

# Duane Arnold

## 2Q/2007 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 30, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

#### **OPERATORS FAILED TO CONTROL A CRITICAL PARAMETER AND RECEIVED A SUBSEQUENT AUTOMATIC SCRAM SIGNAL.**

A finding of very low safety significance was self-revealed regarding the failure of the control room crew to establish control of a critical parameter, Reactor Pressure Vessel (RPV) level, in a timely manner during the feedwater recovery efforts following the manual scram initiated due to the loss of the 1A2 bus and the associated loss of the 'B' Reactor Feed Pump (RFP) and 'B' Condensate Pump. This resulted in a second automatic reactor protection system (RPS) actuation on low RPV level. The inspectors determined that the failure to ensure positive control of RPV level to preclude receiving an automatic protective system actuation was a performance deficiency warranting further evaluation. The licensee subsequently restored feedwater flow, completed the reactor shutdown, and entered this issue into their corrective action program. This finding did not result in a violation of NRC requirements.

The finding was more than minor because it adversely impacted the initiating events cornerstone attribute for human performance which limits the likelihood of events that upset plant stability and challenge critical safety functions. Although the crew's actions resulted in an automatic RPS actuation, the finding was determined to be of very low safety significance since it did not impact any mitigating systems capability. Additionally, no violations of NRC requirements occurred.

Inspection Report# : [2007003](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

#### **FAILURE TO PERFORM QUALIFIED UT REACTOR VESSEL SHELL WELDS.**

The inspectors identified a Non-Cited Violation (NCV) of 10 CFR 50.55a(g)4 for failure to complete a Code qualified volumetric examination of the reactor vessel shell welds during the previous refueling outage No.19. Specifically, the licensee used a longer cable length than that used in the ultrasonic examination procedure demonstration, which may have affected the flaw detection capability. On February 19, 2007, the licensee submitted a relief request to allow deferral of the affected reactor vessel weld examinations until the next refueling outage. The cause of this finding was related to the work practices component of the human performance cross-cutting area because the licensee failed to ensure adequate oversight of vendor activities with respect to review of the vendor's procedure for examination of reactor vessel welds. Specifically, the licensee approved procedure ISwT-PDI-AUT1, "Automated Inside Surface Ultrasonic Examination of Ferritic Vessel Wall Greater Than 4.0 Inches in Thickness," without adequately understanding and challenging the vendor's basis for changing essential procedure variables.

This finding was of more than minor significance because the finding could be reasonably viewed as a precursor to a significant event involving the ability to detect weld flaws prior to weld failure. In addition, the finding was associated with the Initiating Events cornerstone attribute of "Equipment Performance," and 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. Absent NRC intervention, the licensee would have relied on an unqualified ultrasonic examination of reactor vessel shell welds for an indefinite period of service, which may have placed reactor coolant pressure boundary welds at increased risk for undetected cracking, leakage, or component failure. Based on review of industry operational experience, the inspectors did not identify any active degradation mechanisms which affect reactor vessel shell welds. Absent active degradation mechanisms, the inspectors concluded that a structurally significant flaw had not likely developed since completion of the last Code qualified vessel weld ultrasonic examination during the second Code interval (i.e., about 11 years earlier). Therefore, based upon NRC management

review using qualitative measures of risk in accordance with Appendix M of Inspection Manual Chapter 609, the NRC determined that this finding was of very low safety significance.

Inspection Report# : [2007002](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

### **UNQUALIFIED MAIN STEAM SAFETY RELIEF VALVE WELD REPAIR.**

The inspectors identified a NCV of 10 CFR 50.55a(g)4 for failure to complete Code qualified weld repairs for the main steam safety relief valve PSV-4401. Specifically, the weld procedures for this repair were not qualified by performing tensile and guided bend tests intended to demonstrate that the weld procedure produced welds with satisfactory strength and ductility for the intended service. Without these tests, the inspectors were concerned that these non-Code conforming weld repairs affecting the pressure boundary (valve body) could lead to cracking and failure of PSV-4401 valve body or bellows when this valve was placed in service. The licensee determined that this issue affected the structural integrity of the safety relief valve (SRV) pilot bellows and could cause the SRVs to not operate in an overpressure condition and declared all of the relief valves inoperable and entered this issue into the corrective action program. The cause of this finding was related to the work practices component of the human performance cross-cutting area because the licensee failed to ensure adequate oversight of vendor activities with respect to review of the vendor's weld procedures for repair of reactor coolant pressure boundary retaining components (PSV-4401). Specifically, during review of vendor procedures 889C W-6d and 889C W-1, the licensee did not demonstrate adequate understanding of Code requirements and/or did not sufficiently challenge the vendor's basis for not performing weld procedure qualification tests.

This finding was of more than minor significance because the finding could be reasonably viewed as a precursor to a significant event involving the failure of repair welds from weld flaws introduced by use of an unqualified welding process. In addition, the finding was associated with the Initiating Events cornerstone attribute of "Equipment Performance," and 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. Absent NRC intervention, the licensee would have relied on unqualified weld repairs on PSV-4401 for an indefinite period of service, which may have placed the reactor coolant pressure boundary at increased risk for weld failure resulting in leakage, or an inoperable relief valve. The NRC evaluated this finding in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for the At-Power Situation," and because this issue was identified prior to repressurizing the plant, determined that this finding was of very low safety significance.

Inspection Report# : [2007002](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **UNPLANNED REACTOR PROTECTION SYSTEM AUTOMATIC SCRAM DUE TO INADEQUATE PROCEDURE.**

A finding of very low safety significance and an associated NCV of 10 CFR 50, Appendix B, Criterion 5, was self-revealed when an unplanned RPS reactor scram occurred during surveillance testing due to a scram discharge volume (SDV) high level. On March 2, 2007, with the reactor shutdown for a planned refuel outage, operators were performing surveillance testing to verify the backup scram valves ported air when a scram occurs. After inserting a manual scram and verifying that the backup scram valves ported air, the operators reset the scram. A short time later an unanticipated automatic scram was inserted due to a SDV high level. The operators bypassed the SDV high level scram and reset the scram. Corrective Action Process document (CAP) 048038 was entered into the licensee's corrective action program to document the automatic scram.

This issue was more than minor because it directly affects the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. Specifically, the Human Performance attribute as well as the configuration control attribute for controlling the shutdown equipment lineup. The NRC evaluated this finding in accordance with IMC 0609, Appendix G, "Shutdown Operation Significance Determination Process," and the finding was determined to be of very low safety significance because it did not impact any of the 5 shutdown safety functions identified. The inspectors also determined that the cause of this finding was related to the work practices component of the human performance cross-cutting area

because operations personnel failed to communicate human error prevention techniques, such as holding pre-job briefings, self and peer checking, and proper documentation of activities during performance of the surveillance testing.

Inspection Report# : [2007002](#) (*pdf*)

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## Mitigating Systems

**Significance:**  Jun 30, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **LIFTING OF HPCI DISCHARGE RELIEF VALVE DURING PLANNED SURVEILLANCE TESTING.**

A finding of very low safety significance and an associated Non-Cited Violation (NCV) of 10 CFR 50 Appendix B, Criterion 3, was self-revealed when PSV2302, the HPCI discharge pressure relief valve, stuck open during planned testing of the High Pressure Coolant Injection (HPCI) System. The inspectors determined that the failure to provide sufficient margin between the HPCI discharge relief valve setpoint and the peak discharge pressure of the HPCI system upon startup was a performance deficiency warranting further evaluation. The licensee completed a temporary modification to remove the HPCI keep-fill modification and the HPCI system was returned to operable status.

The finding was determined to be more than minor because the engineering calculation error resulted in a condition where there was a reasonable doubt on the operability of the HPCI system. This issue screened as having a very low safety significance since the finding is a design deficiency confirmed not to result in a loss of operability per the part 9900 technical guidance for operability determination process for operability and functional assessment. This issue was also related to the decision making component of the human performance cross-cutting area, because engineering personnel failed to conduct an effective review of the safety-significant HPCI keep-fill modification and identify that the relief valve setpoint did not provide sufficient margin to prevent an unintended consequence. Specifically, the lifting of the relief valve due to the peak HPCI system discharge pressure seen during system startup.

Inspection Report# : [2007003](#) (*pdf*)

**Significance:**  Jun 30, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **TS ALLOWED OUTAGE TIME EXCEEDED FOR INOPERABLE EDGs.**

A finding of very low safety significance and an associated NCV of Technical Specification (TS) 3.8.1.b, Electrical Power Systems, AC Sources-Operating, was self-revealed when a leak was discovered coming from the lube oil filter (LOF) cover on the 'B' Emergency Diesel Generator (EDG) during surveillance testing. The leak rate was approximately 0.21 gallons per minute, and the licensee determined that the 'B' EDG would not have been capable of performing its 7-day unassisted operation design requirement. The licensee declared the 'B' EDG inoperable, entered the issue into their corrective action program, and initiated a work order to repair the oil leak. During the licensee's investigation, the apparent cause of the LOF leak was the installation of the wrong oil filter cover o-ring while performing the liner replacement maintenance during the recent refueling outage conducted by the vendor six weeks prior.

The finding was determined to be more than minor because the 'B' EDG was returned to service with the incorrect o-ring installed and the leak that developed resulted in subsequent equipment inoperability. Additionally, based upon the licensee's past operability evaluation, the TS limiting condition for operation (LCO) allowed outage time for one EDG inoperable with the plant at power was exceeded. Since this issue was not a design or qualification deficiency, did not result in a loss of safety function, and was not considered potentially risk significant to a seismic, flooding, or severe weather initiating event, the issue screened as having a very low safety significance. This issue was also related to the work practices component of the human performance cross-cutting area, because maintenance personnel failed to ensure supervisory and management oversight of work activities, including contractors, supported nuclear safety. Specifically, the personnel performing maintenance activities for reassembly of the LOF were not supervised, an incorrect LOF cover o-ring was installed, and the equipment was subsequently returned to service.

Inspection Report# : [2007003](#) (*pdf*)

**Significance:** SL-IV Jun 30, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION TO THE NRC ON NRC FORM 396.**

The inspectors identified a Level IV NCV of 10 CFR 50.9, "Completeness and Accuracy of Information." The inspectors identified that the facility licensee, on March 30, 2007, submitted to the NRC, an NRC Form 396, "Certification of Medical Examination By Facility Licensee," for a licensed operator applying for renewal of his reactor operator license, that was not complete and accurate in all material respects. Specifically, the NRC Form 396 certified that the licensed operator was not required to have a "corrective lens" restriction on his license. When the NRC questioned the licensee on the accuracy of the most recent biennial medical examination on the submitted NRC Form 396, the licensee submitted a revised NRC Form 396 on April 19, 2007. The revised NRC Form 396 included a new date for the most recent biennial medical examination, but also showed that the licensed individual was required to have a "corrective lens" restriction added to his license. This information was material to the NRC because the NRC relies on this certification to determine whether an applicant meets the requirements to operate the controls of a nuclear power plant pursuant to 10 CFR Part 55.

The finding was determined to be more than minor because the information associated with the license renewal of the individual was provided to the NRC under a signed statement by the Site Vice President and could have impacted an NRC licensing decision. The licensed operator could have been, without NRC intervention, issued a license without a "corrective lens" restriction added to his license. The finding was determined to be of low safety significance because the license renewal application for the reactor operator was not renewed until complete and accurate information was received on a revised NRC Form 396 that showed a "corrective lens" restriction for the licensed individual.

Inspection Report# : [2007003](#) (*pdf*)



**Significance:** G Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO TAKE PROMPT CORRECTIVE ACTION TO CORRECT AN OPERABLE BUT NONCONFORMING CONDITION ON THE EMERGENCY DIESEL GENERATORS.**

A finding of very low safety significance and an associated NCV of 10 CFR 50, Appendix B, Criterion 16, was identified by the inspectors for failure to take prompt corrective action to repair an operable but nonconforming condition on the 'A' and 'B' Emergency Diesel Generators (EDGs). On December 7, 2005, engineering personnel identified that during testing to simulate a Loss of Offsite Power concurrent with a Loss of Coolant Accident (LOOP/LOCA), the output voltage of the EDGs momentarily dropped below 75 percent of nominal voltage during the loading sequence of the EDG. The Updated Final Safety Analysis Report (UFSAR) states that the output voltage of the EDG shall not drop below 75 percent of nominal with the exception of the initial loading. The licensee failed to correct the nonconforming condition on the EDGs during the first available opportunity, which was the refueling outage that occurred in the first quarter of 2007. The failure to correct the nonconforming condition was entered into the licensee's corrective action program as CAP 047955.

This issue is more than minor because it directly impacts the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The NRC evaluated this finding using IMC 0609 Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations." The finding was determined to be of very low safety significance since the finding is a design deficiency confirmed not to result in a loss of operability per part 9900 technical guidance for the operability determination process for operability and functional assessment.

Inspection Report# : [2007002](#) (*pdf*)



**Significance:** G Feb 11, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

**Recorded Pressure above Design Limits Not Entered into Corrective Action System**

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action" having very low safety significance (Green). Specifically, the licensee failed to identify and correct a condition adverse to quality regarding a pressure significantly over the design value recorded on a high pressure coolant

injection system vent line during a surveillance test on February 11, 2006 until prompted by the NRC. As corrective actions, the licensee performed calculations to assess the issue. The primary cause of this violation was related to the cross-cutting area of human performance because the licensee failed to use a systematic process when faced with an unexpected plant condition during a special test.

This issue was more than minor because the finding was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the reliability of systems that respond to initiating events. Specifically, the pressure pulse exceeded the design pressure rating of the piping. Without evaluation, the licensee could not ensure the availability and reliability of the over-stressed vent piping to withstand normal operation. The issue was of very low safety significance based on a Phase 1 screening in accordance with IMC 0609, Appendix A.

Inspection Report# : [2006008](#) (*pdf*)

**Significance:**  Feb 11, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

### **Non-conservative Analysis Methodology**

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance (Green). Specifically, the licensee's calculation to show that the existing feedwater piping system configuration met the acceptance criteria of ASME Boiler and Pressure Vessel Code, Section III, Appendix F used a method of analysis that did not evaluate the dynamic effect of impact forces as specified by the design basis piping code, ANSI B31.1, "Power Piping." As corrective actions, the licensee performed calculations to assess the issue. The primary cause of this violation was related to the cross-cutting area of human performance because the licensee did not have adequate guidance on how to evaluate the dynamic effect of impact for variable spring hanger determined to exceed their available seismic travel.

The inspectors concluded that the finding was greater than minor because it affected the Mitigating Systems Cornerstone attribute of design control, and if left uncorrected, the finding could become a more significant safety concern. Specifically, the failure to evaluate the dynamic effect of impact as required by the ANSI B31.1 design basis code in similar operability calculations could result in exceeding the ASME Section III, Appendix F acceptance limits used to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The issue was of very low safety significance based on a Phase 1 screening in accordance with IMC 0609, Appendix A.

Inspection Report# : [2006008](#) (*pdf*)

**Significance:**  Dec 31, 2006

Identified By: NRC

Item Type: FIN Finding

### **CREW PERFORMANCE ON THE DYNAMIC SCENARIO PORTION OF THE 2006 FACILITY-ADMINISTERED ANNUAL REQUALIFICATION EXAMINATION OPERATING TEST.**

A finding of very low safety significance was identified. The finding was associated with unsatisfactory operating crew performance on the simulator during facility-administered licensed annual operator requalification examinations. Of the ten crews evaluated, two did not pass their annual operating tests. The finding is of very low safety significance because the failures occurred during testing of the operators on the simulator, because there were no actual consequences to the failures, and because the crews were removed from watch-standing duties, retrained, and re-evaluated before they were authorized to return to control room watches. This issue was documented in the licensee's corrective action process (CAP) as CAP 044379.

Inspection Report# : [2006005](#) (*pdf*)

**Significance:**  Jun 07, 2005

Identified By: NRC

Item Type: VIO Violation

### **Failure to Demonstrate Adequacy of Design Assumption for Torus Attached Piping**

A violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" having very low safety significance was

identified by the inspector. Specifically, the licensee failed to demonstrate that a 1996 high pressure coolant injection (HPCI) modification was subjected to design control measures commensurate with those applied to the original design. The licensee also failed to apply design control measures to verify the adequacy of the design in order to assure that the design basis for torus attached piping was correctly translated into the modification's specifications, drawings, procedures and instructions.

The finding was more than minor because the finding was associated with the cornerstone attribute of design control in the mitigating system cornerstone and the finding was determined to affect the associated cornerstone objective of ensuring the availability of the HPCI system when called upon. Under the worst case scenario, movement of the torus with the additional valve weight on the HPCI turbine exhaust line would result in crimping of the line. Crimping of the line would create additional backpressure in the HPCI turbine and would result in a decrease in the amount of water being injected into the reactor vessel. The finding was determined to be of very low safety significance based upon a Phase 2 analysis of those transients which would involve movement of the torus.

The finding was cited since the licensee did not enter the issue into its corrective action program and did not take actions to correct the noncompliance.

Inspection Report# : [2005010](#) (*pdf*)

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## Barrier Integrity

**Significance:**  Jun 30, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO IMPLEMENT THE APPROPRIATE PROCEDURAL CONTROLS PRIOR TO USING NYLON ROPE TO SECURE UNDERWATER LIGHTS IN THE SPENT FUEL POOL.**

The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR 50 Appendix B, Criterion 5, when licensee staff failed to implement the appropriate controls to properly store underwater lights in the spent fuel pool. The licensee entered the issue into the corrective action program for resolution. This issue was also related to the work practices component of the human performance cross-cutting area. Specifically, the aspect related to procedural compliance, as the station procedure that described the appropriate controls for storing items in the pool, was not followed.

The finding was determined to be more than minor because the finding could be reasonably viewed as a precursor to a more significant event. Specifically, the failure to follow the approved process for controlling the use of nylon ropes in the spent fuel pool could result in the ropes being in place for an extended period of time. This increased the potential for unplanned radiation exposure either due to wicking or from damage to the underlying fuel assemblies, if the ropes degraded causing the lights to fall. The finding was considered to be of very low safety significance since it was determined to affect only the fuel cladding function of the Barrier Cornerstone.

Inspection Report# : [2007003](#) (*pdf*)

**Significance:**  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO INCLUDE ACCEPTANCE CRITERIA IN TROUBLESHOOTING INSTRUCTION FORM FOR CONTROL BUILDING STANDBY FILTER UNIT TESTING.**

A finding of very low safety significance and an associated NCV of 10 CFR 50, Appendix B, Criterion 5, was identified by the inspectors when engineering and operations personnel failed to include acceptance criteria in a Troubleshooting Instruction Form (TIF). On February 12, 2007, engineering and operations personnel completed a TIF to determine the effects upon the control building envelope of open penetrations between the cable spreading room and the turbine building. The TIF failed to include acceptance criteria to identify whether the Standby Filter Units (SFUs) were being left in an operable condition at the completion of the troubleshooting activity. At the completion of the TIF, operations personnel failed to immediately identify that the as-left control building static pressure was less than the Technical Specification (TS) required limit of > 0.1 inches water gauge relative to the

outside atmosphere. When the Shift Manager later identified that the TS requirement was not met, core alterations and fuel moves were secured and the issue was entered into the licensee's corrective action program as CAP 047315.

This issue was more than minor because it directly impacts the barrier integrity cornerstone objective to provide reasonable assurance that physical barriers (containment) protect the public from radio nuclide release caused by accident and events. The NRC evaluated this finding in accordance with IMC 0609, Appendix G, "Shutdown Operation Significance Determination Process," and the finding was determined to be of very low safety significance because it did not require a phase 2 quantitative assessment. The inspectors also determined that the cause of this finding was related to the work control component of the human performance cross-cutting area because engineering and operations personnel failed to appropriately coordinate work activities by communicating, coordinating, and cooperating with each other during activities in which interdepartmental coordination is necessary to assure plant and human performance.

Inspection Report# : [2007002](#) (*pdf*)

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## Emergency Preparedness

**Significance:** **W** Dec 05, 2006

Identified By: NRC

Item Type: VIO Violation

### **Failure of the licensee's exercise critique process**

The inspectors identified a finding when the licensee's critique presented to the NRC on October 19, 2006, failed to properly identify a weakness that was associated with a risk significant planning standard.

The finding was more than minor because it was associated with the Emergency Preparedness Cornerstone and affected the cornerstone objective of ensuring that the licensee was capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Specifically, the licensee's critique did not identify a performance weakness associated with a failure to recognize an emergency action level entry condition. Additionally, the critique failed to adequately identify a weakness that demonstrated a level of performance that could preclude effective implementation of the Emergency Plan in an actual emergency. This finding potentially has low to moderate safety significance (White) because the licensee's exercise critique failed to identify a weakness that is associated with a RSPS.

After considering the information developed during the inspection, the information presented at the Regulatory Conference on March 1, 2007, and the additional information you provided in your apparent cause evaluation dated December 21, 2006, the NRC has concluded that the inspection finding was appropriately characterized as White, an issue with low to moderate increased importance to safety, which may require additional NRC inspections.

Inspection Report# : [2006009](#) (*pdf*)

Inspection Report# : [2007501](#) (*pdf*)

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## Occupational Radiation Safety

**Significance:** **G** Mar 31, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **WORKERS INAPPROPRIATELY ENTERED A HIGH RADIATION AREA.**

A self-revealed finding of very low safety significance and an associated NCV of TS 5.7.1 were identified for the failure to satisfy TS requirements for worker access into a high radiation area with dose rates in accessible areas between 100 and 1000 mrem/hour at 30 centimeters. Workers entered the reactor building 716' Northwest Corner Room (NWCR) which was posted as a high radiation area (HRA), without adequate recognition of the area radiological conditions and without positive radiological control over the activities within the area. The electronic dosimetry (ED) worn by one of the workers alarmed when significantly higher than expected dose rates were

encountered.

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 As-Low-As-Is-Reasonably-Achievable (ALARA) planning or work controls, there was no overexposure, nor did a substantial potential for an overexposure exist given the radiological conditions in the area and the workers response to the ED alarm. Also, the licensee's ability to assess worker dose was not compromised. Corrective actions taken by the licensee included reminding radiation protection staff to better coordinate entries into these areas with operations staff, and plans to reevaluate the radiation protection department practices for entry into high radiation areas, and in general for entry into high radiation areas with the potential for significant dose rate gradients. A cross-cutting aspect in the area of human performance was associated with this finding in the work practices component. Inspection Report# : [2007002](#) (*pdf*)

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## Public Radiation Safety

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

Last modified : August 24, 2007