Arkansas Nuclear 1
3Q/2009 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2009
Identified By: NRC
Item Type: FIN Finding
Failure to Follow Procedure to Obtain OSRC Review Prior to Restart
The inspector identified a finding for failure of operations personnel to follow procedures to obtain an Operational Safety Review Committee review and approval prior to restart of the unit where the cause of the trip had not been positively identified. Specifically, on December 13, 2008, and again on December 23, 2008, Unit 1 was restarted without an Operational Safety Review Committee review and approval as required by the Post Transient Review procedure (OP-1015.037), Attachment B. In both cases, the cause of the trip was identified as probable. The licensee entered this issue into their corrective action program as condition report CR-ANO-C-2009-01217.

The performance deficiency was greater than minor because it could be reasonably viewed as a precursor to a significant event, as evidenced by the December 20, 2008 manual reactor trip. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," this finding affects the initiating events cornerstone and is determined to have very low safety significance by NRC management review 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. The finding was determined to have a crosscutting aspect in the area of Human Performance associated with Decision-Making [H.1(b)], in that the licensee made non-conservative assumptions in the decisions to restart the unit after each trip. The licensee failed to conduct sufficient effectiveness reviews to verify the validity of the underlying assumptions.

Inspection Report# : 2009008 *(pdf)*

Significance: G Jun 23, 2009
Identified By: NRC
Item Type: FIN Finding
Failure to Follow Station Planning Procedure Results in an Inadequate Work Instruction
The inspectors identified a finding associated with a station planner's failure to follow procedure which resulted in inadequate work instructions. This is a finding because the isophase blower is not safety related equipment. Specifically, contrary to station procedure EN-WM-105, "Planning'" Revision 5, the work instructions generated to replace worn parts for isophase blower C-8A, did not provide sufficient details, nor provide references to appropriate instructions which provided sufficient detail, concerning reassembly of the damper positioner. This resulted in the positioner being incorrectly reassembled during the maintenance which caused the damper to not open or shut reliably. The licensee entered this issue into their corrective action program as Condition Report CR ANO 1-2009 865.

The performance deficiency was more than minor because it affected the procedure quality attribute of the Initiating Events Cornerstone, and it directly affected the cornerstone objective to limit the likelihood of those events that upset plant stability during power operations. Using Inspection Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, this finding was determined to have very low safety significance 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. The finding was determined to have a crosscutting aspect in the area of Human Performance associated with Work Practices [H.4(b)], in that the licensee failed to define and effectively communicate expectations regarding procedural compliance and personnel follow procedures. Specifically, station planners failed to follow EN-WM-105 when developing work instructions for a reference level work package which resulted in an inadequate work package for the planned activities for the isophase blower.

Inspection Report# : 2009003 *(pdf)*

Significance: G Jun 23, 2009
Identified By: Self-Revealing
Item Type: FIN Finding
Trip of a Main Feed Pump Due to Electromagnetic Interference
The inspectors documented a self-revealing finding associated with the trip of main feed pump P 1B on April 9, 2009. Specifically, the main feed pump tripped due to an intermittent electromagnetic interference signal. This interference caused the digital speed monitor to sense an over speed condition and generate a trip signal for the main feed pump turbine, when no such condition actually existed. This issue was the result of the licensee not properly implementing a modification whose purpose it was to noise harden the main feed pumps control cabinets. The licensee entered this issue into their corrective action program as Condition Report CR ANO 1 2009 0760.

The performance deficiency was more than minor because it affected the design control attribute of the Initiating Events Cornerstone, and it directly affected the cornerstone objective to limit the likelihood of those events that upset plant stability during power operations. Using Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheet, this finding was determined to have very low safety significance 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. The finding was determined to have a crosscutting aspect in the area of Problem Identification and Resolution associated with the Corrective Action Program [P.1(c)], in that the licensee failed to thoroughly evaluate problems such that the resolutions address causes and extent of conditions, as necessary. This is indicative of current plant performance because the licensee continues to inadequately evaluate issues and develop appropriate resolutions.
Inspection Report# : 2009003 *(pdf)*

Significance: G Mar 24, 2009
Identified By: Self-Revealing
Item Type: FIN Finding
Inadequate Service Air Compressor Torque Value Led to Loss of Control Rod Drive Cooling and Manual Reactor Trip
The inspectors documented a self-revealing finding associated with the Unit 1 February 5, 2009, manual reactor trip. The unit was manually tripped because control rod drive mechanism cooling was lost when the head gasket on Service Air Compressor C 3A failed. The failure of the head gasket was caused by a reduction in torque applied on the head gasket bolts during maintenance. The applied torque values were lower than the torque values recommended by the vendor. The licensee entered this issue into their corrective action program as Condition Report ANO 1 2009 0225.

The performance deficiency was more than minor because it was associated with the design control attribute of the Initiating Events Cornerstone and it directly affected the cornerstone objective to limit the likelihood of those events that upset plant stability during power operations. Using Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheet, this finding was determined to have very low safety significance 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. This finding was determined not to have a crosscutting aspect because the decision to lower the torque value was made in 2001 and was not indicative of current plant performance.
Inspection Report# : 2009002 *(pdf)*

Significance: G Mar 24, 2009
Identified By: NRC
Item Type: FIN Finding
Failure to Follow Procedure for Use of a Torque Amplifying Device on a Valve in the Generator Hydrogen System
The inspectors documented a self revealing finding because an auxiliary operator failed to follow procedure instructions that prohibited the use of torque amplifying devices on plant valves. The operators used such a device on a main generator hydrogen skid valve and inadvertently disassembled the valve. The subsequent hydrogen leak started a fire. Control room operators manually tripped the reactor and entered Mode 3. The failure to follow the procedure in this instance was not a violation of NRC requirements because the hydrogen system was not safety related. The

licensee entered this issue into their corrective action program as Condition Report ANO 1-2009-0254.

The finding was more than minor because it was associated with the Human Performance attribute of the Initiating Events Cornerstone and it directly affected the cornerstone objective to limit the likelihood of those events that upset plant stability during power operations, and is therefore a finding. Using the Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheet, this finding had very low safety significance 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. This finding had a crosscutting aspect in the area of Human Performance associated with Work Practices [H.4(a)], in that licensee personnel failed to use human error prevention techniques, such as self and peer checks and STAR (stop, act, think, and review), and failed to stop in the face of uncertainty or unexpected circumstance to ensure that work activities were performed safely and without consequence. Specifically, the auxiliary operator did not use human error techniques, nor did the operator stop the hydrogen addition evolution when unexpected circumstance arose.

Inspection Report# : 2009002 *(pdf)*

Significance: G Dec 31, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedure for Reactor Vessel Head Lift
While performing a review in accordance with Operating Experience Smart Sample FY2007 03, "Crane and Heavy Lift Inspection, Supplemental Guidance for Inspection Procedure 71111.20," the inspectors identified a noncited violation of Technical Specification 5.4.1, "Procedures," associated with the licensee’s failure to ensure that adequate procedures were available for removal and reinstallation of the Unit 1 reactor vessel head. Specifically, Procedures OP 1504.007, "Unit 1 Reactor Vessel Closure Head Removal and Storage," Revision 14; and OP 1504.009, "Unit 1 Reactor Vessel Closure Head Installation, Revision 17, allowed the vessel closure head to be lifted to a height which exceeded the maximum analyzed height in the head drop analysis. This issue was entered into the licensee's corrective action program as Condition Report ANO 1 2008 1555.

The finding was determined to be more than minor because it was associated with the procedure quality attribute of the initiating events cornerstone, and it directly 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. Using NRC Manual Chapter 0609, “Significance Determination Process,” Appendix G, “Shutdown Operations Significance Determination Process,” the inspectors determined that the finding was not a loss of shutdown control. The finding was further evaluated using Manual Chapter 0609, Appendix G, Attachment 1, “Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for Both PWRs and BWRs,” Checklist 3. The finding was determined to have very low safety significance because the event did not: 1) affect core heat removal, 2) inventory control, 3) power availability guidelines, 4) containment control guidelines, and 5) reactivity guidelines. The finding had a crosscutting aspect in the area of Human Performance associated with Resources [H.2(c)], because the licensee failed to provide complete, accurate and up to date procedures and work packages for the removal and installation of the reactor vessel closure head.

Inspection Report# : 2008005 *(pdf)*

Significance: G Dec 31, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Control Transient Combustible Material in the Auxiliary Building
The inspectors identified a Green noncited violation of Technical Specification 5.4.1, "Procedures," associated with the licensee’s failure to adequately implement the fire protection program. Specifically, again on multiple occasions station personnel exceeded or challenged combustible limits specified in Procedure EN DC 161, "Control of Combustibles," Revision 2, without taking the prescribed compensatory actions. The inspectors also identified that, in some cases, the procedure was not even invoked.

The inspectors determined that the failure of station personnel to follow Procedure EN DC 161, "Control of

Combustibles," Revision 2, was a performance deficiency and therefore a finding. The finding was determined to be more than minor because it affected the protection against external factors attribute and it directly affected the Initiating Events 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. Using NRC Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the condition represented a low degradation of a fire prevention and administration controls. The finding had a crosscutting aspect in the area of Problem Identification and Resolution associated with the Corrective Action Program because the licensee failed to take appropriate actions to address an adverse trend in a timely manner, which allowed the adverse trend to continue and reoccur on multiple occasions [P.1(d)].

Inspection Report# : 2008005 *(pdf)*

Significance: G Dec 31, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Correct and Prevent Recurrence of a Significant Condition Adverse to Quality Associated with Fires
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," associated with a fire that occurred in the Arkansas Nuclear One switchyard while Entergy Arkansas contractors performed welding activities. Specifically, the licensee failed to correct a significant condition adverse to quality stemming from a long history of procedural violations of Procedure EN DC 127, "Control of Hot Work and Ignition Sources." The licensee entered the issue into their corrective action as Condition Report ANO C 2008 2305.

The inspectors determined that the licensee's failure to adequately implement corrective actions from previously identified trend of small fires since 2003, which constitutes a significant condition adverse to quality, was a performance deficiency and therefore a finding. The finding was determined to be more than minor because it affected the protection against external factors attribute and it directly affected the Initiating Events 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. Using NRC Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the condition represented a low degradation of a fire prevention and administration controls. The finding had a crosscutting aspect in the area of Human Performance associated with Work Practices in that the licensee failed to ensure supervisory and management oversight of work activities, especially contractors, such that nuclear safety was supported [H.4(c)].

Inspection Report# : 2008005 *(pdf)*

Mitigating Systems

Significance: G Sep 23, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
FAILURE TO ADEQUATELY MONITOR THE PERFORMANCE OF STATION HIGH ENERGY LINE BREAK DOOR LATCHES
Green. The inspectors documented a self-revealing violation of 10 CFR 50.65(a)(2) associated with the licensee's failure to appropriately monitor station high energy line break doors, which are scoped into their Maintenance Rule Program, in a manner that provided reasonable assurance that these doors were capable of fulfilling their safety function. Specifically, the licensee had no maintenance task or inspection activity to check for degradation of the latching mechanism of station high energy line break doors. The failure of these doors would result in the removal of a hazard barrier that could have an adverse impact on equipment necessary to mitigate the consequences of a high energy line break event. The licensee entered this issue into their corrective action program as Condition Report ANO 1 2009 0425.

The performance deficiency was more than minor because it affected the equipment performance attribute of the

Mitigating Systems Cornerstone and directly affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences, and is therefore a finding. Using Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheets, this finding was determined to have a very low safety significance because the finding (1) is not a design or qualification issue confirmed not to result in a loss of operability or functionality; (2) did not represent an actual loss of safety function of the system or train; (3) did not result in the loss of one or more trains of nontechnical specification equipment; and (4) did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding did not have a crosscutting aspect because the cause of the performance deficiency is not indicative of current plant performance as high energy line break doors were scoped into the Maintenance Rule Program in the 1990s.

Inspection Report# : 2009004 *(pdf)*

Significance: G Sep 23, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE MAINTENANCE PROCEDURE GOVERNING REPAIRS TO UNIT 1 HIGH ENERGY LINE BREAK DOOR
Green. The inspectors identified a noncited violation of Technical Specification 5.4.1.a, “Procedures,” for an inadequate maintenance procedure governing repairs to a Unit 1 high energy line break door. This resulted in a condition where the door was not able to perform its function of isolating the emergency feedwater pumps from a harsh environment that would result from a main feedwater critical crack high energy line break event. The pumps would have experienced a harsh environment during this event and been rendered inoperable. This issue was entered into the licensee's corrective action program as Condition Report ANO 1 2009 1421.

The performance deficiency was more than minor because it affected the protection against external events attribute of the Mitigating Systems Cornerstone and directly affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and is therefore a finding. Using Inspection Manual Chapter 0609, “Significance Determination Process,” and with the assistance of three regional senior reactor analysts, a Phase 3 evaluation was completed. The calculated change in core damage frequency was 8.8E 8, which is less than 1E-6, therefore, the finding was determined to be of very low safety significance. This finding did not have a crosscutting aspect because the performance deficiency was not associated with any of the crosscutting aspects listed in Manual Chapter 0305, “Operating Reactor Assessment Program,” dated August 11, 2009.

Inspection Report# : 2009004 *(pdf)*

Significance: G Sep 23, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ENSURE THAT CONDITIONS ADVERSE TO QUALITY ARE APPROPRIATELY ENTERED INTO THE CORRECTION ACTION PROGRAM
Green. The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” for the licensee’s failure to have adequate measures established to assure that, when a condition adverse to quality was identified, it was appropriately entered into the stations corrective action program. Specifically, the licensee’s staff has repeatedly failed to enter conditions adverse to quality, identified during investigation of issues, into the corrective action program. The licensee entered this issue into their corrective action program as Condition Reports ANO C 2009 1544 and ANO C 2008 1536.

The performance deficiency was determined to be more than minor because, if left uncorrected, station personnel's failure to enter conditions adverse to quality into the station corrective action program would result in the licensee’s failure to recognize that risk-significant equipment is in a degraded condition and, as such, may not be able to perform its specified safety function, and is therefore a finding. Using Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheets, this finding was determined to have a very low safety significance because the finding (1) was not a qualification deficiency confirmed not to result in loss of operability; (2) did not lead

to an actual loss of system safety function; (3) did not result in the loss of safety function of a single train for greater than its technical specification allowed outage time; (4) did not represent an actual loss of safety function of one or more nontechnical specification trains of equipment designated as risk-significant per 10 CFR 50.65, for greater than 24 hours; and (5) it did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding had a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program [P.1(a)], in that licensee personnel failed to implement a corrective action program with a low threshold for identifying issues. This also includes identifying such issues completely, accurately, and in a timely manner commensurate with their safety significance.

Inspection Report# : 2009004 *(pdf)*

Significance: G Jun 23, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Procedure and Perform Postmaintenance Testing Prior to Declaring Equipment Operable
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” associated with licensee personnel’s failure to follow station procedures. Specifically, following work completed on high pressure safety injection pump P 36C, on April 24, 2009, the specified postmaintenance testing was not performed until April 27, 2009, but the pump was declared operable by the operations department following performance of a quarterly surveillance run. Subsequently, when the postmaintenance testing inspection was performed, maintenance personnel identified a damaged tee fitting which resulted in the pump being declared inoperable. The licensee entered this issue into their corrective action program as Condition Report CR ANO 1 2009 0872.

The performance deficiency was more than minor because, if left uncorrected, it could result in more significant concerns. Specifically, during future corrective maintenance work on safety related equipment, the failure to perform the specified postmaintenance testing, or have operations perform a proper evaluation of the equipment prior to declaring the equipment operable, could result in other more risk significant equipment being inoperable with the licensee unaware of the issue. Using the Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheet, this finding was determined to have a very low safety significance because the finding: (1) is not a design or qualification issue confirmed not to result in a loss of operability of the pump; (2) did not lead to an actual loss of safety function of the system or train; (3) did not result in the loss of one or more trains of nontechnical specification equipment; and (4) did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding was determined to have a crosscutting aspect in the area of Human Performance associated with Work Practices [H.3(b)], in that the licensee failed to appropriately coordinate work activities by incorporating actions to address the need to keep personnel apprised of work status and the operational impact of work activities
Inspection Report# : 2009003 *(pdf)*

Significance: G Mar 24, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedure for Reactor Protection System Maintenance
The inspectors identified a noncited violation of Technical Specification 5.4.1.a, “Procedures,” for an inadequate maintenance procedure governing reactor protection system Channel A flux/delta flux/flow trip circuit. Specifically, the instructions did not provide sufficient details concerning the tightening of screws on a circuit card during a surveillance. This resulted in improper maintenance which rendered the channel inoperable after it was returned to service. The licensee had previously identified problems with the adjustment of these screws. In addition, the inspectors identified a significant contributor to the event. The lead qualified technician on the job failed to follow a maintenance procedure and provide continuous supervision to a non-qualified technician that was performing the sensitive maintenance. The licensee entered this issue into their corrective action program as Condition Reports ANO 1 2009 0066 and ANO-1-2009-0464.

The performance deficiencies were more than minor because, if left uncorrected, they could result in more significant

concerns. Specifically, during future surveillance and maintenance work, a reactor protection system circuit could again be rendered inoperable by inadequate maintenance and go undetected for a longer time period. In addition, unqualified individuals performing unsupervised maintenance could render various pieces of mitigating equipment inoperable or cause initiating events. Using the Inspection Manual Chapter 0609, “Significance Determination Process,” Phase 1 Worksheet, this finding had very low safety significance because the finding: (1) resulted in a loss of operability of reactor protection system Channel A; (2) did not lead to an actual loss of safety function of the system or train; (3) did not result in the loss of one or more trains of nontechnical specification equipment; and (4) did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding had a crosscutting aspect in the area of Problem Identification and Resolution, Corrective Action Program component [P.1 (c)] because the licensee failed to thoroughly evaluate the problem such that the resolution addressed the causes – i.e., failure to properly supervise the trainee

Inspection Report# : 2009002 *(pdf)*

Barrier Integrity

Significance: G Dec 31, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Adequately Implement Foreign Material Exclusion Controls
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," associated with the licensee’s failure to adequately implement Station Procedure EN MA 118, Revision 4, "Foreign Material Exclusion." Specifically, on multiple occasions during Refueling Outage 1R21, the licensee failed to implement appropriate foreign material exclusion controls in areas designated as Zone 1 foreign material exclusion areas in accordance with Station Procedure EN MA 118. This issue was entered into the licensee's corrective action program as Condition Report ANO 1 2008 2491.

The finding was more than minor because it was similar to the non minor considerations of Example 3.j in NRC Manual Chapter 0612, Appendix E, "Examples of Minor Issues," in that significant programmatic deficiencies were identified associated with this issue that could lead to worse errors if left uncorrected. Specifically, station personnel’s continued failure to implement appropriate foreign material exclusion controls would result in the introduction of foreign material into critical areas, such as the spent fuel pool or the reactor cavity, which in turn would result in degradation and adverse impacts on materials and systems associated with these areas. Using NRC Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheet, the finding was determined to have very low safety significance because the finding was only associated with the fuel barrier. This finding had a crosscutting aspect in the area of Human Performance associated with Work Practices [H.4(b)] in that the licensee failed to effectively train personnel on the foreign material exclusion procedure which resulted in a failure to follow procedure by workers and supervisors.

Inspection Report# : 2008005 *(pdf)*

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: SL-IV Mar 24, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Complete and Accurate Information to the NRC Following a Plant Trip
The inspectors identified a noncited Severity Level IV violation of 10 CFR 50.9, "Complete and Accurate Information," because the licensee provided inaccurate information to the NRC following a reactor trip. Specifically, while making a 10 CFR 50.72 report (for a site fire, which had prompted a manual reactor trip) the licensee informed the NRC headquarters operations officer (on a recorded line) that all control rods had fully inserted into the core. On the contrary, one control rod had failed to fully insert, although the reactor was in a shutdown condition. Operations personnel had failed to use 3-way communications when discussing the control rod positions during the event. After the licensee determined the actual control rod position, the information was not provided directly to the NRC. The information was considered material to the NRC's informational needs because the NRC may have initiated different short term response measures had the NRC known that one control rod was partially out. This issue was entered into the licensee's corrective action program as Condition Reports ANO 1 2009 0260 and ANO-1-2009-0281.

The finding was more than minor because the information was material to the NRC's decision making processes. In accordance with Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," the violation was subject to the traditional enforcement process because 10 CFR 50.9 violations impact the NRC's ability to perform its regulatory function. Using the Enforcement Policy, Supplement VII, "Miscellaneous Matters," the inspectors characterized the violation as a Severity Level IV violation because it did not meet the Severity Level I, II or III criteria. NRC management reviewed the finding and determined that it was of very low safety significance (Green). Because the violation was of very low safety significance and was entered into the corrective action program, this violation is being treated as a noncited violation, consistent with the NRC Enforcement Policy, Section VI.A. The finding had a crosscutting aspect in the area of Human Performance (Work Practices component) because operations personnel failed to utilize human error prevention techniques (3-way communication) when gathering information to provide to the NRC [H.4(a)].
Inspection Report# : 2009002 *(pdf)*

Last modified : December 10, 2009