

D.C. Cook 2

3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Introduction of Manual Action in Station Blackout Response Procedure

A finding of very low safety significance was identified by the inspectors associated with a non-cited violation of 10 CFR 50.59(d)(1). The issue involved an inadequate evaluation under 10 CFR 50.59 with respect to introduction of a new manual action in place of a previously automatic action. This issue was entered into the licensee's corrective action system and the licensee prepared a new evaluation in accordance with 10 CFR 50.59.

This finding was assigned a significance level of very low safety significance based on management review. The violation was categorized as Severity Level IV based on the underlying technical issue for the finding having screened out as having very low significance using the Phase 1 worksheet of Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." (Section 1R21.1.b)

Inspection Report# : [2005007\(pdf\)](#)

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Hydrometer Not Calibrated for Temperatures Seen During Surveillances

Green. A finding of very low safety significance was identified by the inspectors associated with a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XII, "Measuring and Test Equipment." Specifically, the licensee did not calibrate a digital hydrometer over all the temperature ranges under which the hydrometer was used. This issue was entered into the licensee's corrective action system and the licensee was evaluating the necessary corrective actions.

This finding was more than minor because it could lead to a more serious situation. Specifically, continued reliance on a hydrometer that was not calibrated for the temperatures at which it was being used could reasonably lead to a situation where the actual specific gravity was below the technical specification limits without that being noticed. This finding was of very low safety significance because it screened out using the Phase 1 worksheet of Inspection Manual Chapter 0609, Appendix A. (Section 1R21.2.b1)

Inspection Report# : [2005007\(pdf\)](#)

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Torquing Requirements in 250 Vdc Safety-Related Battery Procedures

Green. A finding of very low safety significance was identified by the inspectors associated with a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." Specifically, the licensee failed to ensure that adequate battery terminal connection torque values were specified in the AB, CD and N batteries maintenance and surveillance procedures. The licensee entered the issue into its corrective action system, confirmed that the N-train of safety-related batteries were correctly torqued, revised one procedure and was evaluating the additional corrective actions needed.

This finding was more than minor because the finding was associated with the attribute of equipment performance, which affected the mitigating systems cornerstone objective of ensuring the availability and reliability of the 250 VDC power system to respond to initiating events to prevent undesirable consequences. Specifically, inconsistent torquing requirements specified in maintenance and surveillance procedures used to perform maintenance activities on safety related batteries could potentially result in unacceptable battery terminal connections and render the safety-related battery incapable of performing its required safety function. This finding was of very low safety significance because it screened out using the Phase 1 worksheet of Inspection Manual Chapter 0609, Appendix A. (Section 1R21.2.b2)

Inspection Report# : [2005007\(pdf\)](#)

G**Significance:** Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Single Cell Non-Class 1E Battery Charger Procedure Deficiencies

Green. A finding of very low safety significance was identified by the inspectors associated with a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." Specifically, the licensee failed to ensure that procedure 12-IHP-5021-EMP-009 contained adequate verification such that an independent observer could ensure that adequate electrical isolation had been maintained when a non-Class 1E single cell battery charger was used to charge a single battery cell on safety-related batteries. This issue was entered into the licensee's corrective action system and the licensee was evaluating other corrective actions.

This finding was more than minor in that the finding was associated with the attribute of equipment performance, which affected the mitigating system's cornerstone objective of ensuring the availability and reliability of the DC power system to respond to initiating events to prevent undesirable consequences. Specifically, failure to install a fuse could result in inadequate electrical isolation between the non-Class 1E single cell battery charger and safety-related battery. Without adequate isolation, a fault on the non-Class 1E charger could potentially render the safety-related battery incapable of performing its required safety function. This finding was of very low safety significance because it screened out using the Phase 1 worksheet of Inspection Manual Chapter 0609, Appendix A. (Section 1R21.3.b1)

Inspection Report# : [2005007\(pdf\)](#)**G****Significance:** Sep 30, 2005

Identified By: NRC

Item Type: FIN Finding

Electrolytic Capacitors in Battery Chargers Not Energized Annually

Green. A finding of very low safety significance was identified by the inspectors which was not associated with a non-cited violation. Specifically, the licensee failed to ensure that each of the 250 VDC battery chargers was energized for a minimum of eight hours per year. The vendor required this minimum energization in order to ensure the electrolytic capacitors installed in the chargers would meet the qualified replacement life of 10 years. This issue was entered into the licensee's corrective action system and the licensee was evaluating other corrective actions.

This finding was more than minor because it was associated with the attribute of equipment performance, which affected the mitigating system's cornerstone objective of ensuring the availability and reliability of the DC power system to respond to initiating events to prevent undesirable consequences. Specifically, the failure to energize the electrolytic capacitors for at least 8 hours annually could lead to the degradation of the capacitors with resultant degradation of the voltage going to the batteries. This finding was of very low safety significance because it screened out using the Phase 1 worksheet of Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." (Section 1R21.3.b2)

Inspection Report# : [2005007\(pdf\)](#)**Significance:** TBD Aug 31, 2005

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Provide Complete and Accurate Information to the NRC Which Impacted A Licensing Decision

The licensee provided incomplete and inaccurate information in a letter to the NRC dated August 2, 2004. Specifically, the licensee, in its response to an apparent violation, which was subsequently issued as a Severity Level III Notice of Violation issued on September 29, 2004, incorrectly stated that: "a 100 percent review (self-assessment) of all operator medical records was performed in February and March of 2004;" and that full compliance was achieved on April 8, 2004. During an April 2005 followup review of the licensee's corrective actions for the Severity Level III violation, the NRC identified three additional examples of licensed operators with a potentially disqualifying medical condition that existed prior to the licensee's February and March 2004 review of its medical records, that had not been reported to the NRC. The licensee made changes to their administrative procedures to ensure clarity in regard to medical reporting requirements and required an annual medical file review in addition to an annual discussion with their medical review official to ensure a mutual understanding of the appropriate regulatory requirements.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated using the traditional enforcement process. The regulatory significance was important because the incorrect information was provided under a signed statement to the NRC and impacted an enforcement decision. The issue was preliminarily determined to be an apparent violation of 10 CFR 50.9.

Inspection Report# : [2005006\(pdf\)](#)**Significance:** TBD Aug 31, 2005

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Provide Complete and Accurate Information to the NRC Which Impacted A Licensing Decision

The NRC identified that on May 5, 2004, a senior licensee representative submitted to the NRC a Form NRC - 396 to support an application for renewal of an SRO license, that was not complete and accurate in all material respects. The Form NRC - 396 certified that the applicant met the medical requirements of ANSI/ANS 3.4-1983 and that the applicant would not require any restrictions to the individual's license. In fact, the applicant had a potentially disqualifying medical condition dating back to October 30, 1998. [Note: The information concerning the individual's specific medical condition is considered medical privacy information under 10 CFR 2.390(2)(6) and is not specifically discussed here.] The

medical condition was potentially disqualifying in accordance with ANSI/ANS 3.4, 1983, and required that the individual's license be amended to include an operating restriction. The information is material to the NRC because the NRC relies on this certification to determine whether the applicant meets the requirements to operate the controls of a nuclear power plant pursuant to 10 CFR Part 55. The licensee made changes to their administrative procedures to ensure clarity in regard to medical reporting requirements and required an annual medical file review in addition to an annual discussion with their medical review official to ensure a mutual understanding of the appropriate regulatory requirements.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated using the traditional enforcement process. The regulatory significance was important because the incorrect information was provided under a signed statement to the NRC and impacted a licensing decision for the individual. The issue was preliminarily determined to be an apparent violation of 10 CFR 50.9.

Inspection Report# : [2005006\(pdf\)](#)

Significance: TBD Aug 31, 2005

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Report A Change In A License Operators Medical Condition

The NRC identified that from November 29, 1998, until May 18, 2005, the licensee did not report the change in medical status of an SRO that acquired a potentially disqualifying medical condition as required by 10 CFR 55.25. The medical condition was potentially disqualifying in accordance with ANSI/ANS 3.4, 1983, and required that the individual's license be amended when it was finally reported on May 18, 2005, to include an operating restriction. [Note: The information concerning the individual's specific medical condition is considered medical privacy information under 10 CFR 2.390(2)(6) and is not specifically discussed here.] The issue was more than minor because the NRC relies on this certification to determine whether the applicant meets the requirements to operate the controls of a nuclear power plant pursuant to 10 CFR Part 55. The licensee made changes to their administrative procedures to ensure clarity in regard to medical reporting requirements and required an annual medical file review in addition to an annual discussion with their medical review official to ensure a mutual understanding of the appropriate regulatory requirements.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. The regulatory significance was important because information was not provided that would have resulted in a licensing decision for the individual. The issue was preliminarily determined to be an apparent violation of 10 CFR 55.25.

Inspection Report# : [2005006\(pdf\)](#)

Significance: TBD Aug 31, 2005

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Provide Complete and Accurate Information to the NRC Which Impacted A Licensing Decision

On April 26, 2004, a senior licensee representative submitted to the NRC a Form NRC - 396 to support an amendment request of a Senior Reactor Operator (SRO) license, that was not complete and accurate in all material respects. The Form NRC - 396 certified that the applicant met the medical requirements of ANSI/ANS 3.4-1983 and that the applicant would not require any restrictions to the individual's license. In fact, the applicant had a potentially disqualifying medical condition dating back to 2003. The medical condition was potentially disqualifying in accordance with ANSI/ANS 3.4-1983, and required that the individual's license be amended to include an operating restriction. [Note: The information concerning the individual's specific medical condition is considered medical privacy information under 10 CFR 2.390(2)(6) and is not specifically discussed here.] The issue was more than minor because the NRC relies on this certification to determine whether the applicant meets the requirements to operate the controls of a nuclear power plant pursuant to 10 CFR Part 55. The licensee made changes to their administrative procedures to ensure clarity in regard to medical reporting requirements and required an annual medical file review in addition to an annual discussion with their medical review official to ensure a mutual understanding of the appropriate regulatory requirements. Since NRC intervention was required to identify the requirement for the operator to have a license restriction, this issue was considered NRC-identified.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. The regulatory significance was important because the incorrect information was provided under a signed statement to the NRC and impacted a licensing decision for the individual. The issue was preliminarily determined to be an apparent violation of 10 CFR 50.9.

Inspection Report# : [2005006\(pdf\)](#)

Significance: TBD Aug 31, 2005

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Report A Change In A License Operators Medical Condition

The NRC identified that from January 6, 2003, until May 18, 2005, the licensee did not report the change in medical status of an SRO that acquired a potentially disqualifying medical condition as required by 10 CFR 55.25. The medical condition was potentially disqualifying in accordance with ANSI/ANS 3.4, 1983, and required that the individual's license be amended when it was finally reported on May 18, 2005, to include an operating restriction. [Note: The information concerning the individual's specific medical condition is considered medical privacy information under 10 CFR 2.390(2)(6) and is not specifically discussed here.] The issue was more than minor because the NRC relies on this certification to determine whether the applicant meets the requirements to operate the controls of a nuclear power plant pursuant to 10 CFR Part 55. The apparent violation was determined to be of significant regulatory concern because a licensing action was not taken because information was not provided by the licensee. Since NRC intervention was required to identify the requirement for the operator to have a license restriction, this issue was considered NRC identified.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. The regulatory significance was important because information was not provided that would have affected a licensing decision for the individual. The issue was preliminarily determined to be an apparent violation of 10 CFR 55.25.

Inspection Report# : [2005006\(pdf\)](#)

Significance: TBD Aug 31, 2005

Identified By: NRC

Item Type: AV Apparent Violation

Failure to Provide Complete and Accurate Information to the NRC Which Impacted A Licensing Decision

On November 4, 2002, a senior licensee representative submitted to the NRC a Form NRC - 396 to support an application for an SRO license, that was not complete and accurate in all material respects. The Form NRC - 396 certified that the applicant met the medical requirements of ANSI/ANS 3.4-1983 and that the applicant would not require any restrictions to the individual's license. In fact, the applicant had a potentially disqualifying medical condition in accordance with ANSI/ANS 3.4-1983. The medical condition required that the individual's license be amended to include an operating restriction. [Note: The information concerning the individual's specific medical condition is considered medical privacy information under 10 CFR 2.390(2)(6) and is not specifically discussed here.] The issue is more than minor because the NRC relies on this certification to determine whether the applicant meets the requirements to operate the controls of a nuclear power plant pursuant to 10 CFR Part 55. The licensee made changes to their administrative procedures to ensure clarity in regard to medical reporting requirements and required an annual medical file review in addition to an annual discussion with their medical review official to ensure a mutual understanding of the appropriate regulatory requirements. Since NRC intervention was required to identify the requirement for the operator to have a license restriction prior to his initial license being issued, this issue was considered NRC-identified.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. The regulatory significance was important because the incorrect information was provided under a signed statement to the NRC and impacted a licensing decision for the individual. The issue was preliminarily determined to be an apparent violation of 10 CFR 50.9.

Inspection Report# : [2005006\(pdf\)](#)

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Significance: Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Prompt Corrective Actions for Conditions Adverse to Quality

The inspectors identified two examples of a finding of very low safety significance and a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," associated with the review of operating experience information. Licensee personnel failed to take prompt and effective corrective actions to address asbestos-filled spiral wound gaskets subject to limited shelf life, which resulted in a steam leak from the Unit 2 pressurizer manway cover. The licensee also failed to take prompt and effective corrective actions to address tempered 414 stainless steel centrifugal charging pump shafts susceptible to high cycle fatigue cracking, which resulted in the failure of the Unit 1 west charging pump. The licensee subsequently replaced the failed components. The inspectors considered each of the two examples separately when completing the SDP review since each example occurred apart in time and neither one influenced the other.

The failure of the Unit 2 pressurizer manway gasket was associated with the equipment performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operation. Specifically, the manway gasket failure resulted in reactor coolant system (RCS) leakage that necessitated the reactor be shut down for repair. The inspectors determined that this example was of very low safety significance during a Phase 1 SDP evaluation because it would not likely result in exceeding the Technical Specification limit for identified RCS leakage and would not likely affect other mitigation systems, resulting in a total loss of their safety function. As part of the licensee's immediate corrective actions, the gasket was replaced.

The Unit 1 charging pump failure was associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors performed a Phase 1 SDP review of this finding. The inspectors determined that the additional outage time for the Unit 1 west charging pump was a degradation of the Mitigating System Cornerstone; however, this finding 1) was not a design deficiency or qualification deficiency confirmed to result in a loss of function per Generic Letter 91-18; 2) did not represent an actual loss of safety function of a system; 3) did not represent an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time; 4) did not represent an actual loss of safety function of one or more non-Technical Specification trains of equipment designated as risk significant; and 5) did not screen as potentially risk significant due to seismic, flooding, or a severe weather initiating event. Therefore, the finding was considered to be of very low safety significance. As part of the licensee's immediate corrective actions, the charging pump was replaced.

Inspection Report# : [2005004\(pdf\)](#)

G

Significance: Mar 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Test Procedure for Testing the Unit 2 West Centrifugal Charging Pump Discharge Check Valve

The inspectors identified a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," associated

with a self-revealed event. The licensee failed to perform testing of the Unit 2 West centrifugal charging pump discharge check valve with a procedure that was appropriate to the circumstances. This resulted in operators over-pressurizing the low pressure side of the charging pump and a portion of the pump's suction piping up to and including the isolation valve. The licensee replaced the entire pump and the suction piping up to and including the suction valve and implemented appropriate changes to the test procedure to prevent a recurrence. This finding affected the cross-cutting issue of human performance (personnel).

The inspectors determined that this finding was more than a minor safety concern because it was associated with the Procedure Quality attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences since the West charging pump was rendered unavailable for an extended period of time to correct the problem. Although this issue affected the availability of the West charging pump, the inspectors concluded that because the East charging pump remained operable and because additional sufficient mitigating capability existed, this issue was of very low safety significance.

Inspection Report# : [2005002\(pdf\)](#)

Barrier Integrity

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Significance: Mar 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Unit 2 Containment Ventilation Isolation Function Rendered Inoperable During Core Alterations

The inspectors identified a Non-Cited Violation of Technical Specifications (TS) 3.0.4, 3.9.4.c, and 3.9.9 associated with a self-revealed event. The licensee failed to maintain both trains of the Unit 2 containment purge and exhaust isolation valves' automatic isolation function operable during core alterations and commenced core alterations without meeting the applicable TS Limiting Conditions for Operation associated with the automatic isolation function. The licensee restored both trains of the automatic isolation function to an operable status upon discovery and implemented appropriate process controls to prevent a recurrence. This finding affected the cross-cutting issue of human performance (personnel/organization).

The inspectors determined that this issue could become a more significant safety concern if left uncorrected and was therefore more than a minor concern. Specifically, the failure to correctly implement the above TS requirements could reasonably result in a release of radioactivity in the event of a fuel handling accident in the Containment Building prior to identification of the inoperability of the automatic isolation function and manual closure of the valves. Although this issue affected the integrity of the reactor containment during core alterations, the inspectors concluded that because the Unit 2 containment purge and exhaust isolation valves could have been manually closed by operators in the Control Room and because the Containment Building radiation monitors and high radiation alarm function remained operable during this time, this issue was of very low safety significance.

Inspection Report# : [2005002\(pdf\)](#)

G

Significance: Mar 31, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Unit 2 Containment Integrity and Automatic Isolation Function for Non-Essential Service Water Supply and Return Lines to Containment Instrument Room East Ventilation Until Rendered Inoperable

The inspectors identified a Non-Cited Violation of TS 3.0.4, 3.6.1.1, 3.6.1.2, and 3.6.3.1 associated with a self-revealed event. The licensee failed to maintain drain valves between redundant containment isolation valves in the non-essential service water supply and return lines for the Unit 2 containment instrument room east ventilation unit closed as required to meet containment integrity, containment leakage, and containment isolation valve requirements. In addition, the licensee changed operational modes without meeting the applicable TS Limiting Conditions for Operation associated with TS 3.6.1.1 and 3.6.3.1. The licensee restored compliance with the above requirements by closing the inboard containment isolation valves and affected drain valves upon discovery and implemented corrective actions to prevent a recurrence, which included procedure changes to assure continuity of configuration control. This finding affected the cross-cutting issue of human performance (personnel/organization).

The inspectors determined that this issue could become a more significant safety concern if left uncorrected and was therefore more than a minor concern. Specifically, the failure to correctly implement the above TS requirements could reasonably result in a release of radioactivity to the environment in the event of an accident in the Containment Building. Although this issue affected the integrity of the reactor containment, the inspectors concluded that the issue was of very low safety significance because the very small diameter holes in the ventilation unit cooling coils and the small diameter drain lines would be a very small leakage path and would not have a significant impact on the Large Early Release Frequency.

Inspection Report# : [2005002\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Obtain a Pre-Job Briefing Prior to Entry Into a High Radiation Area

A self-revealing NCV was identified for the failure to follow plant procedures for ensuring workers are adequately briefed on radiological conditions and are equipped with required dosimetry, prior to entering a high radiation area. As a result of this failure, two workers entered a high radiation area without knowledge of the radiological conditions. The electronic dosimetry worn by one of the workers alarmed when elevated dose rates were encountered. A NCV of Technical Specification 6.8.1 was identified for the failure to comply with the radiation protection procedure that governs the control of access into high radiation areas. Corrective actions taken by the licensee included performance management (coaching) of the involved personnel. The licensee was also considering enhanced administrative measures to ensure workers understand high radiation area access controls and additional physical controls to reduce the potential for future unauthorized high radiation area entries.

The issue was more than minor because it was associated with the Program/Process attribute of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective to ensure adequate protection of worker health and safety from exposure to radiation. The issue represents a finding of very low safety significance because it did not involve ALARA planning or work controls, there was no overexposure or substantial potential for an overexposure given the radiological conditions in the area, nor was the licensee's ability to assess worker dose compromised.

Inspection Report# : [2005005\(pdf\)](#)

Significance:  Dec 17, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Promptly Correct Radiological Survey Maps

A finding of very low safety significance was identified by the inspectors when licensee personnel failed to adequately address repetitive radiological posting errors. The issue was more than minor since it was associated with the Program and Process attribute of the Occupational Radiation Safety cornerstone and adversely affected the cornerstone objective of ensuring the adequate protection of worker health and safety from exposure to radiation.

The finding was of very low safety significance since the issue did not directly impact As Low As Reasonably Achievable (ALARA) planning or work controls, was not associated with an overexposure or a substantial potential for an overexposure, or compromise the licensee's ability to assess dose. As part of the licensee's immediate corrective actions, areas with survey maps which were outdated were immediately updated to reflect the most recent survey results. One Non-Cited Violation of Technical Specification 6.8.1 was identified.

Inspection Report# : [2004014\(pdf\)](#)

Public Radiation Safety

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Develop an Adequate Procedure to Ensure Proper ODCM Implementation During Venting of a Volume Control Tank

The inspectors identified a NCV for the failure to establish adequate written procedure(s) for Offsite Dose Calculation Manual (ODCM) implementation to ensure that the radiological impact from venting the Volume Control Tank (VCT) to the environment was properly assessed prior to the release, and that the release was properly quantified and reported. A NCV of Technical Specification 6.8.1 was identified for the failure to establish adequate procedures for implementation of the ODCM for venting the VCT to the atmosphere. Corrective actions planned by the licensee include the derivation of an offsite dose based bounding condition for determining that the reactor coolant system has been adequately degassed, along with procedural enhancements and instructions. Since a similar VCT venting issue was identified by the licensee in 2003 but not fully evaluated to allow all aspects of the issue to be corrected, the finding also relates to the cross-cutting area of problem identification and resolution (corrective actions).

The issue was more than minor because it was associated with the Program/Process attribute of the Public Radiation Safety Cornerstone and potentially affected the cornerstone objective to ensure adequate protection of the public from exposure to radioactive materials from the release of gaseous effluents. The issue represents a finding of very low safety significance because a dose assessment performed by the licensee

subsequent to the VCT venting determined that 10 CFR 50, Appendix I guidelines and ODCM limits were met and therefore there was minimal actual risk to the public.

Inspection Report# : [2005005\(pdf\)](#)

Physical Protection

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

Miscellaneous

Significance: N/A Dec 17, 2004

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The inspectors concluded that the licensee's corrective action program was adequately identifying, prioritizing, evaluating and resolving problems. The conclusion of inspectors, largely born out in the opinions of the licensee staff who were interviewed, was that the identification of issues was good, but that problem resolution, though improved, needed further improvement. Licensee efforts through a Recovery Plan appeared to have a positive effect on problem resolution and the issues identified by the inspectors were of very low significance. The inspectors also concluded, based on the activities performed, that there was no evidence to support that management did not foster an environment where workers felt free to raise safety issues.

Inspection Report# : [2004014\(pdf\)](#)

Significance: SL-III Jun 04, 2004

Identified By: NRC

Item Type: VIO Violation

Failure to Provide Complete and Accurate Information to the NRC Which Impacted A Licensing Decision.

D. C. Cook management personnel informed NRC Region III by letter dated March 24, 2004, that one senior reactor operator had a pre-existing medical condition (since 1996) that required the presence of another qualified individual (i.e., "no solo") when performing licensed duties and requested a "no solo" license restriction for the individual. The letter from the company physician also described a medication the individual was taking for the medical condition. The medical condition described by the physician was considered a disqualifying condition in accordance with American National Standards Institute/American Nuclear Society (ANSI/ANS)-3.4 - 1983, "American National Standard Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants." On December 28, 1999, the licensee provided information to the NRC regarding the medical status of the same individual applying for a renewal of the individual's senior reactor operator license with no recommendation for a "no solo" license. The individual's license was renewed by the NRC on February 1, 2000, based on the information provided by the licensee on December 28, 1999. Again, the medical condition was considered a disqualifying condition in accordance with ANSI/ANS-3.4 - 1983, and should have been reported to the NRC on NRC Form 396 for the renewal of the applicant's license requesting a "no solo" restriction on the individual's license. Therefore, the information provided to the NRC on December 28, 1999, was material to the NRC licensing action. [Note: The information concerning the individual's specific medical condition is considered medical privacy information under 10 CFR 2.390(2)(6) and is not specifically discussed here.]

As noted above, Region III received a letter from the D. C. Cook Nuclear Power Plant dated March 24, 2004, requesting a "no solo" license restriction for the individual. Region III received another letter from the D. C. Cook Nuclear Power Plant dated May 20, 2004, notifying the NRC that the recommendation of the "no solo" license condition for the individual not be implemented. The letter stated that upon further review of the individual's medical records, the company physician determined that the individual met ANSI/ANS-3.4 - 1983 to work as an operator in a multi-person facility; therefore, no license condition for solo operation was required. The NRC's medical officer again determined on May 26, 2004, that the operator required a "no solo" restriction to the operator's license. Since NRC intervention was required to identify the requirement for the operator to have a "no solo" restriction, this apparent violation was considered NRC identified.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. The finding was determined to be of low safety significance because the operator had not acted in a solo capacity prior to the license being amended. However, the regulatory significance was important because the incorrect information was provided under a signed statement to the NRC and impacted a licensing decision for the individual. The issue was preliminarily determined to be an apparent violation of 10 CFR 50.9.

AV Closed. Notice of Violation Issued September 29, 2004.

Inspection Report# : [2005004\(pdf\)](#)

Inspection Report# : [2004007\(pdf\)](#)

Last modified : November 30, 2005