indications for those systems required to control the plant. Additionally, the inspectors reviewed the Updated Final Safety Analysis Report (UFSAR) and performance requirements for systems selected for inspection and verified that operator actions were appropriate as specified by plant specific procedures.

The inspectors completed one sample.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment (71111.04)

Quarterly Partial System Walkdowns

a. Inspection Scope

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

- Unit 1 Train B residual heat removal heat exchanger inspection for boric acid degradation, in accordance with Work Order 405118 on August 26, 2008.
- Unit 1 Train A diesel generator in accordance with Procedure SOP-609A, "Diesel Generator System," Revision 17, while the Unit 1 Train B diesel generator was inoperable on August 27, 2008

The inspectors selected these systems based on their risk significance relative to the reactor safety cornerstones at the time they were inspected. The inspectors attempted to identify any discrepancies that could impact the function of the system and, therefore, potentially increase risk. The inspectors reviewed applicable operating procedures, system diagrams, UFSAR, Technical Specification requirements, outstanding work orders, Smart Forms, 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.

The inspectors completed two samples.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

.1 Quarterly Fire Inspection Tours (71111.05Q)

a. Inspection Scope

The inspectors conducted fire protection walkdowns which were focused on availability, accessibility, and the condition of firefighting equipment in the following risk-significant plant areas:

- Fire Zone SD-009 – Unit 1 Train A Switchgear Room 83 on June 24, 2008
- Fire Zone 2SB-008 – Unit 2 Safeguards Building 810' Corridor on June 26, 2008

- Safety Related Structures for Transient Combustibles on August 1, 2008
- Fire Zone 60 – Unit 2 Cable Spreading Room on August 15, 2008

The inspectors reviewed areas to assess if the licensee 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 with later additional insights, their potential to impact equipment which could initiate or mitigate a plant transient, or their impact on the plant's ability to respond to a security event. Using the documents listed in the attachment, 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. The inspectors also verified that minor issues identified during the inspection were entered into the licensee's corrective action program. Documents reviewed are listed in the attachment.

The inspectors completed four samples.

b. Findings

Introduction: The inspectors identified a Green noncited violation for the licensee's repeated failure to obtain an approved transient combustible permit before introducing transient combustibles into plant areas. On five occasions, inspectors observed transient combustibles in the plant without a permit.

Description: In order to meet the Comanche Peak Fire Protection Program goal of preventing fires from starting, the licensee has administrative controls to minimize the amount of combustibles placed in safety-related areas. These controls require site personnel to obtain an approved permit before introducing combustibles into the plant. The permit serves to track and analyze the combustibles, ensure they have a limited stay, and ensure that compensatory measures are in place.

Between June 26 and August 11, 2008, inspectors identified five occasions where transient combustibles were left unattended without a transient combustible permit. The five examples identified were:

- Wood pallets in the 810' Safeguards Building hallway (SMF-2009-002180-00)
- Plastic sheets on top of the Unit 2 Train B batteries (SMF-2008-002276-00)
- Empty resin barrels and wood pallets in the 810' Safeguards Building hallway (SMF-2008-02501-00)
- Hoses and other material in Auxiliary Building 790' Room X-166 (SMF-2008-002673-00)

- Ropes, harnesses, and other material in the service water intake structure (SMF-2008-002673-00)

The inspectors concluded that the licensee failed to obtain transient combustible permits. Typically, when the licensee issues a transient combustible permit, the compensatory measure is for a firewatch to tour the area on a schedule looking for signs of fire. The first four examples occurred in areas where an individual on a fire watch tour passed through the area for different reasons. However, the combustibles in the service water intake structure were not on the route of a fire watch tour, leaving them without compensatory measures.

On August 21, 2008, the licensee documented the adverse trend in the area of combustible loading in Smart Form SMF-2008-002698. The licensee performed a cause analysis and determined that a lack of recent training and converting to a new system for preparing transient combustible permits without training was the cause. However, the inspectors performed interviews of licensee personnel and determined that they had sufficient knowledge of the control and documentation requirements for transient combustibles. Therefore, the inspectors concluded that the cause of the violation was the failure of personnel to follow the procedural requirements of the transient combustible program.

Analysis: The inspectors determined that the failure to obtain a transient combustible permit is a performance deficiency which resulted in combustibles being placed in the plant that were undocumented, unanalyzed, and potentially without compensatory measures. The finding was determined to be more than minor because it affected the protection against external factors attribute of the initiating events cornerstone, and it directly affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using NRC Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance (Green) because the condition represented a low degradation of fire prevention and administrative controls and the amount of combustibles was within the combustible loading calculations.

The cause of the finding was related to the Human Performance crosscutting component of Work Practices, in that, the licensee failed to effectively communicate expectations, and that personnel failed to follow procedures [H4.b].

Enforcement: Technical Specification 5.4.1.d requires, in part, that written procedures shall be established, implemented, and maintained covering Fire Protection Program implementation. Procedure STA-729, "Control of Transient Combustibles, Ignition Sources, and Fire Watches," Revision 7, implements the requirements of the Fire Protection Program. Procedure STA-729, step 6.2.2 requires, in part, that for transient combustibles being introduced into plant areas, a transient combustible permit shall be submitted to the fire protection supervisor for review and approval prior to the introduction of the materials. Contrary to the above, on five occasions between June and August 2008, the licensee introduced transient combustibles into plant areas and failed to obtain a reviewed and approved transient combustible permit by the fire protection supervisor prior to the introduction of the materials. Since the violation was of very low safety significance and was documented in the licensee's corrective action

program as Smart Form SMF-2008-002698, it is being treated as a noncited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000445/2008004-01; 05000446/2008004-01), Failure to Control Transient Combustibles.

.2 Annual Fire Protection Drill Observation (71111.05A)

a. Inspection Scope

On June 12 and June 26, 2008, the inspectors observed portions of two fire brigade drills to evaluate the readiness of licensee personnel to prevent and fight fires, including the following aspects: (1) the number of personnel assigned to the fire brigade; (2) use of protective clothing; (3) use of breathing apparatuses; (4) brigade leader command and control; (5) implementation of prefire strategies and briefs; (6) access routes to the fire and timeliness of the fire brigade response; (7) communications between the fire brigade and control room; (8) effectiveness of radio communications; (9) placement and use of fire hoses; (10) entry into the fire area; (11) use of firefighting equipment; (12) use of fire preplans; (13) adherence to the drill scenario; (14) the drill critique, and (15) restoration from the fire drill. The licensee simulated a fire inside the Unit 1 Train A emergency diesel generator room.

The inspectors completed one sample.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Regualification Program

Resident Inspector Quarterly Review (71111.11Q)

a. Inspection Scope

On August 11, 2008, the inspectors observed two crews of licensed operators in the plant's simulator during licensed operator regualification examinations to verify that operator performance was adequate, evaluators were identifying and documenting crew performance problems, and training was being conducted in accordance with licensee procedures. The inspectors evaluated the following areas:

- Licensed operator performance
- Crew's clarity and formality of communications
- Crew's ability to take timely actions in the conservative direction
- Crew's prioritization, interpretation, and verification of annunciator alarms
- Crew's correct use and implementation of abnormal and emergency procedures
- Control board manipulations

- Oversight and direction from supervisors
- Crew's ability to identify and implement appropriate Technical Specification actions and Emergency Plan actions and notifications

The inspectors compared crew's performance in these areas to pre-established operator action expectations and successful critical task completion requirements.

The inspectors completed one sample.

b. Findings

No findings of significance were identified.

1R12 Maintenance Effectiveness (71111.12)

a. Inspection Scope

The inspectors evaluated degraded performance issues involving the following risk-significant systems:

- Units 1 and 2 radiation monitors
- Units 1 and 2 emergency diesel generators

The inspectors reviewed events such as where ineffective equipment maintenance had resulted in valid or invalid automatic actuations of engineered safeguards systems 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) of the maintenance rule
- Characterizing system reliability issues for performance
- Charging unavailability for performance
- Trending key parameters for condition monitoring
- Ensuring proper 10 CFR 50.65(a)(1) or (a)(2) classification or reclassification
- Verifying appropriate performance criteria for structures, systems, and components and/or functions classified as (a)(2) or appropriate and adequate goals and corrective actions for systems classified as (a)(1)

The inspectors assessed performance issues with respect to the reliability, availability, and condition monitoring of the system. In addition, the inspectors verified maintenance effectiveness issues were entered into the corrective action program with the appropriate significance characterization. Documents reviewed are listed in the attachment.

The inspectors completed two samples.

b. Findings

No findings of significance 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:

- Unit 2 Train A diesel generator on July 13, 2008
- Unit 2 Turbine driven auxiliary feed water pump on July 17, 2008
- Unit 1 Train A component cooling water heat exchanger on September 3, 2008

These activities were selected based on their potential risk significance relative to the reactor safety cornerstones. As applicable for each activity, the inspectors verified that risk assessments were performed as required by 10 CFR 50.65(a)(4) and were accurate and complete. When emergent work was performed, the inspectors verified that the plant risk was promptly reassessed and managed. 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 Technical Specification requirements and walked down portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met.

The inspectors completed three samples.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed the following issues:

- SMF-2008-001609, Unit 2, Safety Injection Accumulator 2-04 out-leakage/possible safety injection system gas voiding

- SMF-2008-000688, Unit 2, Diesel Generator 2-01 fuel injector mounting stud broke during diesel run
- SMF-2008-002803, Unit 2, Containment sump abnormally high flow rates due to steam generator steam leak
- SMF-2008-001984, Unit 2, Diesel Generator 2-02 indicator cock

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 Specification and UFSAR 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. The inspectors also reviewed a sampling of corrective action documents to verify that the licensee was identifying and correcting any deficiencies associated with operability evaluations.

The inspectors completed four samples.

b. Findings

Introduction: A Green self-revealing noncited violation of Technical Specification 5.4.1.a was reviewed for the failure of the licensee to follow the procedure for testing the emergency diesel generator. As a result, the diesel generator was started with a cylinder indicator cock open, which affected cylinder performance.

Description: On June 10, 2008, the Unit 2 operators prepared to perform a 24-hour test of Diesel Generator 2-02 in accordance with OPT-214B, "Diesel Generator Operability Test." The operators performed Attachment 10.3, "Train B DG Engine Roll Water Check," prior to starting the diesel generator the licensee failed to reclose Indicator Cock 1L. Approximately 8 hours later, the engine was started and exhaust gases exited the open indicator cock. Operators shutdown the diesel generator, closed the indicator cock, and recommenced the testing.

The licensee performed an operability determination of the diesel generator. The evaluation referenced Technical Evaluation 91-2160 that generically stated that, "with a single indicator cock open, the diesel generator would still come up to rated speed and voltage in the required time and the loading capability of the engine would not be adversely affected." The inspectors agreed with the licensee's conclusion that the diesel generator would start and load in the appropriate time, but concluded that the cylinder's performance would be adversely affected.

The inspectors reviewed the licensee's basic cause evaluation for the event. The causal evaluation indicated that the nuclear equipment operators had difficulty using the limited torque socket wrench to close the indicator cocks. The socket portion of the tool prevented visual observation of the operating nut rise during indicator cock closure. The

licensee determined this was the likely cause of the indicator cock being left open after the engine water roll check. The inspectors agreed with the initial basic cause evaluation.

Analysis: The inspectors determined that the licensee's failure to ensure that all the indicator cocks were closed as required by Procedure OPT-214B was a performance deficiency. The finding was more than minor because it was associated with the availability/reliability of equipment performance attribute of the mitigating systems cornerstone, and it directly affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using the Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Characterization and Screening of Findings," the finding screened as having a very low safety significance (Green) because it resulted in a minimal degradation of a diesel generator cylinder.

The cause of this finding was related to the Human Performance crosscutting component of Resources, in that, the licensee failed to provide adequate equipment to close the indicator cock [H2.d].

Enforcement: 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, February 1978. Regulatory Guide 1.33 requires, in part, procedures for surveillance test including emergency power tests. Procedure OPT-214B, "Diesel Generator Operability Test," Revision 13, provides written instructions for testing the emergency diesel generators. Procedure OPT 214B, Attachment 10.3, provides instructions on the performance of the engine water roll check. Upon completion of the water roll, step AI of Attachment 10.3 directs, in part, to close the indicator cocks on all cylinders. Contrary to the above, on June 10, 2008, when performing the water roll of the Diesel Generator 2-02, operators failed to close all the indicator cocks on the engine and left Indicator Cock 1L open. Since the violation was of very low safety significance and was documented in the licensee's corrective action program as Smart Form 2008-001984, it is being treated as a noncited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000446/2008004-02), Failure to Follow Diesel Generator Test Procedure.

1R18 Plant Modifications (71111.18)

a. Inspection Scope

For the plant modification described below, the inspectors reviewed the UFSAR, Technical Specifications, implementing work orders, and associated drawings. The inspectors verified that the modification had the proper tagging and that the design bases, license bases, and performance capability had not been degraded through the modification. The inspectors identified this sample from a walkdown of the plant.

- Fire hose attached to discharge piping to redirect flow to a nonradioactive drain from relief Valve 2CH-0281, "containment chill water supply header relief valve," that is also a containment isolation valve

The inspectors completed one sample.

b. Findings

Introduction: The inspectors identified a Green noncited violation of Technical Specification 5.4.1a for failure to comply with the licensee's work control procedure which requires that all transient equipment be tracked. Specifically, a fire hose was attached to the discharge piping of a vent chill water relief valve, which is a containment isolation valve, in order to redirect the discharge to a nonradioactive drain; however, the hose was not tracked in MAXIMO, the licensee's computer program for tracking work.

Description: During a walkdown, the inspectors identified a fire hose being used to reroute the discharge of relief Valve 2CH-0281 for the vent chill water system. This relief valve, also a containment isolation valve, is designed to relieve pressure built up by thermal expansion in the containment penetration after the penetration isolation valves are closed. The licensee attached a fire hose to the end of the valve discharge piping and routed it from the radioactive drain to a nonradioactive drain so that vent chill water would not drain into the radioactive waste system when the valve lifted or leaked. However, the hose was opaque and routed such that potential leakage from the relief valve was not visible to the operators.

The inspectors informed the licensee about the installed hose. When the licensee removed the hose, several gallons of water discharged from the pipe. The presence of water indicated that the kinked hose was holding water inside of the discharge piping downstream of the relief valve. The licensee concluded that the water was residual water from a previous lift of the relief valve and that the valve was not leaking. The residual water in the relief valve discharge piping, held by a kinked hose, would adversely affect the relieving characteristics of the valve by creating additional backpressure against the valve. Therefore, the inspectors concluded that attaching a hose to the discharge piping of the valve could have adversely affected the containment penetration integrity. The licensee performed a test on a mock-up of the pipe and hose and determined that the valve would be able to perform its safety function under the created backpressure.

The inspectors noted that there are three similar containment isolation relief valves on the vent chill water system in both units for a total of four valves. The inspectors discovered, through interviews, that hoses had been periodically placed on the valves over the last 10 years. In 2006, the licensee removed the hoses from the discharge piping of relief Valve 2CH-0282 and discovered a similar condition with water in the discharge piping. The licensee indicated a hose was not installed on the discharge piping of relief Valve 2CH-0281 in 2006. However, the inspectors noted that a hose was attached to relief Valve 2CH-0281 discharge piping during this inspection indicating that a hose was attached sometime within the last 2 years.

Analysis: The inspectors determined the failure to comply with a work control procedure resulted in a condition where the containment penetration integrity could have been adversely affected, was a performance deficiency. This finding was greater than minor because it was similar to NRC Inspection Manual Chapter 0612, Appendix E, "Examples of Minor Issues," Example 4.a, and met the "not minor if" criteria because the licensee failed to perform evaluations on this finding and the inspectors determined that the safety-related equipment was adversely affected. Using NRC Inspection Manual Chapter 0609, Attachment 4, "Phase 1 - Initial Characterization and Screening of

Findings,” the inspectors determined that the finding was of very low safety significance because the deficiency did not result in an actual open pathway of the reactor containment penetration, and that the valve would have been able to perform its safety function.

The cause of this finding was related to the Human Performance crosscutting component of Work Practices, in that, the licensee failed to define and effectively communicate expectations regarding procedural compliance and personnel failed to follow procedures [H4.b].

Enforcement: Technical Specification 5.4.1.a requires, in part, that written procedures shall be established, implemented, and maintained covering the activities specified in Regulatory Guide 1.33, Appendix A. Regulatory Guide 1.33, Appendix A, Item 9.e., requires, in part, procedures for the control of maintenance, repair, replacement, and modification work. Procedure STA-606, “Control of Maintenance and Work Activities,” Revision 29, Step 6.1.6 requires, in part, that transient equipment shall be tracked in MAXIMO to ensure the requirements of Procedure STA-602 (Temporary Modifications and Transient Equipment Placements) are satisfied. Contrary to the above, the licensee failed to track transient equipment (i.e., fire hose) in MAXIMO to ensure the requirements of Procedure STA-606 were satisfied. Since the violation was of very low safety significance and was documented in the licensee’s corrective action program as Smart Form SMF-2008-002765, it is being treated as a noncited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000446/2008004-03), Unevaluated Temporary Modification of a Containment Isolation Valve.

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:

- Diesel Driven Fire Pump X-05 following troubleshooting maintenance, in accordance with Procedure OPT-220, “Fire Suppression Water System Operability Test,” Revision 9, observed on August 19, 2008
- Unit 1 Train B diesel generator following routine maintenance, in accordance with Procedure SOP-609A, “Diesel Generator System,” Revision 17, observed on August 27, 2008

These activities were selected based upon the structure, system, or component's ability to impact risk. The inspectors evaluated these activities for the following (as applicable): the effect of testing on the plant had been adequately addressed, testing was adequate for the maintenance performed, acceptance criteria were clear and demonstrated operational readiness, test instrumentation was appropriate, tests were performed as written in accordance with properly reviewed and approved procedures, equipment was returned to its operational status following testing (temporary modifications or jumpers required for test performance were properly removed after test completion), and test documentation was properly evaluated. The inspectors evaluated the activities against Technical Specification, the UFSAR, 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 in the corrective action program and that the problems were being corrected commensurate with their importance to safety.

The inspectors completed two samples.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed and/or reviewed the test results for the following surveillance activities to determine whether risk-significant systems and equipment were capable of performing their intended safety functions:

In-Service Testing

- Unit 2 Train A containment spray pumps in accordance with Procedure OPT-205B, "Containment Spray System," Revision 14, observed on July 14, 2008

Routine Surveillance Testing

- Unit 1 Train B safety injection system leakage inspection in accordance with Procedure ETP-204A, "Safety Injection System Radioactive Leakage Inspection Test," Revision 3, observed on July 11, 2008
- Unit 2, Surveillance Procedure INC-7552B, "Sensor Response Time Testing White Noise Analysis," Revision 1, observed on July 30, 2008

Containment Isolation valve

- Unit 1 hydrogen purge supply local leak rate test, in accordance with Procedure OPT-821A, "Appendix J Leak Rate Test of Penetration MIII-0018," Revision 2, observed on September 5, 2008

The inspectors observed in-plant activities and reviewed procedures and associated records to determine whether: any unacceptable preconditioning occurred; effects of the testing were adequately addressed by control room personnel or engineers prior to the commencement of the testing; acceptance criteria were clearly stated, demonstrated operational readiness, and were consistent with the system design basis; plant equipment calibration was correct, accurate, and properly documented; as left setpoints were within required ranges; and the calibration frequency were in accordance with Technical Specification, the UFSAR, procedures, and applicable commitments; measuring and test equipment calibration was current; test equipment was used within

the required range and accuracy; applicable prerequisites described in the test procedures were satisfied; test frequencies met TS requirements to demonstrate operability and reliability; tests were performed in accordance with the test procedures and other applicable procedures; jumpers and lifted leads were controlled and restored where used; test data and results were accurate, complete, within limits, and valid; test equipment was removed after testing; where applicable for in-service testing activities, testing was performed in accordance with the applicable version of Section XI, American Society of Mechanical Engineers Code, and reference values were consistent with the system design basis; where applicable, test results not meeting acceptance criteria were addressed with an adequate operability evaluation or the system or component was declared inoperable; where applicable for safety-related instrumentation and control surveillance tests, reference setting data were accurately incorporated in the test procedure; equipment was returned to a position or status required to support the performance of its safety functions; and all problems identified during the testing were appropriately documented and dispositioned in the corrective action program.

The inspectors completed one in-service testing inspection sample, two routine surveillance testing samples, and one containment isolation surveillance sample for a total of four samples.

b. Findings

No findings of significance were identified.

Cornerstone: Emergency Preparedness

1EP4 Emergency Action Level and Emergency Plan Changes (71114.04)

a. Inspection Scope

The inspectors performed an in-office review of Revision 35 to the Comanche Peak Steam Electric Station Emergency Plan, submitted June 26, 2008. This revision revised the definitions of emergency classifications to be consistent with NRC Bulletin 2005-02, "Emergency Preparedness and Response Actions for Security-Based Events," updated references to the State of Texas Department of Public Safety and offsite command and control functions, removed the description of the location of the licensee's Alternate Emergency Operations Facility located in Granbury, Texas, and made minor administrative corrections to the text.

The revision was compared to its previous revision, to the criteria of NUREG-0654, "Criteria for Preparation and Evaluation of Radiological Emergency Response Plans and Preparedness in Support of Nuclear Power Plants," Revision 1, and to the standards in 10 CFR 50.47(b) to determine if the revision adequately implemented the requirements of 10 CFR 50.54(q). This review was not documented in a Safety Evaluation Report and did not constitute an approval of the licensee's changes; therefore, the revisions are subject to future inspection.

The inspectors completed one sample.

b. Findings

No findings of significance were identified.

1EP6 Drill Evaluation (71114.06)

a. Inspection Scope

On August 13, 2008, the inspectors evaluated the conduct of a licensee emergency drill 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 Technical Support Center to determine whether the event classification, notifications, and protective action recommendations were performed in accordance with procedures. The inspectors also attended the licensee drill critique to compare 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. As part of the inspection, the inspectors reviewed the drill package and other documents listed in the attachment.

The inspectors completed one sample.

b. Findings

No findings of significance were identified.

2 RADIATION SAFETY

Cornerstone: Occupational Radiation Safety

2OS1 Access Control to Radiologically Significant Areas (71121.01)

a. Inspection Scope

This area was inspected to assess the licensee's performance in implementing physical and administrative controls for airborne radioactivity areas, radiation areas, high radiation areas, and worker adherence to these controls. The inspectors used the requirements in 10 CFR Part 20, the Technical Specifications, and the licensee's procedures required by Technical Specifications as criteria for determining compliance. During the inspection, the inspectors interviewed the radiation protection manager, radiation protection supervisors, and radiation workers. The inspectors performed independent radiation dose rate measurements and reviewed the following items:

- Performance indicator events and associated documentation packages reported by the licensee in the Occupational Radiation Safety Cornerstone
- Controls (surveys, posting, and barricades) of radiation, high radiation, or airborne radioactivity areas
- Radiation work permits, procedures, engineering controls, and air sampler locations

- Physical and programmatic controls for highly activated or contaminated materials (nonfuel) stored within spent fuel and other storage pools
- Posting and locking of entrances to accessible high dose rate - high radiation areas and very high radiation areas

The inspectors completed 5 of the required 21 samples.

b. Findings

No findings of significance were identified.

2OS2 ALARA Planning and Controls (71121.02)

a. Inspection Scope

The inspectors assessed licensee performance with respect to maintaining individual and collective radiation exposures ALARA. The inspectors used the requirements in 10 CFR Part 20 and the licensee's procedures required by Technical Specifications as criteria for determining compliance. The inspectors interviewed licensee personnel and reviewed:

- Current 3-year rolling average collective exposure
- Work activities from previous work history data which resulted in the highest personnel collective exposures
- Site-specific trends in collective exposures, plant historical data, and source-term measurements
- Site-specific ALARA procedures
- Eight work activities of highest exposure significance completed during the last outage
- ALARA work activity evaluations, exposure estimates, and exposure mitigation requirements
- Intended versus actual work activity doses and the reasons for any inconsistencies
- Shielding requests and dose/benefit analyses
- Postjob (work activity) reviews
- Assumptions and basis for the current annual collective exposure estimate, the methodology for estimating work activity exposures, the intended dose outcome, and the accuracy of dose rate and man-hour estimates

- Method for adjusting exposure estimates, or re-planning work, when unexpected changes in scope or emergent work were encountered
- Use of engineering controls to achieve dose reductions and dose reduction benefits afforded by shielding
- Records detailing the historical trends and current status of tracked plant source terms and contingency plans for expected changes in the source term due to changes in plant fuel performance issues or changes in plant primary chemistry
- Radiation worker and radiation protection technician performance during work activities in radiation areas, airborne radioactivity areas, or high radiation areas
- Declared pregnant workers during the current assessment period, monitoring controls, and the exposure results
- Self-assessments, audits, and special reports related to the ALARA program since the last inspection
- Resolution through the corrective action process of problems identified through postjob reviews and postoutage ALARA report critiques
- Corrective action documents related to the ALARA program and follow-up activities, such as initial problem identification, characterization, and tracking
- Effectiveness of self-assessment activities with respect to identifying and addressing repetitive deficiencies or significant individual deficiencies

The inspectors completed 15 of the required 15 samples and 4 of the optional samples.

b. Findings

No findings of significance 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 second quarter 2008 performance indicators for any obvious inconsistencies prior to its public release in accordance with 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 of significance were identified.

.2 Occupational Exposure Control Effectiveness

a. Inspection Scope

The inspectors reviewed licensee documents from January 1 through June 30, 2008. The review included corrective action documentation that identified occurrences in locked high radiation areas (as defined in the licensee's Technical Specifications), very high radiation areas (as defined in 10 CFR 20.1003), and unplanned personnel exposures (as defined in Nuclear Energy Institute 99-02, "Regulatory Assessment Indicator Guideline," Revision 5). Additional records reviewed included ALARA records and whole body counts of selected individual exposures. The inspectors interviewed licensee personnel that were accountable for collecting and evaluating the performance indicator data. In addition, the inspectors toured plant areas to verify that high radiation, locked high radiation, and very high radiation areas were properly controlled. Performance indicator definitions and guidance contained in NEI 99-02, Revision 5, were used to verify the basis in reporting for each data element.

The inspectors completed one sample.

b. Findings

No findings of significance were identified.

.3 Radiological Effluent Technical Specification/Offsite Dose Calculation Manual
Radiological Effluent Occurrences

a. Inspection Scope

The inspectors reviewed licensee documents from January 1 through June 30, 2008. Licensee records reviewed included corrective action documentation that identified occurrences for liquid or gaseous effluent releases that exceeded performance indicator thresholds and those reported to the NRC. The inspectors interviewed licensee personnel that were accountable for collecting and evaluating the performance indicator data. Performance indicator definitions and guidance contained in NEI 99-02, Revision 5, were used to verify the basis in reporting for each data element.

The inspectors completed one sample.

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems (71152)

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness, Public Radiation Safety, Occupational Radiation Safety, and Physical Protection

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. 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 of significance were identified.

4OA3 Event Followup (71153)

25 kV Transformer Fire

a. Inspection Scope

On July 2, 2008, a nonsafety-related 25 kV Transformer T-5274 faulted and caught on fire in a parking lot outside the protected area. The inspectors responded to the site to evaluate the effect of the fire on the plant. To combat the fire and ensure power was removed from the transformer, the licensee de-energized the 25 kV loop. This resulted in a loss of power to several outlying buildings and the MET tower. The inspectors verified that security lighting and safety-related equipment were not effected by the fire. The inspectors discussed the emergency plan classification of the fire with the shift manager and agreed with the shift manager that no emergency declaration was required. The licensee documented the transformer failure in Smart Form 2008-002223.

b. Findings

No findings of significance were identified.

4OA5 Other Activities

Review of National Fire Protection Association (NFPA) Code Compliance Issue

a. Inspection Scope

The inspectors reviewed the construction of fire-rated roll-up doors to determine whether the licensee had installed the doors in accordance with the NFPA Standard 80-1977, "Fire Doors and Windows."

The inspectors conducted this inspection by interviewing fire protection personnel, reviewing design specifications, calculations and drawings, and performing walk downs of the fire-rated roll-up doors.

b. Findings

Introduction: The inspectors identified a Green noncited violation of License Condition 2.G because the licensee failed to ensure that two fire-rated roll-up doors complied with the mounting requirements in NFPA 80-1977. Specifically, the licensee used bolts with a diameter less than the required 3/8-inch. The licensee placed this deficiency into their corrective action program as Smartform SMF-2008-001637.

Description: The licensee used fire-rated roll-up doors to separate some fire areas. The roll-up door frames were attached to angle iron door frames with machine screws, and the cowl was attached directly to the wall above the door frame with Hilti Kwik-bolts.

During the review of the door configurations, the inspectors determined that while the licensee had installed their fire-rated roll-up doors in accordance with the vendor and site installation requirements, roll-up Fire Doors E-45 and E-45B did not meet the mounting requirements specified in NFPA 80-1977, Sections 6-4.1.3 and 6-4.1.4. For these doors, the licensee had used bolts of smaller diameter than the minimum required 3/8-inch. Specifically, the licensee had installed Fire Doors E-45 and E-45B using 1/4-inch diameter Hilti Kwik-bolts to attach the frame to the doorjamb and 1/4-inch diameter machine screws to attach the roll-up door guides to the metal frame. The licensee initiated an action to evaluate the discrepant door configuration in Smartform SMF-2008-001637.

Analysis: Failure to meet the mounting requirements of NFPA 80-1977 for fire-rated roll-up doors is a performance deficiency. The inspectors determined this deficiency was more than minor because it was similar to the "more than minor" description in Manual Chapter 0612, Appendix E, Example 3.g. This finding affected the mitigating systems cornerstone. This fire confinement finding was assigned a Moderate A degradation rating because the roll-up fire door had improperly installed fire door hardware. In accordance with Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1, Step 1.3.2, Question 5, the exposed fire area contains no potential damage targets closer than 20 feet (i.e., passive barrier) to the exposing fire area that would result in a demand for safe shutdown and the fire barrier would remain functional for at least 20 minutes. Therefore, the degraded fire-rated roll-up doors had very low risk significance. Their finding had no cross cutting aspects given that it had existed since original construction.

Enforcement: License Condition 2.G specifies, Luminant Generation Company LLC shall implement and maintain in effect all provisions of the approved fire protection program as described in the Final Safety Analysis Report through Amendment 78 and as approved in the SER (NUREG-0797) and its supplements through SSER 24, subject to the following provision:

"Luminant Generation Company LLC may make changes to the approved fire protection program without prior approval of the Commission only if those changes would not adversely affect the ability to achieve and maintain safe shutdown in the event of a fire."

Final Safety Analysis Report, Section 9.5.1.1 specifies that the Fire Protection Report is part of the approved fire protection program. Fire Protection Report, Section II-7.1, "Compliance Codes and Standards," specifies that the licensee committed to comply with NFPA 80-1977. NFPA 80-1977, Section 6-4.1.3 specifies, "On brick and concrete walls, the guide mounting bolts shall pass through the wall and thread into nuts on the opposite side. Nuts shall be provided with suitable washers. Through bolts, not less than 3/8-inch diameter shall be used." Section 6-4.1.4 specifies, "When structural steel frames are used at jambs, guides shall be secured to the frame with machine bolts of not less than 3/8-inch diameter."

Contrary to the above, the licensee failed to implement and maintain in effect all provisions of the approved fire protection program. Specifically, since original construction, the inspectors determined that the licensee had failed to install Fire Doors E-45 and E-45B in accordance with the requirements of NFPA 80-1977, Sections 6-4.1.3 and 6-4.1.4. The licensee had used 1/4-inch diameter Hilti Kwik-bolts as guide mounting bolts to secure the frame to the jamb and had used 1/4-inch diameter machine bolts to secure the guides to the frame instead of the minimum specified 3/8-inch diameter bolts. Because the licensee included this deficiency in their corrective action program, as Smartform SMF-2008-001637, Evaluation 2, and because the deficiency had very low safety significance, this finding will be treated as a noncited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000445/05000446/2008004-04), Failure to Ensure Roll-up Fire Doors Complied with Fire Code.

4OA6 Management Meetings

Exit Meeting Summaries

On July 7, 2008, the inspectors presented the results of the fire-rated roll-up door evaluation with Mr. T. Hope, Manager, Nuclear Licensing, and other members of his staff who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

On July 17, 2008, the inspectors presented the occupational radiation safety inspection results to Mr. B. Patrick, Manager, Radiation and Industrial Safety, and other members of his staff who acknowledged the results of the inspection. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

On July 30, 2008, the inspectors conducted a telephonic exit meeting to present the results of the in-office inspection of the licensee's changes to the emergency plan to Mr. M. Bozeman, Manager, Nuclear Emergency Planning, who acknowledged the findings.

On September 17, 2008, the resident inspection results were presented to Mr. D. Kross, Plant Manager, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors examined proprietary information during the inspection. No proprietary information has been included in the inspection report.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

M. Blevins, Executive Vice President and Chief Nuclear Officer
M. Bozeman, Manager, Nuclear Emergency Planning
R. Flores, Site Vice President
D. Goodwin, Director, Operations
B. Hamilton, Director, Engineering Support
T. Hope, Manager, Nuclear Licensing
D. Kross, Plant Manager
M. Lucas, Vice President, Nuclear Engineering and Support
F. Madden, Director, Oversight and Regulatory Affairs
B. Mays, Director, Site Engineering
E. Meaders, Manager, Work Control/Outage
B. Patrick, Manager, Radiation and Industrial Safety
M. Pearson, Director, Performance Improvement
S. Smith, Director, Maintenance
K. Tate, Manager, Security
D. Walling, Manager, Training
D. Wilder, Manager, Plant Support

Nuclear Regulatory Commission

C. Johnson, Branch Chief

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened

None.

Opened and Closed

05000445/2008004-01 05000446/2008004-01	NCV	Failure to Control Transient Combustibles (Section 1R05)
05000446/2008004-02	NCV	Failure to Follow Diesel Generator Test Procedure (Section 1R15)
05000446/2008004-03	NCV	Unevaluated Temporary Modification of Containment Isolation Valve (Section 1R18)
05000445/2008004-04 05000446/2008004-04	NCV	Failure to Ensure Roll-up Fire Doors Complied With Fire Code (Section 4OA5)

Closed

None.

Discussed

None.

LIST OF DOCUMENTS REVIEWED

Section 1R05: Fire Protection

Smart Forms

SMF-2008-002180-00
SMF-2008-002276-00
SMF-2008-002501-00
SMF-2008-002673-00
SMF-2008-002698-00

Procedure

STA-729, Control of Transient Combustibles, Ignition Sources, and Fire Watches, Revision 7

Section 1R18: Plant Modifications

Smart Forms

SMF-2006-000549-00
SMF-2008-001821-00
SMF-2008-002765-00

Section 1R19: Postmaintenance Testing

Procedures

MSM-P0-3343, Emergency Diesel Engine Crankshaft Deflection and Thrust Measurements, Revision 2

Work Orders

3439372
3561993

Section 1EP6: Drill Evaluation

Smart Forms

SMF-2008-002628-00 SMF-2008-002629-00 SMF-2008-002637-00 SMF-2008-002643-00
SMF-2008-002644-00 SMF-2008-002645-00 SMF-2008-002646-00 SMF-2008-002647-00

Section 2OS1: Access Controls to Radiologically Significant Areas (71121.01) and
Section 2OS2: ALARA Planning and Controls (71121.02)

Smart Forms

SMF-2008-000959	SMF-2008-000973	SMF-2008-001012	SMF-2008-001042
SMF-2008-001059	SMF-2008-001092	SMF-2008-001148	SMF-2008-001195
SMF-2008-001201	SMF-2008-001233	SMF-2008-001234	SMF-2008-001265
SMF-2008-001312	SMF-2008-001362	SMF-2008-001366	SMF-2008-001440
SMF-2008-001554	SMF-2008-001574	SMF-2008-001592	SMF-2008-001833
SMF-2008-001845	SMF-2008-001996	SMF-2008-002007	SMF-2008-002087

Radiation Work Permits

2008-2201	2008-2209	2008-2246	2008-2400	2008-2401	2008-2403
2008-2407	2008-2600				

Procedures

STA-651, ALARA Program, Revision 10
STA-656, Radiation Work Control, Revision 13
STA-657, ALARA Job Planning/Debriefing, Revision 12

Shielding Requests

08-03	08-06	08-13
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Other

Five Year Dose Reduction Plan
2RF10 Outage ALARA Report

Section 4OA5: Other Activities (71111.05T)

Specifications

Calculation 16345/6-CS(S)-149, Rolling Steel Doors Subject to Seismic Loads, Revision 3
Design Change Authorization 92488
NFPA 80-1977, Fire Doors and Windows
NFPA 80-1983, Fire Doors and Windows
Specification 2323-AS-25, Rolling Steel Doors, Revision 1
Specification 2323-SS-30, Structural Embedments, Revision 3

Drawings

123362, Sheet1	123362X1, Sheet 6	123120, Sheet 2
123362X1, Sheet 2	123362X1, Sheet 7	128788, Sheet 1
123362X1, Sheet 3	123362X1, Sheet 16	124568, Sheet 1

Miscellaneous

Smart Form SMF-2008-001637

Procedure STA-738, Fire Protection Systems/Equipment Impairments, Revision 6

Fire impairment sheets for the 10 doors that had discrepancies

Procedure FPI-508, Electrical and Control Building Elevation 854'-4", Revision 4