

Monticello

2Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Nov 07, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY A CONDITION ADVERSE TO QUALITY.

The NRC identified a Green NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to identify and correct a Condition Adverse to Quality (CAQ). Specifically, the licensee failed to capture in the CAP a concern with the potential corrosion of magnesium motor rotor fan blades associated with safety-related motor operated valves (MOV's). The MOV's were associated with the reactor recirculation and residual heat removal (specifically the low pressure core injection mode) systems. The concern was identified during an internal licensee review of OE. The failure to capture this item in the CAP resulted in the licensee not being able to utilize the CAP process to ensure that the CAQ had been properly evaluated and corrected. This finding has an associated cross cutting aspect associated in the area of PI&R, Corrective Action Program for the failure to properly evaluate the potential impact of the CAQ on the affected, safety related MOV's. [P.1(C)]

The finding is more than minor because it directly affected the Human Performance attribute of the Initiating Events Cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions while at power. The finding also directly affected the Equipment Performance attribute of the Mitigating System Cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding is of very low safety significance, because the issue only involved the potential degradation, but not the actual loss of a plant component (i.e., there was no actual initiating event nor loss of a mitigating system).

Inspection Report# : [2008008](#) (*pdf*)

Significance:  Nov 03, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE PROCEDURAL GUIDANCE FOR CONTROL ROD DRIVE SYSTEM VALVE OPERATION.

A self-revealed finding of very low safety significance, associated with a NCV of 10 CFR 50, Appendix B, Criterion V, was identified for inadequate procedural guidance after operator response to the reactor scram and vessel isolation was complicated by rising water level. Specifically, the operating instructions for the control rod drive system were inadequate in that procedures did not provide direction to control the addition of water to the reactor pressure vessel when the operators determined it was necessary to restore level to the emergency operating procedure specified control band of +9 to +48 inches. Additionally, the inspectors determined that the performance deficiency affected the cross-cutting area of Problem Identification and Resolution, having Corrective Action Program (CAP) components, and involving aspects associated with timely resolution of identified problems when safety concerns are raised under alternative processes (i.e., a procedure change request initiated as a result of a self assessment)(P.1(e)). Operators took action to close the control rod drive valve that was causing water level to rise and used safety relief valve actuations to remove inventory to return water level to the band specified by the emergency procedure.

The finding was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because it impacted the Initiating Events Cornerstone attribute of procedure quality with the objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. The finding was determined to be of very low safety significance because it did not result in an actual impairment of mitigating systems or the reactor coolant system boundary.

Inspection Report# : [2008009](#) (*pdf*)

G**Significance:** Nov 03, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO SCOPE INTO THE MAINTENANCE RULE MONITORING PROGRAM THE 34.5KV CABLES.

The inspectors identified a finding of very low safety significance and NCV of 10 CFR 50.65 (a)(1) for the licensee's failure to establish an effective monitoring and corrective action plan that included the 34.5kV underground feeder cables routed from 2RS to 2R transformer in the scope of a monitoring program that met the requirements of 10 CFR 50.65 (a)(1). The inspectors determined that the preventive maintenance and testing methodology implemented for the 34.5 kV cables was not sufficient to establish the condition of the cables and therefore the exemption of paragraph (a) (2) of 10 CFR 50.65 was not applicable. Additionally, the preventive maintenance and testing methodology implemented for the 34.5 kV cables did not provide the necessary information needed to ensure that the 2R transformer was capable of fulfilling its intended function and therefore the performance goal was not effectively assessed prior to the functional failures of the cables on September 11, 2008. The inspectors determined that the preventive maintenance and testing methodology implemented for the 34.5 kV cables, to identify deteriorating cable insulation conditions prior to failure, was inadequate and therefore the exemption of paragraph (a)(2) of 10 CFR 50.65 was not applicable. Additionally, the finding was determined to be cross-cutting in the area Human Performance, Work Practices, in that supervision and management oversight of work activities did not identify that the periodic maintenance and performance monitoring of the cables did not appropriately support the Maintenance Rule credited function during the periodic evaluations performed for the systems (H.4(c)).

This finding was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix E, Example 7.d because a failure of the cables did occur resulting in a reactor scram and vessel isolation. In addition, it affected the Initiating Events Cornerstone attribute of equipment performance reliability. Specifically, the failure to establish an effective monitoring and corrective action plan that included the 34.5kV underground feeder cables in the scope of a monitoring program that met the requirements of 10 CFR 50.65 (a)(1) contributed to lack of effective monitoring and early identification of degradation of these cables. The inspectors evaluated the finding in accordance with IMC 0609.04, "Phase 1 - Initial Screening and Characterization of Findings." The 2RS to 2R transformer cable failures that occurred did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Therefore, the finding screened as having very low safety significance.

Inspection Report# : [2008009](#) (pdf)**G****Significance:** Nov 03, 2008

Identified By: NRC

Item Type: FIN Finding

INADEQUATE MEDIUM VOLTAGE CABLE TESTING PROGRAM.

The inspectors identified a finding of very low safety significance with no associated violation of regulatory requirements for the licensee's failure to establish and implement an effective test control program that demonstrated that underground 34.5kV medium voltage cables subjected to submersion would perform satisfactorily in service. Specifically, prior to the September 11, 2008, cable failure, the licensee failed to establish and implement an adequate test control program, and failed to ensure that appropriate cable testing was being periodically performed and that test results were trended to identify adverse trends prior to cable failures. In addition, NMC Corporate Directive CD 5.33, "Underground Electrical Cable Management Program," dated April 6, 2006 required, in part, that Monticello Nuclear Generating Plant (MNGP) develop a site underground electrical cable management program to monitor and trend performance of underground electrical cables. The failure to conduct adequate cable testing potentially contributed to the failure of the underground submerged 34.5kV feeder cables routed from 2RS to 2R transformers. Additionally, the inspectors determined that the finding had a cross-cutting aspect in the area of Problem Identification and Resolution. Specifically, the licensee failed to incorporate known relevant internal and external operating experience related to numerous industry concerns and failures of similar underground submerged cables (P.2(a)).

This finding was determined to be more than minor because if left uncorrected the finding could become a more significant safety concern. The finding is of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. An NCV was not issued because these cables were classified as non-safety related cables.

Inspection Report# : [2008009](#) (pdf)

Significance:  Nov 03, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO CORRECTLY IMPLEMENT THE POST SCRAM CHECKLIST.

A self-revealed finding of very low safety significance, associated with a NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified following a loss of shutdown cooling on September 20, 2008. Specifically, operators failed to complete the shutdown checklist following the scram on September 11, 2008, and did not close the reference leg fill valve from the control rod drive system. When the control rod drive pump was started on September 20, the reference leg experienced a pressure spike and the resulting full RPS actuation and Group 2 isolation signals resulted in a loss of shutdown cooling. Additionally, the finding was determined to be cross-cutting in the area of Human Performance, Work Practices, in that the licensee failed to ensure supervisory and management oversight of work activities such that nuclear safety is supported. In this instance, operations shift management did not track implementation of the shutdown checklist to ensure completion (H.4(c)).

This finding was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because it impacted the Initiating Events Cornerstone attribute of configuration control with the objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. Inspectors determined that this finding was of very low safety significance using IMC 0609, "Significance Determination Process," Appendix G, Attachment 3, "Phase 2 Significance Determination Process Template for BWR during Shutdown."

Inspection Report# : [2008009](#) (pdf)

Significance:  Sep 30, 2008

Identified By: Self-Revealing

Item Type: FIN Finding

IMPROPER INSTALLATION OF GROUNDING TRUCKS.

. A finding of very low safety significance was self-revealed when plant operators attempted to install incorrect components (motor test devices instead of bus grounding trucks) into two 4160 volt breaker cubicles during the implementation of a clearance associated with planned maintenance on the 2R station auxiliary transformer. No violation of NRC requirements was identified. The licensee took immediate corrective actions and entered the issue into their corrective action program. The inspectors determined that the performance deficiency affected the cross-cutting area of Human Performance, having work practices components, and involving aspects associated with ensuring supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported. [H.4(c)]

The finding was more than minor because it could reasonably be viewed as a precursor to a significant event. The finding is not suitable for SDP evaluation, but has been reviewed by NRC management and is determined to be a finding of very low safety significance because the repeated attempts to install the wrong components (motor test devices instead of bus ground trucks) into 4160 volt breaker cubicles did not adversely impact the operation of electrical buses 12 and 13, nor did it result in a significant plant transient. Therefore, the finding was considered to be of very low safety significance.

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

Mitigating Systems

Significance: SL-III May 27, 2009

Identified By: NRC

Item Type: VIO Violation

Failure to notify NRC of licensed operator's change in medical status per 50.74 & 50.9.

During an NRC inspection conducted on November 25, 2008 through February 2, 2009, violations of NRC requirements were identified. In accordance with the NRC Enforcement Policy, the violations are listed below:

1. Title 10 CFR 50.74(c) requires that each licensee notify the appropriate Regional Administrator within 30 days of the permanent disability or illness, as described in 10 CFR 55.25, of a licensed operator or a senior operator. Contrary to the above, from July 8, 2004, until November 25, 2008, a period greater than 30 days, the licensee failed to notify the Region III Regional Administrator of a permanent disability or illness of a licensed senior operator. Specifically, the licensee was informed on July 8, 2004, that the operator was taking prescribed medication for hypertension, a permanent disability or illness.

2. Title 10 CFR 50.9 requires, in part, that information provided to the Commission by an applicant for a license or by a licensee or information required by statute or by the Commission's regulations, Orders, or license conditions to be maintained by the applicant or the licensee shall be complete and accurate in all material respects. Title 10 CFR 55.23 requires, in part, that to certify the medical fitness of the applicant, an authorized representative of the facility licensee shall complete and sign NRC Form 396, "Certification of Medical Examination by Facility Licensee." The NRC Form 396, when signed by an authorized representative of the facility licensee, certifies that a physician conducted a medical examination of the applicant and that the guidance contained in American National Standards Institute/American Nuclear Society (ANSI/ANS) 3.4-1983, "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants" was followed in conducting the examination and making the determination of medical qualification. The ANSI/ANS 3.4-1983, Section 5.3, provides, in part, that the presence of certain medical conditions, unless adequately compensated by the methods specified in Subsections 5.3.1 through 5.3.9, shall disqualify the individual. Contrary to the above, on September 11, 2008, the facility licensee provided information to the NRC that was not complete and accurate in all material respects. Specifically, the licensee submitted NRC Form 396 for renewal of a senior reactor operator's license and the NRC Form 396 certified that the applicant met the medical requirements of ANSI/ANS 3.4-1983 with the single restriction that the applicant was required to wear corrective lenses when performing licensed duties. However, in July 2004, the senior reactor operator was prescribed medication to adequately compensate for hypertension, a disqualifying medical condition. The certification by the senior licensee facility representative was material to the NRC because the NRC relied upon this certification to renew the senior reactor operator's license pursuant to 10 CFR Part 55 when the license should have been modified to note the additional restriction that the senior reactor operator was required to take medication as prescribed to maintain his qualification.

This is a Severity Level III problem (Supplement VII).

This violation closes both AV 2009008-01 and 2009008-02.

Inspection Report# : [2009009](#) (pdf)

Significance:  Apr 01, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

USE OF NON-QUALITY DOCUMENTS IN THE ABSENCE OF APPROVED PROCEDURES TO MODIFY THE NORMAL OPERATION OF IRM 11 AND IRM 18.

The inspectors identified a finding of very low significance and NCV of 10 CFR 50, Appendix B, Criterion V, for the licensee approving the use of non-quality documents in the absence of approved procedures to modify the normal operation of intermediate range monitor (IRM) 11 and IRM 18. Implementation of this guidance would have resulted in a condition that would not have been in compliance with Technical Specifications. Once identified, the licensee took immediate corrective actions to correct the situation and entered the issue into their corrective action program. The inspectors determined that the performance deficiency affected the cross cutting area of Human Performance, having decision making components, and involving aspects associated with using conservative assumptions in decision making and adopting requirements to demonstrate that proposed actions are safe in order to proceed, rather than a requirement to demonstrate that it is unsafe in order to disapprove actions. [H.1(b)]

The inspectors determined that the finding was more than minor because it impacted the Reactor Safety Mitigating System Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using IIMC 0609, Appendix A, Attachment 1, "Significance Determination of Reactor Inspection Findings for At-Power Situations," using the Phase 1 Worksheet for the Mitigating Systems Cornerstone. After answering 'No' to all five questions in the Mitigating

Systems Cornerstone column of Table 4a, "Characterization Worksheet for Initiating Events, Mitigating Systems, and Barrier Integrity Cornerstones," the inspectors concluded that the finding was of very low safety significance.

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

Significance:  Apr 01, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY EVALUATE TEMPORARY CHANGES TO RCIC SURVEILLANCE PROCEDURES PRIOR TO IMPLEMENTATION.

A finding of very low safety significance and NCV of 10 CFR 50, Appendix B, Criterion V, was self revealed when the performance of an inadequately prepared temporary procedure change resulted in the inadvertent repositioning of a reactor core isolation cooling (RCIC) containment isolation valve during the system restoration section of a RCIC surveillance test. The licensee took immediate corrective actions to identify the cause of the inadvertent valve actuation and to restore the valve to its proper position. The licensee entered this issue into their corrective action program. The inspectors determined that the performance deficiency affected the cross cutting area of Human Performance, having work practices components, and involving aspects associated with appropriately coordinating work activities by incorporating actions to ensure that supervisory and management oversight of work activities is sufficient to support nuclear safety. [H.4(c)]

The inspectors determined that the failure to adequately evaluate the impact of making temporary changes to existing plant procedures used to conduct Technical Specification surveillance testing was a performance deficiency warranting significance evaluation in accordance with IMC 0612, Appendix B, "Issue Disposition Screening." The inspectors determined that the finding was more than minor because, if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. The inspectors evaluated the finding using IMC 0609, Appendix A, Attachment 1, "Significance Determination of Reactor Inspection Findings for At-Power Situations," using the Phase 1 Worksheet for the Mitigating Systems Cornerstone. After answering 'No' to all five questions in the Mitigating Systems Cornerstone column of Table 4a, "Characterization Worksheet for Initiating Events, Mitigating Systems, and Barrier Integrity Cornerstones," the inspectors concluded that the finding was of very low safety significance.

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

Significance:  Nov 07, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY IDENTIFY A CONDITION ADVERSE TO QUALITY AND IDENTIFY CORRECTIVE ACTIONS TO PREVENT RECURRENCE.

The NRC identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to identify a Condition Adverse to Quality (CAQ). Specifically, the licensee did not identify a maintenance preventable functional failure (MPFF) associated with the HPCI system. The MPFF was associated with the in-service test (IST) failure of the HPCI accumulator check valve (AI-611) during the 2007 refueling outage. The failure was caused by debris that was lodged in the valve seat. Of particular significance, was the fact that the issue was the subject of three licensee initiated action requests (ARs) between March 2007 to February 2008, regarding the test failure, the failure to evaluate past-operability and the failure to evaluate the maintenance rule aspects, none of which properly evaluated the issue. The licensee identified the MPFF after an NRC inspector questioned the adequacy of the previous evaluations, in particular, why the source of the debris had never been evaluated. This finding also has an associated cross-cutting aspect associated in the area of PI&R, Corrective Action Program for the failure to properly evaluate the HPCI accumulator check valve IST failure. [P.1(C)]

The finding is more than minor because it affects the Equipment Performance attribute of the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance, because the HPCI system remained operable and available.

Inspection Report# : [2008008](#) (*pdf*)

G**Significance:** Nov 03, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE/IMPROPER MAINTENANCE ON HPCI SV-1 VALVE.

A self-revealed finding of very low safety significance, associated with a NCV of TS 5.4.1, was identified following a failure of the high pressure coolant injection (HPCI) System to trip when reactor pressure vessel (RPV) water level reached the trip setpoint of +48 inches. Investigation revealed that the normally de-energized HPCI trip solenoid valve, SV-1, failed to trip promptly when actuated and was degraded due to improper reassembly of the solenoid valve after refurbishment in 1996 and degraded elastomers. Follow-up investigation revealed that although a 2003 engineering evaluation recommended a periodic replacement of the elastomers in this valve as an enhancement action, no preventive maintenance activity was created or performed prior to the failure even though the recommended interval had been exceeded since the last overhaul. Additionally, the finding was determined to be cross-cutting in the area of Human Performance, Work Practices, in that supervision and management oversight of work activities did not identify that the preventive maintenance recommendation had not been resolved since 2003 (H.4(c)).

This finding was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because it impacted the Mitigating Systems Cornerstone attribute of equipment performance with the objective of ensuring the availability, reliability and capability of systems to prevent undesirable consequences. Inspectors determined that this finding was of very low safety significance after completing a Phase 1 evaluation of the Mitigating System Cornerstone in accordance with IMC 0609, Attachment 4, "Initial Screening and Characterization of Findings" and answering all questions "No" in the Table 4a worksheet.

Inspection Report# : [2008009](#) (*pdf*)**G****Significance:** Sep 30, 2008

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOLLOWING REPETITIVE FAILURE OF LPCI RECIRCULATION RISER DIFFERENTIAL PRESSURE INSTRUMENT.

A finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was self-revealed for failing to appropriately correct a known condition adverse-to-quality associated with a low pressure coolant injection (LPCI) recirculation riser differential pressure instrument. Due to the lack of appropriate corrective action to replace the 'D' channel instrument microswitch prior to an anticipated failure, the instrument was found inoperable during a quarterly Technical Specification (TS) surveillance test. The licensee took immediate corrective actions and entered the issue into their corrective action program. The inspectors determined that the performance deficiency affected the cross-cutting area of Problem Identification and Resolution, having corrective action program components, and involving aspects associated with taking appropriate corrective actions to address safety issues. [P.1(d)]

The inspectors determined that the finding was more than minor because it involved the equipment performance attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors applied IMC 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings" to this finding. Under Column 2 of the Table 4a worksheet, the inspectors answered: "No" to Question 1 related to design or qualification deficiencies; "No" to Questions 2, 3 and 4 related to loss of train or system safety functions; and "No" to Question 5 related to seismic, flooding and severe weather. Therefore, the finding was considered to be of very low safety significance.

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

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH TECHNICAL SPECIFICATION AND RWP REQUIREMENTS DURING WORK IN A LOCKED HIGH RADIATION AREA.

A self-revealed finding of very low safety significance and an associated non-cited violation (NCV) of Technical Specification 5.7.1.b was identified for the failure to comply with the requirements of the radiation work permit during ultrasonic testing preparations in the condenser hot side, an area posted as a locked high radiation area, on January 2, 2009. Specifically, a mechanical maintenance worker was directed by the outage control center staff to leave his assigned work area and to investigate a leak near the 'D' moisture separator. The worker was briefed on the high radiation area conditions at the ultrasonic testing preparation area; however, the individual was not briefed on the radiological conditions along his path to the 'D' moisture separator. As a result, the worker encountered radiation levels greater than those anticipated and received a dose rate alarm on his electronic dosimeter. The licensee's corrective actions included counseling of the involved workers and conducting a stand-down with the operations department to reinforce radiological requirements and communication expectations. A radiation protection liaison was also assigned to the outage control center for the remainder of the down-power to ensure that work assignments were coordinated with the appropriate supervisor, rather than interfacing directly with the worker. The licensee had completed an apparent cause evaluation to formulate additional actions to prevent recurrence.

The finding was 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, access into high radiation areas whose radiological conditions were unknown placed the worker at risk for unnecessary radiation exposure. The finding was determined to be of very low safety significance because it was not an as-low-as-is-reasonably-achievable (ALARA) planning issue; there was no overexposure or substantial potential for an overexposure; and the licensee's ability to assess worker dose was not compromised. The finding involved a cross-cutting aspect in the area of human performance related to work practices; in that, radiation work permit compliance for access into 'D' moisture separator areas was not effectively communicated to the worker, and the worker failed to follow the radiation work permit. [H.4.b]

Inspection Report# : [2009003](#) (*pdf*)

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: N/A Nov 07, 2008

Identified By: NRC

Item Type: FIN Finding

2008 Biennial PI&R Inspection Summary

The licensee was effective at identifying problems and incorporating them into the corrective action program (CAP). In general, issues were appropriately prioritized, evaluated, and corrected. Licensee audits and self-assessments were generally thorough, probing, and made good use of outside resources to maintain independence. Operating Experience (OE) was appropriately screened and disseminated and was considered as a potential precursor during cause evaluations. Plant staff was aware of the importance of having a strong safety conscious work environment (SCWE) and expressed a willingness to raise safety issues. No one interviewed had experienced retaliation for safety issues raised, or knew of anyone who had failed to raise issues. All persons interviewed had an adequate knowledge of the CAP and the employee concerns program (ECP).

However, the inspectors identified several concerns that were similar to those noted during prior PI&R inspections. The licensee had a continued lack of sensitivity to internal CAP performance indicators, in that some of these indicators, which showed potential deficiencies in the program, had not been evaluated. There were also continued concerns with the proper documentation of issues. Specifically, the inspectors found several examples where the documentation of an issue was insufficient to verify whether it had been appropriately evaluated or resolved. There were also continued problems with the handling of issues identified through the licensee's Differing Professional Opinion (DPO) process. The inspectors also observed that the station had not taken appropriate corrective action to address an adverse trend in Human Performance.

There were two Green findings identified during this inspection. One finding was for failing to properly identify and evaluate a Maintenance Rule Functional Failure associated with the High Pressure Coolant Injection (HPCI) system. The second finding was for failing to capture a Conditions Adverse to Quality (CAQ) in the CAP, during a licensee review of OE. Both findings also had associated NCVs.

Inspection Report# : [2008008](#) (*pdf*)

Last modified : August 31, 2009