

Perry 1

1Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

INEFFECTIVE CORRECTIVE ACTIONS ASSOCIATED WITH THE MOTOR FEEDWATER PUMP IN 10 CFR 50.65(a)(1) STATUS

A finding of very low safety significance and associated NCV of 10 CFR 50.65(a)(1) was identified by the inspectors for the licensee's failure to take reasonable corrective action to avoid recurrence of unavailability of a component in accordance with the maintenance rule. The inspectors determined that the licensee failed to implement the corrective action identified by the expert review panel, after the motor feedwater pump (MFP) did not meet licensee established goals. Specifically, the licensee failed to continuously run a purifier on the MFP lube oil sump to ensure the MFP was capable of fulfilling its intended function. On August 2, 2008, the portable lube oil purifier failed and the licensee did not connect a readily available purifier until after water intrusion into the oil rendered the MFP unavailable on August 7, 2008, and the plant entered YELLOW probabilistic safety assessment (PSA) risk. The licensee entered this issue into their corrective action program, attached the available lube oil purifier to restore the MFP, and purchased an additional lube oil purifier to ensure the plant would continue to implement the program's corrective action to avoid further MFP unavailability.

The finding was determined to be more than minor because 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 plant operations. Specifically, the failure to implement a corrective action challenged the availability of a risk-significant component with a known degraded equipment problem and placed the plant in unplanned YELLOW PSA risk. The primary cause of this finding was related to the cross-cutting area of Problem Identification and Resolution per IMC 0305 P.1(c) because the organization failed to properly prioritize the purification system repair. The inspectors determined that the finding was of very low safety significance following an SDP review.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE INSPECTIONS ON THE RPV HEAD STRONGBACK LIFTING DEVICE MAJOR LOAD-CARRYING WELDS AND CRITICAL AREAS

The inspectors identified a finding of very low safety significance and an NCV of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control." The inspectors determined that the licensee failed to perform required nondestructive testing on the reactor pressure vessel (RPV) head strongback. Specifically, on February 25, 2009, the licensee failed to conduct a complete nondestructive examination (NDE) of a structural weld associated with the strongback lifting device. As part of their corrective actions, the licensee entered the issue into its corrective action program and performed a functionality assessment of the RPV head strongback, prior to lifting the RPV head, to assure that the strongback could perform its design function.

The finding was determined to be more than minor because 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 operations. Specifically, the purpose of the NDE testing of RPV head strongback major load carrying welds and critical areas is to limit the likelihood of an RPV head strongback structural component failure, and hence, to assure safe load handling of heavy

loads over the reactor core or over safety-related systems. The inspectors determined that the finding was of very low safety significance following a qualitative SDP review. The primary cause of this finding was related to the cross-cutting area of Problem Identification and Resolution per IMC 0305 P.1(c), because the licensee failed to thoroughly evaluate corrective actions to ensure they appropriately addressed the identified issue.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

LOSS OF SERVICE AIRE TO MAIN STEAM LINE PLUGS

A finding of very low safety significance and associated NCV of Technical Specification Section 5.4.1 was self-revealed on March 7, 2009, when main steam line plug seal pressure began to drop unexpectedly while the reactor cavity was flooded for refueling operations. Operators failed to conduct an adequate shift turnover regarding the configuration of service air isolation valves to containment affecting the main steam line plugs and subsequently isolated the air supply to the plug seals. As part of their immediate corrective actions, licensee personnel restored air to the main steam line plug seals and entered the issue into their corrective action program.

The finding was determined to be more than minor because the finding was associated with the Initiating Events cornerstone attribute of configuration control and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. Specifically, loss of air pressure to main steam line seals increased the likelihood of a loss of reactor water inventory event during refueling operations. The finding was determined to be of very low safety significance following a Phase II SDP review. This finding has a cross-cutting aspect in the area of Human Performance, work control, per IMC 0305 H.3(b) because the licensee did not appropriately coordinate work activities associated with service air system testing.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

MAINTENANCE ON HPCS SYSTEM RESULTED IN EMERGENCY OPERATING PROCEDURE ENTRY

A finding of very low safety significance and associated NCV of Technical Specification Section 5.4.1 was self-revealed on February 3, 2009, when the control room received an unexpected high pressure core spray (HPCS) pump room sump level high alarm and entered Emergency Operating Procedure (EOP) – 3, "Secondary Containment Control." The licensee did not properly control a maintenance activity on the HPCS system resulting in unexpected water spray in the HPCS pump room. As part of their immediate corrective actions, licensee personnel recovered from the drain down of the system and entered the issue into their corrective action program.

This finding was considered more than minor because it was associated with the human performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability. The event challenged shutdown operations as operators entered the EOP and responded to reports of significant water spray entering the pump room. The finding was determined, through an SDP analysis, to be of very low safety significance as no mitigation equipment or functions were affected. The primary cause of this finding was related to the cross-cutting aspect in the area of Human Performance per IMC 0305 H.3(a) because the organization failed to appropriately plan work activities that impact plant structures and systems, and failed to ensure appropriate contingencies were in place to perform a maintenance activity.

Inspection Report# : [2009002](#) (*pdf*)

Significance:  Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

INSPECTION PROCEDURE FOR RPV HEAD STRONGBACK OMITTED NON-DESTRUCTIVE TESTING OF STRUCTURAL WELDS

The inspectors identified a finding of very low safety significance (Green) and an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings." Specifically, the licensee failed to perform nondestructive testing of reactor pressure vessel (RPV) head strongback major load carrying welds and critical areas required by American National Standards Institute (ANSI) N14.6-1978. The issue was entered into the licensee's corrective action program, and the licensee revised a procedure to perform nondestructive testing of RPV head strongback major load carrying welds and critical areas.

The finding was determined to be more than minor because the finding was associated with the Initiating Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown. Specifically, the purpose of the nondestructive testing of RPV head strongback major load carrying welds and critical areas is to limit the likelihood of a RPV head strongback structural component failure, and hence, to ensure safe load handling of heavy loads over the reactor core or over safety-related systems, structures and components. The inspectors determined that the finding was of very low safety significance following a qualitative significance determination process review. The finding has a cross-cutting aspect in the area of human performance as defined in Inspection Manual Chapter 0305 H.2(c), because the licensee did not provide a complete, accurate, and up-to-date procedure to plant personnel.

Inspection Report# : [2008005](#) (*pdf*)

Significance:  Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

CONTAINMENT POLAR CRANE TROLLEY SEISMIC RESTRAINTS DID NOT MEET SEISMIC CATEGORY I REQUIREMENTS

The inspectors identified a finding of very low safety significance (Green) and an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," in that, the design basis structural analysis for the containment polar crane trolley did not adequately evaluate the trolley seismic restraints. Specifically, the trolley seismic restraint calculation failed to ensure that design stresses remained below acceptance limits. Also, the as-built configuration of the trolley seismic restraints was not in accordance with the analyzed condition. As a result, the design basis calculation was not sufficient to ensure conformance with Seismic Category I requirements for safe load handling of heavy loads over the reactor core or over safety-related systems, structures and components. The issues were entered into the licensee's corrective action program. The licensee initiated the revision of the trolley seismic restraint calculation and the restoration of the trolley seismic restraint as-built condition to meet Seismic Category I requirements.

The finding was determined to be more than minor because 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. Specifically, compliance with Seismic Category I design requirements was to ensure safe load handling of heavy loads over the reactor core or over safety-related systems, structures and components. The inspectors determined that the finding was of very low safety significance following a qualitative significance determination process review.

Inspection Report# : [2008005](#) (*pdf*)

Significance:  Sep 30, 2008

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Adequately Manage Risk Associated With Working Around a Risk-Significant Underground Vault

A finding of very low safety significance was self-revealed on July 30, 2008. While performing inspection and dewatering of an underground vault area, plant workers inadvertently dropped a man-hole cover into the vault. The 15-foot vault area contained 125 Volts direct current control power conduits that supplied fault protection circuitry for switchyard breakers. The licensee entered the issue into their corrective action program.

This finding was considered more than minor because it was related to maintenance risk assessment and risk management issues. Specifically, the licensee failed to manage risk for maintenance activities associated with the

electrical switchyard that could increase the likelihood of initiating events by causing a loss of offsite power. The finding was determined through a SDP analysis to be of very low safety significance as no mitigation equipment or functions were affected. This finding had a cross-cutting aspect in the area of Human Performance as defined in IMC 0305 H.4(a), because the organization failed to ensure the use of human error prevention techniques commensurate with the risk of the assigned task. No violation of NRC requirements occurred.

Inspection Report# : [2008004](#) (*pdf*)

Significance:  Sep 30, 2008

Identified By: Self-Revealing

Item Type: FIN Finding

Loss of Configuration Control of the Hydrogen Water Chemistry Injection System Resulting in High Radiation Levels.

A finding of very low safety significance was self-revealed on June 28, 2008, when high radiation alarms for all four main steam lines were received in the control room during a plant power maneuver. Specifically, maintenance technicians failed to adhere to procedures and manipulated a hydrogen water chemistry control system while performing a surveillance test associated with the plant off-gas system. The off-gas system surveillance test procedure did not address operation of the hydrogen water chemistry control system and the technicians were not trained to operate the system. As part of their immediate corrective actions, the licensee corrected the system lineup to reduce radiation levels and entered the issue into their corrective action program.

This finding was considered more than minor because the manipulation of plant systems that are different from those specified in the authorized work procedure would become a more significant safety concern if left uncorrected. In this case, the finding led to an unexpected increase in radiation levels in areas accessible to plant personnel and was associated with the operating equipment lineup of the configuration control attribute of the Initiating Events Cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability. The finding was determined through a SDP analysis to be of very low safety significance as no mitigation equipment or functions were affected and no actual increase in personnel exposure occurred. This finding has a cross-cutting aspect in the area of Human Performance as defined in IMC 0305 H.4(b), because the organization failed to ensure that personnel do not proceed with a task in the face of uncertainty. No violation of NRC requirements occurred.

Inspection Report# : [2008004](#) (*pdf*)

Significance:  Jun 30, 2008

Identified By: NRC

Item Type: FIN Finding

FAILURE TO IDENTIFY A DEGRADED FLOW CONTROL VALVE CONNECTOR

The inspectors identified a finding of very low safety significance for the failure of licensee personnel to adhere to corrective action program procedures. Specifically, during inspection of the linear velocity transducer connector for the 'A' flow control valve actuator, the connector was found in a degraded state, and personnel applied tape to the connector. Licensee personnel did not initiate a condition report to address this condition or to assess operability, and the connector later failed causing reactor flow and power oscillations. The licensee entered the issue of failure to adhere to corrective action program procedures into their corrective action program. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution because the organization failed to properly identify issues related to nuclear safety P.1(a).

This finding was considered more than minor because it was associated with the equipment performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability. The finding was determined through a Significance Determination Process analysis to be of very low safety significance because no mitigation equipment or functions were affected. No violation of NRC requirements occurred.

Inspection Report# : [2008003](#) (*pdf*)

Mitigating Systems

Significance: SL-IV Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO REPORT ALL 10 CFR 50.73 REPORTABLE EVENTS ASSOCIATED WITH THE DISCOVERY OF LOOSE CONTAINMENT GRATING

The inspectors identified a non-cited violation of 10 CFR 50.73(a)(1), "Licensee Event Reports." The inspectors determined that the licensee failed to submit a required Licensee Event Report (LER) within 60 days after discovery of conditions requiring a report. On August 26, 2007, the licensee identified improperly installed containment floor grating that affected safety system operability. The licensee failed to report conditions of operations prohibited by Technical Specification, operations in an unanalyzed condition, and loss of safety function from August 6 to August 9, 2007, that were associated with inoperability of low pressure core injection 'A.' The licensee entered this issue into their corrective action program.

The primary cause of this non-cited violation was related to the cross-cutting area of problem identification and resolution as defined in Inspection Manual Chapter 0305 P.1(c) because the licensee failed to thoroughly evaluate problems for reportability conditions.

Inspection Report# : [2008005](#) (pdf)

Significance:  Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Impaired Fire Barrier for Safety-Related Building

The inspectors identified a finding of very low safety significance and an associated NCV of the Perry Nuclear Power Plant Operating License Condition C(6). During a maintenance activity, licensee personnel degraded a fire barrier in a manner that was contrary to the procedural requirements of the Perry Plant Fire Protection Program. As part of their immediate corrective action, the licensee restored the fire barrier and entered the issue into their corrective action program.

The inspectors determined that the performance deficiency was more than minor in accordance with IMC 0612, Appendix B, "Issue Disposition Screening," because the finding was associated with protection against external factors 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. Specifically, by the inappropriate use of fixed impairments on the fire doors between the diesel fire pump room and the emergency service water pumphouse, the licensee removed a fire barrier which could impact safety-related equipment. The finding was determined to be of very low safety significance during a Phase 2 SDP review. This finding has a cross-cutting aspect in the area of Human Performance as defined by IMC 0305 H.4(a), because the licensee did not ensure that appropriate human error prevention techniques were used.

Inspection Report# : [2008004](#) (pdf)

Significance:  Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Compensatory Measures for a Risk-Management Activity

The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR 50.65(a)(4) for failure to assess and manage the risk associated with maintenance activity affecting the low pressure core spray system. Specifically, the licensee removed floor plugs in the auxiliary building and failed to implement risk control measures to assure operability of low pressure core spray. As part of their immediate corrective actions, the licensee personnel re-installed building floor plugs and returned low pressure core spray to an operable status.

The finding was considered more than minor because the licensee failed to prescribe significant compensatory measures for external conditions; and if the practice were left uncorrected, the issue would become a more significant safety concern. The finding was of very low safety significance because the incremental core damage frequency associated with the activity was less than 1×10^{-6} . This finding has a cross-cutting aspect in the area of Human Performance as defined in IMC 0305 H.3(a), because the organization failed to adequately plan work activities that are associated with risk.

Inspection Report# : [2008004](#) (pdf)

Significance:  Sep 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement a Procedurally-Required Risk management Activity for a Protected Train

The inspectors identified a finding of very low safety significance and a NCV of 10 CFR 50.65(a)(4) for failure to implement a procedurally-required risk management activity for a safety system protected train. The licensee failed to provide required management oversight of work on emergency closed cooling 'A' while the plant was in Yellow Risk. The licensee entered the issue into their corrective action program.

The finding was considered more than minor because the licensee failed to effectively manage significant compensatory measures for an elevated risk condition; and if the practice were left uncorrected, the issue would become a more significant safety concern. The finding was of very low safety significance, because the incremental core damage frequency associated with the activity was less than 1×10^{-6} . This finding has a cross-cutting aspect in the area of Human Performance as defined by IMC 0305 H.3(a), because the organization failed to adequately plan work activities that are associated with risk.

Inspection Report# : [2008004](#) (pdf)

Significance:  Sep 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Use procedures for Work Affecting Safety

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed on August 4, 2008, when contract workers bored a hole into a safety-related structure in an inappropriate location. The workers did not use documented instructions, procedures, or drawings when performing the work. As part of their immediate corrective actions, the licensee conducted worker training and entered the issue into their corrective action program.

The finding was determined to be more than minor because the finding was associated with the design control attribute of 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. Specifically, the licensee initiated work on a seismically qualified structure in the absence of an approved work package and degraded the structure. The finding was determined to be of very low safety significance because it did not result in safety system inoperability. This finding had a cross-cutting aspect in the area of Human Performance as defined by IMC 0305 H.4.(a), because the licensee failed to communicate human error prevention techniques through a pre-job brief and personnel proceeded in the face of unexpected circumstances.

Inspection Report# : [2008004](#) (pdf)

Significance:  Jun 06, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILED TO PERFORM AN ADEQUATE DESIGN REVIEW FOR EXPECTED CONDITIONS OF THE OFFSITE POWER SUPPLY IN DETERMINING DESIGN INPUTS FOR EVALUATING THE EFFECTS OF OFFSITE VOLTAGE

• Green. A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III,

“Design Control,” was identified by the inspectors for the failure to ensure that the design limits in electrical calculations bound expected operational values. Specifically, the licensee failed to perform an adequate design review for expected conditions of the offsite power supply in determining design inputs for evaluating the effects of offsite voltage on plant equipment and to ensure that proper design control was maintained. During the inspection, the licensee evaluated the conditions and determined that the higher than analyzed offsite power system voltage did not have an impact on the operability of plant equipment. The cause of the finding is related to the cross-cutting area of Problem Identification and Resolution, specifically with respect to Corrective Action Program, because the licensee failed to evaluate and determine the extent of condition of the voltage in the offsite power supply. P.1(c) (Section 1R21.3.b(1))

Inspection Report# : [2008006](#) (*pdf*)

G

Significance: Jun 06, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENSURE THAT EQUIPMENT INSTALLED IN THE PLANT WAS IN ACCORDANCE WITH THE DESIGN DOCUMENTATION

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” was identified by the inspectors for the failure to ensure that equipment installed in the plant was in accordance with the design documentation. The inspectors identified several examples of equipment installed in the plant with electrical characteristics that varied from the design documentation. These conditions were subsequently evaluated and determined not to affect the operability of the equipment. This finding has a cross-cutting aspect in the area of Human Performance, Resources because the licensee did not ensure that personnel, equipment, procedures, and other resources are available and adequate to assure nuclear safety. H.2(c) (Section 1R21.3.b(2))

Inspection Report# : [2008006](#) (*pdf*)

G

Significance: Jun 06, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY AND CORRECT ERRORS AND DISCREPANCIES IN SEISMIC QUALIFICATION DOCUMENTS FOR THE STANDBY LIQUID CONTROL (SLC) STORAGE TANK

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” was identified by the inspectors for the failure to identify and correct errors and discrepancies in seismic qualification documents for the Standby Liquid Control (SLC) storage tank. Subsequent licensee evaluation indicated that stresses in the critical SLC tank components will remain within the acceptance limits. This finding does not have a cross-cutting aspect because it is not indicative of current performance. (Section 1R21.3.b(3))

Inspection Report# : [2008006](#) (*pdf*)

G

Significance: Jun 06, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO TEST REACTOR PROTECTION SYSTEM KEY LOCKED BYPASS SWITCHES

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion XI, “Test Control,” was identified by the inspectors for the failure to test reactor protection system key locked bypass switches. The licensee entered this issue into its corrective action program and initiated procedural changes to require periodic testing of the RPS bypass switches. This finding does not have a cross-cutting aspect because it is not indicative of current performance. (Section 1R21.5.b(1))

Inspection Report# : [2008006](#) (*pdf*)

Significance:  Jan 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADHERE TO PROCEDURES FOR SCAFFOLD AFFECTING CONTAINMENT SYSTEMS

A finding of very low safety significance and associated non-cited violation of Technical Specification 5.4, "Procedures," was identified by the team for the failure to erect scaffolding in accordance with procedural requirements. Specifically, scaffold constructed in the Intermediate Building had seismic bracing attached to a safety related cable tray support and was connected to a duct support without an approved engineering document as specified in procedural requirements.

Although the licensee was able to demonstrate that the cable tray support and duct support were operable, the finding was determined to be more than minor because there was reasonable doubt that the licensee routinely performed engineering evaluations on similar scaffold issues. The finding was determined to be of very low safety significance because it did not represent an actual open pathway in the physical integrity of reactor containment. This finding had a cross-cutting aspect in the area of human performance, work practices, because the licensee failed to ensure supervisory and management oversight of work activities such that nuclear safety is supported. Specifically, the licensee failed to provide effective oversight of the erected seismic scaffold to ensure compliance with procedural requirements [H.4(c)].

Inspection Report# : [2009006](#) (*pdf*)

Significance:  Sep 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Adequacy of Airlock Ball Valve Maintenance

A self-revealed finding of very low safety significance and an associated NCV of 10 CFR Part 50 Appendix B, Criterion 5 , "Procedures," was identified on June 1, 2008, when a containment airlock door seal failed during routine operations. On March 26, 2008, the licensee failed to implement airlock maintenance procedures appropriate to the circumstances and this led to a failure of the containment upper airlock outer door seal. As part of their corrective actions, the licensee conducted training and revised procedures.

The finding was determined to be more than minor because it was associated with the Procedure Quality attribute of the Barrier Integrity Cornerstone and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors determined that the finding was of very low safety significance because the upper airlock inner door remained closed and the finding did not represent an actual open pathway in the physical integrity of reactor containment.

Inspection Report# : [2008004](#) (*pdf*)

Emergency Preparedness

Significance:  Dec 31, 2008

Identified By: Self-Revealing

Item Type: FIN Finding

LOSS OF THE V-1F AND V-2F NON-VITAL BUSES RESULTING THE THE LOSS OF TECHNICAL SUPPORT CENTER COMPUTERS

A finding of very low safety significance was self-revealed on October 30, 2008, when licensee personnel failed to appropriately respond to a Technical Support Center (TSC) computer room high temperature alarm. As a result, electrical power supply to plant emergency response equipment and control systems was interrupted. Affected systems included the Integrated Computer System (ICS), Emergency Response Data System (ERDS), one train of power to the Digital Feedwater Control System (DFWCS), and the chemistry computer. As part of their immediate corrective actions, licensee personnel restored the affected systems entered the issue into their corrective action

program.

This finding is considered more than minor because it was associated with the Facilities and Equipment attribute of the Emergency Preparedness Cornerstone and affected the objective of ensuring the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The finding was determined to be of very low safety significance because the equipment was restored to a functional status in less than seven days. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution because the organization failed to ensure that issues were identified accurately and in a timely manner commensurate with their significance as defined in Inspection Manual Chapter 0305 P.1(a).

Inspection Report# : [2008005](#) (*pdf*)

Occupational Radiation Safety

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO PERFORM AN ADEQUATE EVALUATION TO DETERMINE THE USE OF RESPIRATORY PROTECTION EQUIPMENT AND/OR ENGINEERING CONTROLS

A self-revealed finding of very low safety significance and an associated NCV of 10 CFR 20.1501 was identified for the failure to perform an adequate survey (evaluation) to determine whether the use of respiratory protection equipment and/or engineering controls were necessary to maintain the total effective dose equivalent As-Low-As-Is-Reasonably-Achievable (ALARA). Specifically, a high efficiency particulate air vacuum cleaner that was used during a spent fuel pool clean-up campaign was opened without fully evaluating the potential hazards. As a result, two contracted decontamination technicians received an unplanned intake of radioactive materials. As immediate actions, the licensee assessed the internal dose to the workers and secured the area to minimize additional exposure. The licensee entered the issue into its corrective action program as CR 08-33692.

The finding is more than minor because it impacted the program and process attribute of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation, in that not performing adequate evaluations to determine the use of respiratory protection equipment and/or engineering controls for the work resulted in unplanned, additional dose to workers. The finding was determined to be of very low safety significance because it was not an ALARA planning issue, there was no overexposure nor potential for overexposure, and the licensee's ability to assess dose was not compromised. The finding was determined to have a cross-cutting aspect in the Human Performance area per IMC 0305 H.4(c), because the licensee failed to ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported.

Inspection Report# : [2009002](#) (*pdf*)

Public Radiation Safety

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO DOCUMENT ALL APPLICABLE HAZARDS ON SHIPPING MANIFEST

A self-revealed finding of very low safety significance and an associated NCV of Title 10 CFR 71.5 was identified. Specifically, the licensee failed to comply with Title 49 CFR 172.203(c) and shipped a package of radioactive material with a transport manifest that did not document all applicable hazardous substances. The issue was entered in the licensee's corrective action program as CR 07-23098. The licensee's immediate corrective actions were to provide

a corrected copy of the transport manifest to the waste processor and to initiate an apparent cause investigation to identify corrective actions to avoid recurrence.

The finding is more than minor because it was associated with the Public Radiation Safety cornerstone attribute of Program and Process (transportation program) and affected the cornerstone objective, in that, providing incorrect information, as part of hazard communication, could impact the actions of response personnel. The finding was determined to be of very low safety significance because using the Public Radiation Safety SDP, the inspector determined that: (1) radiation limits were not exceeded; (2) there was no breach of a package during transit; (3) it did not involve a certificate of compliance issue; (4) it was not a low level burial ground nonconformance; and (5) it did not involve a failure to make notifications or provide emergency information. Because the finding was not indicative of current performance, a cross-cutting aspect was not identified.

Inspection Report# : [2009002](#) (*pdf*)

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.

Miscellaneous

Significance: N/A Jan 30, 2009

Identified By: NRC

Item Type: FIN Finding

PI&R Report Summary

Based on the sample selected for review, the team concluded that implementation of the corrective action program (CAP) was adequate. The licensee had a low threshold for identifying problems and entering them in the CAP. Items entered into the CAP were screened and prioritized in a timely manner using established criteria; were properly evaluated commensurate with their safety significance; and corrective actions were generally implemented in a timely manner, commensurate with the safety significance. The team noted that the licensee reviewed operating experience for applicability to station activities. Audits and self assessments were determined to be performed at an appropriate level to identify deficiencies. On the basis of licensee self-assessments and interviews conducted during the inspection, workers at the site expressed freedom to raise safety concerns. The team observed that improvements have been made in the licensee's identification and assessment of human performance issues and in root and full apparent cause analyses quality. While noting some improvement in the identification of negative trends, the team also noted that in at least one case the licensee had not identified a negative trend in an area previously highlighted by an NRC finding and associated non-cited violation.

Inspection Report# : [2009006](#) (*pdf*)

Last modified : May 28, 2009