

Diablo Canyon 2

4Q/2004 Plant Inspection Findings

Initiating Events

G**Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Properly Implement Procedure for Spent Fuel Pool Skimmer Filter Replacement

A self-revealing NCV was identified for the failure to appropriately implement the procedure for spent fuel pool skimmer filter replacement, as required by Technical Specification 5.4.1.a. On December 23, 2004, operators cleared the spent fuel pool skimmer system using Section 6.3.1 of Procedure OP B-7:III, "Spent Fuel Pool System - Shutdown and Clearing and Filter Replacement," Revision 15, instead of the appropriate section, which was Section 6.3.2. A human performance cross cutting aspect was identified for the failure on two occasions to address configuration control concerns with the system.

This finding impacted the Initiating Events Cornerstone and was considered more than minor using Example 5.a of IMC 0612. Specifically, Valve SFS-2-3 was mis-positioned due to the use of the wrong section of Procedure OP B-7:III and then returned to service. Additionally, operators had two opportunities to identify the mis-positioning of Valve SFS-2-3 but failed to identify the condition. The mis-positioned valve resulted in a loss of approximately 36,000 gallons of water from the spent fuel pool. Using the SDP Phase 1 screening worksheet of IMC 0609, Appendix A, the finding was evaluated as a transient initiator, and it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Therefore, the finding was screened as having very low safety significance
Inspection Report# : [2004005\(pdf\)](#)

Mitigating Systems

G**Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Wire and Connect Test Equipment Resulted in Vital Bus De-Energization

A self-revealing, noncited violation was identified for the failure to set up phase sequence test equipment according to procedure, as required by 10 CFR Part 50, Appendix B, Criterion V. This failure resulted in the momentary de-energization of Vital 4kV Bus G and the auto-start of Diesel Engine Generator 2-1. Subsequent investigation by Pacific Gas & Electric Company (PG&E) revealed that the primary side of the test transformer was wired in a wye configuration instead of a delta configuration. This wiring configuration introduced a direct short to ground, which caused the second level undervoltage relay to sense a degraded bus voltage for Vital 4kV Bus G. Subsequently, the relay removed the auxiliary power supply from Bus G and caused DEG 2-1 to start and load onto the bus. This finding involved a human performance cross-cutting aspect for the failure to wire the phase sequence test equipment properly for Vital 4kV Bus G and DEG 2-1.

The finding impacted the Mitigating Systems Cornerstone for ensuring the availability and capability of systems that respond to initiating events to prevent undesirable consequences that was associated with a pre-event human error performance. Considering Example 4.b of IMC 0612, Appendix E, the finding is greater than minor since the incorrect wiring and connection of the test equipment resulted in a vital bus de-energization and the actuation of DEG 2-1. Using Checklist 4 of Inspection Manual Chapter (IMC) 0609, Appendix G, Attachment 1, the finding did not result in the Technical Specifications for AC and DC power sources not being met and the finding was determined not to increase the likelihood of a loss of reactor coolant system inventory, degrade PG&E's ability to terminate a leak path or add reactor coolant system inventory when needed, or degrade PG&E's ability to recover decay heat removal once it is lost. Therefore, the finding was screened as having very low safety significance .

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Dec 31, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate ASCO Valve Qualification Causes Plant Trip

A self revealing violation of 10 CFR 50.49(f) was identified for the failure to maintain approximately 70 safety related solenoid operated valves in an environmentally qualified condition. On February 9, 2002, an age related ASCO solenoid operated valve failure caused a loss of steam generator feedwater event and a Unit 2 manual plant trip. Further, the licensee did not promptly evaluate the extent of condition of the ASCO failure (coil insulation failure), which delayed the identification of elastomer qualification issues for approximately 1 year. In a related finding,

the team identified that the licensee had missed earlier opportunities to identify ASCO elastomer qualification issues, in that they failed to thoroughly evaluate several pertinent NRC information notices and previous valve failures. The failure to: 1) properly establish equipment qualification limits; 2) thoroughly evaluate plant events and failures; and 3) properly evaluate industry operating experience constituted performance concerns. PG&E entered this issue into their corrective action program as Action Request 0613008. These issues have cross-cutting aspects in the area of problem identification and resolution because the original problem investigation did not identify the full scope of the cause and extent of condition, delaying some important corrective actions for approximately 1 year.

This finding was greater than minor because, if left uncorrected, these deficiencies would become a more significant safety concern by increasing the failure rate as the components age. An NRC Senior Reactor Analyst performed a Phase 3 significance determination and the estimated delta-CDF for the finding is 2.2E-8/yr. This violation was of very low risk significance.

Inspection Report# : [2004005\(pdf\)](#)

G

Significance: Sep 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to Promptly Identify Multiple Grounds in Containment Spray Pump 2-2 Control Circuitry

A self-revealing, noncited 10 CFR Part 50, Appendix B, Criterion XVI, was identified for the failure to promptly identify multiple grounds in the breaker control circuitry for Containment Spray Pump 2-2. Specifically, Pacific Gas and Electric Company missed several opportunities, in part because of a failure to utilize the troubleshooting procedure, to pursue the cause of the ground and to address anomalous indications, the proximity of a known ground to other conductors, and operating experience. The grounds degraded control wires affecting the pump's manual/automatic breaker closure circuits, indication circuits, and overcurrent circuits for up to 70 days following the initial ground indication. A problem identification and resolution crosscutting aspect was identified for the troubleshooting and corrective actions associated with the grounds. The grounded cable was subsequently replaced. Similar to Example 4.f in Appendix E of Inspection Manual Chapter 0612, the finding is greater than minor because the multiple grounds affected the operability of containment spray pump 2-2. Using the Inspection Manual Chapter 0609 Phase I Screening Worksheet, the finding was of very low safety significance since there was not an actual reduction of the atmospheric pressure control function for containment.

Inspection Report# : [2004004\(pdf\)](#)

G

Significance: Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Simulator with respect to Backup Seismic Alarm

A noncited violation of 10 CFR 55.46 was identified by the inspectors for the failure to maintain the plant referenced simulator to respond to normal, transient and accident conditions. Pacific Gas and Electric Company removed from service, and abandoned the Backup Seismic System (Terra Tech Instrument) in place in June 2000. However, as of August 31, 2004, the plant referenced simulator still provided an annunciator fed from the backup seismic system when an earthquake of sufficient magnitude was felt. This provided operators with negative training in that operators were trained that the backup seismic system would provide annunciation and indication.

This finding affects the mitigating systems cornerstone and is greater than minor because it results in negative training of the operators to expect an annunciator from a backup seismic system in the event of an earthquake, if the earthquake force monitor was unavailable. Using the flow chart of Appendix I, of Inspection Manual Chapter 0609 of the Significance Determination Process, this issue affects operator actions in that operators may attempt to obtain ground motion from backup seismic monitors that did not exist. Per Inspection Manual Chapter 0609, Appendix I, Item 12, the inspectors determined that the finding was Green because the differences between the plant control room and the plant reference simulator negatively impacted operator actions and resulted in negative training.

Inspection Report# : [2004004\(pdf\)](#)

G

Significance: Jun 25, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design and Test Controls of the Diesel Emergency Generator Fuel Oil Level Control Valves

The team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, for the failure to maintain design control of the diesel emergency generator system fuel oil transfer system requirements. Specifically, the fuel supply to each diesel required that an adequate air supply to operate the air-operated day tank level control valve be maintained in the starting air receivers. The team identified that when the licensee recognized that this design basis was not documented, a calculation was performed to support creating the design basis which did not account for operational leakage from the system, nor did it verify that existing leakage would not prevent fulfilling the safety function. This failure potentially affected the ability of each diesel emergency generator to provide sufficient fuel oil to support 7 days of continuous diesel generator operations following a loss of offsite power. This issue was entered into the corrective action program under Action Request A0613008. This finding involved cross-cutting aspects in the area of problem identification and resolution because the original corrective actions did not correct the problem and properly establish the design basis.

This finding was greater than minor because it was similar to Example 3.i of Manual Chapter 0612, Appendix E. This finding affected the mitigating systems cornerstone. This finding was evaluated using NRC Manual Chapter 0609, Significance Determination Process, Phase 1

worksheet under the mitigating systems cornerstone. The finding was determined to be of very low safety significance because the deficiency was confirmed not to result in a loss of function of the diesel engine generator as a power source per Generic Letter 91-18, Revision 1. The licensee was able to demonstrate that compensatory measures were in place so that this function could be performed manually in a reliable manner because operators would receive a control room alarm which triggered implementation of proceduralized step to manually perform the function. The team confirmed that operators were trained to perform this action.

Inspection Report# : [2004006\(pdf\)](#)

Significance:  Mar 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Translate Design Basis of Diesel Fuel Oil Storage Tank into Implementing Procedures

A noncited violation of 10 CFR Part 50, Appendix B, Criterion III, was identified for the failure to translate the diesel emergency generator fuel oil usage design basis assumptions into procedures. Specifically, Calculation M-786 provided the basis for the Technical Specification minimum required volume of fuel oil in the fuel oil storage tanks to meet a 7 day fuel oil supply following a loss of offsite power for both units. The minimum volume was based on each unit operating only the minimum safety-related loads to achieve and maintain safe shutdown. However, the diesel engine generator minimum safety-related loads were not translated into procedures, nor were any instructions provided to alert operators to take actions to conserve fuel oil. With all six diesel engine generators running fully loaded there is insufficient fuel oil in the fuel oil storage tanks for 7 days of operation.

This issue affects the mitigating systems cornerstone objective to ensure the availability of onsite emergency AC power during the entire period described in the design basis. This issue is more than minor because it could have an actual impact on the ability of the diesel engine generators to mitigate a long-term loss of offsite power event. Using the Phase 1 significance determination process the inspectors determined that the issue was of very low safety-significance because the finding does not represent an actual loss of a safety system or a single train and did not meet the criteria for being risk significant because of an external event.

Inspection Report# : [2004002\(pdf\)](#)

Significance:  Mar 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Procedures for Preventive Maintenance and Operation of Limitorque Motor-operated Valves in a Moist Environment

A noncited violation with two examples was identified by the inspectors for the failure to assure activities affecting quality shall be accomplished in accordance with documented instructions, procedures, or drawings, as required by 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." Specifically, Pacific Gas and Electric failed to provide adequate procedures for preventive maintenance and operation of Limitorque motor-operated valves. The inadequate procedures resulted in the degraded operation of three Limitorque motor-operated valves in the auxiliary saltwater system during quarterly valve surveillance activities.

The performance deficiency associated with the finding is the failure to provide adequate instructions for preventive maintenance and operation of Limitorque motor-operated valves. The preventive maintenance aspect was evident with the Limitorque valves located in a moist environment. This finding impacted the mitigating systems cornerstone for the reliability of the auxiliary saltwater system that affects both shutdown and operating equipment. The finding is greater than minor because the finding would become a more significant safety concern if the problem was left uncorrected. Specifically, the problems of undiscovered rust formation on the valve declutch lever and the out-of-adjustment tripper fingers would continue to affect manual operation of the Limitorque valves and the ability to re-engage the motor operator. Using the SDP Phase 1 Worksheet in Inspection Manual Chapter 0609, the inspectors determined that this finding is of very low safety significance. Although operation of the three auxiliary salt water valves were degraded, the three motor-operated valves were available to perform their intended safety functions. The finding did not result in a loss of safety function or screen as potentially risk significant from the consideration of external event impacts.

Inspection Report# : [2004002\(pdf\)](#)

Significance:  Mar 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Control Placement of Temporary Equipment With Regards to Potential Seismic Impact on Safety-Related Systems

A noncited violation of Technical Specification 5.4.1.a. was identified by the inspectors for the failure to adequately control the storage of temporary equipment that has a potential for seismically-induced system interaction with safety systems. Specifically, on March 18 and then on March 31, the inspectors identified an instance where transient equipment was stored in close proximity to safety systems and considered to be potential seismically-induced system interactions. On March 18, Pacific Gas and Electric identified two other instances where temporary equipment could cause a seismically-induce system interaction with safety systems. In each case the equipment was determined not to impact the functionality of the safety systems in the event of an earthquake.

The finding impacted the mitigating systems cornerstone for protection against external hazards. The issue was determined to be more than minor when compared to Example 4.a of Inspection Manual Chapter 0612, Appendix E. Similar to the example, the inspectors and Pacific Gas

and Electric found four examples on the auxiliary building 140 ft. elevation where temporary equipment was stored contrary to procedures to protect safety-related systems from seismic impact. Using the Significance Determination Process Phase I worksheet in Inspection Manual Chapter 0609, Appendix A, the finding is of very low safety significance since it did not screen as potentially risk significant due to a seismic event. Specifically, the inspectors determined that the finding did not involve the loss or degradation of equipment or function specifically designed to mitigate a seismic event and it does not involve the total loss of any safety function with respect to a seismic event.

Inspection Report# : [2004002\(pdf\)](#)

Barrier Integrity

Significance:  Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Mislabel of Neutron Flux Detector Resulted in Neutronic Decoupling of Detector From the Core

The inspectors identified a noncited violation for the failure to develop a core offload sequence that maintained the source range neutron flux monitors operable, as required by 10 CFR Part 50, Appendix B, Criterion V. Inaccurate labeling of two neutron detectors in the core offload planning tool resulted in the development of a core offload sequence that when implemented resulted in one of the detectors becoming neutronically uncoupled from the core during core alterations. A human performance crosscutting aspect was identified for the labeling error in the core offload planning. A second human performance crosscutting aspect was identified for the failure to ascertain the cause of the downward trend when first identified by the inspectors.

The finding impacts the Barrier Integrity Cornerstone to provide reasonable assurance that physical design barriers protect the public from radio nuclide releases caused by accidents or events and is associated with the barrier performance attribute for procedure quality which could impact cladding. The finding is more than minor when compared to Example 4.e of Inspection Manual Chapter 0612, Appendix E. Similar to the example, Procedure OP B-8DS1, Step 5.2.1, described a responding nuclear instrument as having at least one fuel assembly face-adjacent or diagonally adjacent to the detector. Due to a labeling error in the core offload planning tool, the core offload sequence was developed in a manner that caused a neutron detector (Detector N-52) not to have an adjacent fuel assembly. Using Checklist 4 of Inspection Manual Chapter 0609, Appendix G, Attachment 1, the finding was determined not to increase the likelihood of a loss of reactor coolant system inventory, degrade Pacific Gas & Electric Company's ability to terminate a leak path or add reactor coolant system inventory when needed, or degrade Pacific Gas & Electric Company's ability to recover decay heat removal once it is lost. Therefore, the finding was screened as having very low safety significance.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Correct Containment Fan Cooler Unit Reverse Rotation

The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion XVI, for the failure to promptly correct reverse rotation of containment fan cooler units (CFCUs) for both Units 1 and 2. PG&E observed reverse rotation of CFCUs for approximately 13 years, as a result of the CFCU backdraft dampers sticking partially open. The purpose of the backdraft dampers is to prevent reverse rotation of the CFCUs, which could cause the fan motor to trip on overcurrent when the CFCUs are started following a loss of coolant accident. Prior to Refueling Outage 2R12, 2 CFCUs in Unit 1 and 3 CFCUs in Unit 2 exhibited reverse rotation. One of the CFCUs in Unit 2 was considered inoperable due to reverse rotation and another was only considered operable if it was running.

The finding impacts the Barrier Integrity Cornerstone to provide reasonable assurance that physical design barriers protect the public from radio nuclide releases caused by accidents or events and is associated with the barrier performance attribute. The finding is more than minor when considering Example 3.g of IMC 0612, Appendix E. Similar to the example, PG&E observed reverse rotation of CFCUs for 13 years, and the reverse rotation impacted the operability of the CFCUs. Using the SDP Phase 1 Screening Worksheet from IMC 0609, the finding was determined to be of very low safety significance since it was determined that there was not an actual loss of defense-in-depth in containment pressure control or hydrogen control .

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Sep 30, 2004

Identified By: NRC

Item Type: FIN Finding

Failure to properly implement an operating instruction for an inoperable containment isolation valve.

The inspectors identified a finding for the failure to properly isolate containment isolation Valve VAC-2-FCV-681 (an air-operated containment isolation valve) after it failed to fully stroke open and was declared inoperable. Operators hung administrative tags on the control room switch for the valve but failed to remove the motive force from the valve by isolating air to the actuator. The associated operating instruction required that the valve be closed and deactivated. A human performance crosscutting aspect was identified for the failure to properly implement the

operating instruction for an inoperable containment isolation valve.

This issue affects the barrier integrity cornerstone objective to ensure that systems penetrating the containment and are connected directly to the containment atmosphere have adequate isolation to protect the containment barrier. This issue is greater than minor because failure to properly close and deactivate containment isolation valves could have an actual impact on the ability to isolate a fault outside of containment. Using the Phase 1 significance determination process, the inspectors determined that the issue was of very low safety significance because the finding did not represent an actual open significant pathway to the environment and the penetration was isolated by an active valve having secured flow.
Inspection Report# : [2004004\(pdf\)](#)

Significance:  Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit Change to the Emergency Plan with respect to Backup Seismic System

A violation of 10CFR 50.54(q) was identified by the inspectors for failure to update and submit changes to the emergency plan within 30 days. Specifically, Section 7.5.1 of the Diablo Canyon Emergency Plan stated that a supplemental seismic system, supplied by Terra Tech Corporation, provided backup local indication and control room annunciation on strong ground motion. The Terra Tech system was removed from service, along with its annunciation in the control room, and abandoned in place in July of 2000, but as of September 30, 2004, Pacific Gas and Electric had not revised its emergency plan to reflect this change.

The finding was evaluated using NUREG-1600, "General Statement of Policy and Procedure for NRC Enforcement Actions," Section IV, because licensee reductions in the effectiveness of its emergency plan impact the regulatory process. The finding had greater than minor significance because deletion of conditions indicative of a site area emergency has the potential to impact safety. The finding was determined to be a noncited Severity Level IV violation because the finding involved a violation of a regulatory requirement and did not constitute a failure to meet an emergency planning standard as defined by 10 CFR 50.47(b). This finding has been entered into the licensee's corrective action program as Action Request A0618799.

Inspection Report# : [2004004\(pdf\)](#)

Emergency Preparedness

Significance:  Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish Compensatory Measures to Ensure the Implementation of the Diablo Canyon Emergency Plan

The inspectors identified a violation of 10 CFR 50.54(q) and 50.47.b(4) for the failure to maintain the seismic force monitors during the periods, June 16-19, 1999, December 1-4, 2000, April 25-27, 2002, May 25-29, 2002, November 6-8, 2003, December 30-31, 2003, and August 9-10, 2004, such that the emergency plan designed to meet planning standard (4) in 10 CFR 50.47(b) could be promptly implemented. Specifically, PG&E failed to provide a means for the emergency director to promptly classify seismic events at the notification of unusual event, alert or site area emergency levels, while the seismic force monitor utilized by the operators (emergency director) was out of service or being replaced. This finding had a human performance cross-cutting aspect associated with identifying compensatory measures to address the removal of the earthquake force monitors.

This performance deficiency impacted the emergency preparedness cornerstone because PG&E did not meet an emergency planning requirement and the cause was reasonably within PG&E's control and should have been prevented. It is greater than minor because it has a potential to impact safety and because it was not a record keeping or administrative issue or an insignificant procedural error. This deficiency could have affected the EP Cornerstone objective of ensuring the capability to implement measures to protect the health and safety of the public during an emergency, and is associated with attributes of facilities and equipment, and offsite emergency preparedness. The finding is evaluated using the Emergency Preparedness "Failure to Comply" flowchart of the SDP and is a violation of 10 CFR 50.54(q) and planning standard 50.47(b)(4), which states, in part, that a standard emergency action level and classification system... is in use Utilizing the Failure to Comply Flow Chart in Manual Chapter 0609, the performance deficiency does not result in a failure of the risk significant planning standard (RSPS) or a degraded RSPS in that the unavailability of the seismic monitors would not prevent the declaration of a Site Area Emergency, Alert or Notification of Unusual Event .

Inspection Report# : [2004005\(pdf\)](#)

Occupational Radiation Safety

Significance:  Dec 31, 2004

Identified By: Self Disclosing
Item Type: NCV NonCited Violation

Failure to Lock a High Radiation Area with Dose Rates Greater than 1 Rem per Hour

A self-revealing NCV of Technical Specification 5.7.2 was reviewed as a result of PG&E's failure to prevent unauthorized entry of a portion of the whole body into a high radiation area with dose rates greater than 1 rem per hour. Specifically, on November 14, 2004, PG&E failed to use an effective locking mechanism on the lower access flaps of the primary steam generator shield doors. The ineffective locking mechanism was discovered two days later when workers went to remove suction hoses. This could have allowed an individual to expose the arm above the elbow to dose rates greater than 1 rem per hour. This finding was placed into PG&E's corrective action program.

The finding is greater than minor because it is associated with one of the cornerstone attributes (exposure control) and affected the cornerstone objective because it could have resulted in unplanned, unintended radiation dose. The inspector determined that the finding was of very low significance because (1) it was not an ALARA finding, (2) it was not an overexposure, (3) it did have a substantial potential for overexposure, and (4) it did not compromise the ability to assess doses. This finding also had crosscutting aspects associated with human performance.

Inspection Report# : [2004005\(pdf\)](#)

G

Significance: Dec 31, 2004

Identified By: Self Disclosing
Item Type: NCV NonCited Violation

Failure to Access a High Radiation Area with Dose Rates Greater than 1 Rem per Hour with the Correct Radiation Work Permit

A self-revealing NCV of Technical Specification 5.7.2 was reviewed as a result of PG&E's failure to prevent two individuals from entering a high radiation area with dose rates greater than 1 rem per hour on the incorrect radiation work permit. Two individuals entered an area with dose rates of 6 rem per hour in Reactor Coolant Pump Cubicle 2-4 using a radiation work permit which only allowed entry into areas with dose rates up to 1 rem per hour. This finding was placed into PG&E's corrective action program.

The finding is greater than minor because it is associated with one of the cornerstone attributes (exposure control) and affected the cornerstone objective because it could have resulted in unplanned, unintended radiation dose. The inspector determined that the finding was of very low significance because (1) it was not an ALARA finding, (2) it was not an overexposure, (3) it did have a substantial potential for overexposure, and (4) it did not compromise the ability to assess doses. This finding also had crosscutting aspects associated with human performance.

Inspection Report# : [2004005\(pdf\)](#)

G

Significance: Aug 12, 2004

Identified By: Self Disclosing
Item Type: NCV NonCited Violation

Failure to Perform Radiological Survey of a High Radiation Area

Green. A self-revealing non-cited violation of 10 CFR 20.1501(a) was identified for the failure to perform required radiation surveys in Unit 2 to ensure compliance with 10 CFR 20.1902(b). Specifically, on January 28, 2003, during the performance of venting the volume control tank radiation protection personnel failed to perform adequate surveys of the Unit 2 Gas Decay Tank Room to post an expected high radiation area that would occur during this evolution. This finding involved cross-cutting aspects in the area of problem identification and resolution because the team noted that corrective actions for a similar event under the same circumstances had been ineffective in preventing recurrence. This issue was entered into the corrective action program under Action Request A0572997.

The finding is greater than minor because it was associated with one of the occupational radiation safety cornerstone attributes (exposure), and the finding affected the associated cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material. The inspector processed the issues through the Occupational Radiation Protection Significance Determination Process. This issues were determined to be a Green finding because it was not an ALARA planning and control issue, there was no personnel overexposure or substantial potential for personnel overexposure, and the licensee's ability to assess dose was not compromised.

Inspection Report# : [2004006\(pdf\)](#)

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Jun 25, 2004

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The team concluded that the licensee was effective in identifying, evaluating, and correcting problems, although the team identified some examples where conditions adverse to quality were not properly entered into the Action Request system, allowing problem recurrence. The team found that the evaluation and prioritization of problems were mostly conducted properly, although some significant issues were identified as routine because the licensee's process assigned significance based on the actual consequences of problems, rather than considering the potential consequences under design basis conditions. Corrective actions were generally implemented in a timely manner. However, the team found weaknesses with the alignment of corrective actions with the cause, and with the quality of operability evaluations for issues assigned routine significance, because the licensee did not assign a probable cause statement to routine issues. Licensee audits and assessments were found to be responsive to plant performance issues and effective in identifying areas for improvement. During interviews, station personnel communicated a willingness to enter issues into the corrective action program. The team reviewed the licensee's improvement plans for significant cross-cutting issues in human performance and problem identification and resolution. Although it was too early to determine if these will be effective, the team noted that the Human Performance Improvement Plan did not address problems observed in coordinating and supervising operations during outages.

Inspection Report# : [2004006\(pdf\)](#)

Last modified : March 09, 2005