D.C. Cook 1
2Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Mar 31, 2009
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Follow the Work Control Process
A finding of very low safety significance was identified by the inspectors for the failure to follow the work control process during the execution of a work order associated with the Unit 1 turbine repair project. Specifically, failure to follow established processes resulted in workers cutting into a pressurized control air system line. The primary cause of this finding was related to the cross cutting area of Human Performance because licensee personnel failed to appropriately coordinate work activities by incorporating actions to address the impact of changes to the work scope (H.3(b)).

The finding was determined to be more than minor because the failure to follow the work control process could under different circumstances adversely affect safety related systems and personnel safety. The issue was of very low safety significance because the safety function guidelines for core heat removal, inventory control, power availability, containment integrity, and reactivity control were satisfied. No violation of NRC requirements occurred.
Inspection Report# : 2009002 *(pdf)*

Significance: G Oct 17, 2008
Identified By: NRC
Item Type: FIN Finding
Failure to Provide Adequate Operator Response Procedures for Fire Protection System Operation
A finding of very low safety significance was identified by the team for the failure to have appropriate procedures for control room operator actions. Specifically, a control room annunciator response procedure for a fire protection alarm panel failed to provide appropriate guidance for diagnosing a fire protection system failure as evidenced by the simultaneous operation of all three fire pumps. The licensee entered the issue into their corrective action program and planned to revise the procedure.

The finding was determined to be more than minor because the failure to provide adequate procedural guidance contributed towards operators failing to recognize that a fire protection system pipe break had occurred. The issue was of very low safety significance because there was sufficient pumping capacity to maintain system pressure for a substantive period of time.

Inspection Report# : 2008009 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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: G Jun 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain an Accurate Abnormal Operating Procedure for Loss of Spent Fuel Pit Cooling
The inspectors identified a finding of very low safety significance with an associated Non Citied Violation of Technical Specification 5.4.1 for the failure to adequately maintain a complete and accurate abnormal operating procedure (AOP) in accordance with Regulatory Guide 1.33 regarding the required actions for a loss of spent fuel pit (SFP) cooling. Specifically, a valve specified by the AOP as a method to add water to the SFP had been removed by a plant modification. Consequently, the AOP contained inaccurate guidance that under certain circumstances, such as a loss of the other methods specified in the AOP to add water to the SFP, could hinder an operator's ability to mitigate a loss of SFP cooling. This issue was entered into the licensee's corrective action program as AR 00849705.

The inspectors concluded that this issue could become a more significant safety concern if left uncorrected and was therefore more than a minor concern. This finding was of very low safety significance because it did not result in an actual loss of SFP cooling or inventory. This finding was associated with a cross cutting aspect in the area of problem identification and resolution regarding the corrective action program—low threshold for identifying issues (P.1.a)
Inspection Report# : 2009003 *(pdf)*

Significance: N/A Aug 29, 2008
Identified By: NRC
Item Type: FIN Finding
PI&R Inspection Summary
The inspection team concluded that, based on the samples reviewed, the corrective action (CA) program was capable of effectively identifying, evaluating, and resolving issues. The licensee staff's actions were in compliance with the facility's CAP and 10 CFR Part 50, Appendix B requirements. Specifically, the inspectors concluded that licensee personnel were identifying plant issues at a low threshold, entered the plant issues into the station's CA program in a timely manner, performed an adequate evaluation of the issue and implemented corrective actions in an effective manner. Minor examples of inadequate implementation of the processes were observed and the inspection record indicated that several issues were self-revealed or identified by external organizations. Licensee performance with operating experience, self assessments, audits and maintaining a safety conscious work environment was effective.
Inspection Report# : 2008007 *(pdf)*

Last modified : August 31, 2009