

Cooper nuclear power plant by NuTherm International. According to NPPD, an independent laboratory determined that a relay that failed after 133 hours of service contained a wound wire fault that apparently was caused by a manufacturing flaw. The relay failure, which was first reported to the NRC on April 26, 2016, as a loss of safety function, was characterized as “component infant mortality” and NPPD has determined that the deviation presents a substantial safety hazard, as the relay model was approved for use in safety-related applications.

NuTherm reported on August 30 that after reviewing all procurements of the 700DC-series relays, it found that a total of 49 potentially flawed units were shipped to NPPD (Cooper) and Indiana Michigan Power Company (Cook). NuTherm notified the affected customers of the condition, but the company said that it does not have sufficient information to determine whether the issue creates a substantial safety hazard or would have created a technical specification safety limit violation. NuTherm said that it is taking no further actions at this time as the company has no current orders for the relays and has no units in stock.

■ On August 24, the Georgia Department of Natural Resources (DNR) reported an error with Elekta’s Oncentra Brachy soft-

ware, version 4.5.2, which is used for the planning of medical brachytherapy treatments. According to the DNR, a patient mistreatment involving the software occurred on August 8 due to an inconsistent step size when treating the ring source path. Three other facilities previously identified this issue during quality assurance testing (no patients were involved) and Elekta is working on a bug fix and field notification, the DNR said. Applications using the software have been stopped until a new version is available.

Elekta also reported on August 25 that a user in France notified the company on July 13 that they discovered the same issue with the Oncentra Brachy software during a QA audit. Elekta said that it has determined that an issue exists in versions 4.5, 4.5.1, and 4.5.2 of the software, which will be resolved in the next issued version.

■ Fisher Controls International reported on August 28 that an erroneous rotary seating torque calculation is contained in its FlowScanner 6.6 (build 6.6.000.29) and 6.6 SP1 (build 6.6.000.67) software. According to Fisher Controls, while updating an older FlowScanner software version to 6.6 SP1, a customer performed additional software acceptance validation and discovered a discrepancy between the two software versions when calculating seating torque values for rotary valve

assemblies with a lever arm linkage type. An equation in the software that was incorrectly written in the software code was found to be the cause for the discrepancy.

Fisher Controls said that the equation has been corrected and installation CDs will be ready for distribution to affected customers by December 1, 2017. The company also has initiated a corrective action request to prevent the issue from recurring. Supplied customers include FPL Group (Seabrook), NextEra Energy (Arnold, Point Beach), Dominion (Millstone), and Omaha Public Power District (Fort Calhoun), as well as Southern Company and Exelon PowerLabs.

■ On September 11, Curtiss-Wright Flow Control Company issued a revised report concerning a potential defect in Grayboot socket contacts that was first reported on May 15 (NN, July 2017, p. 76). According to the company, test results, which included cycle aging, functional testing, and pullout force, confirmed that the affected socket contacts will continue to perform their intended safety function throughout their qualified life. Based on the findings, Curtiss-Wright is recommending no further actions for the notified utilities. Any potentially affected socket contacts, either in inventory or installed, are acceptable for use in their intended safety-related application, the company said. **IN**

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