# D.C. Cook 1
# 4Q/2009 Plant Inspection Findings

---

## Initiating Events

**Significance:** G Dec 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to maintain safety related cables in underground manholes from becoming repeatedly submerged.**
The inspectors identified a finding of very low safety significance with an associated Non Cited Violation of 10 CFR Part 50 Appendix B, Criterion III, “Design Control,” for failing to maintain safety related cables in an environment for which they were designed. Specifically, frequently submerged safety-related cables in manholes MH1PA, MH1PB, MH1PC, and MH1PD were designed to be moisture resistant and not completely submerged in water. For corrective actions, the frequency for conducting preventive maintenance to inspect the manholes for water and pump out the water, as needed, was reduced from monthly to weekly for manhole MH1PA and to biweekly for manholes MH1PB, MH1PC, and MH1PD. In addition, engineering personnel were evaluating permanent solutions to prevent the manholes from filling with water, which would eliminate the need for manual pumping. This finding was entered into the licensee’s corrective action program as AR 00859564.

This finding affected the Initiating Events cornerstone and was more than minor because the issue could become a more significant safety concern if left uncorrected. Specifically, allowing safety related cables to be repeatedly submerged in water in underground manholes could degrade the cable insulation and result in cable failure. The finding was of very low safety significance because the finding does not contribute to both the likelihood of a reactor trip and the likelihood that mitigating equipment or functions would be lost. This finding was associated with a cross cutting aspect in the area of problem identification and resolution in corrective action program – corrective actions. (P.1.d)

Inspection Report# : 2009005 *(pdf)*

---

## Mitigating Systems

**Significance:** G Dec 31, 2009
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
**Installation of non conforming parts on the safety related emergency diesel generators.**
One self revealed finding of very low safety significance with an associated Non Cited Violation of 10 CFR Part 50, Appendix B, Criterion XV, “Non conforming Materials, Parts, or Components,” was identified for installing non conforming parts on the safety related emergency diesel generators. Specifically, the licensee installed several Delivery Valve Holder (DVH) assemblies that were fabricated using material previously identified as being prone to cracking, non conforming, on all four safety related Emergency Diesel Generators (EDG). Consequently, on June 10, 2009, during an operability run for the Unit 2 CD EDG, a DVH cracked, which resulted in a fuel oil leak on the 6F fuel injector line. For corrective actions, the licensee replaced all non conforming DVHs with new DVHs that were fabricated using materials that were not prone to cracking. Additional corrective actions included revising several procedures associated with the dedication plan and receipt inspection program. This issue was entered into the licensee’s corrective action program as condition report AR 00852905.

This finding affected the Mitigating Systems cornerstone and was more than minor because the issue could become a more significant safety concern if left uncorrected. Specifically, installing non conforming parts on safety related equipment under certain circumstances could result in the subsequent degradation or loss of equipment required for

safe shut down of the plant. This finding was of very low safety significance because the finding is a qualification deficiency that did not result in the loss of operability or functionality of the EDGs. This finding was associated with a cross cutting aspect in the area of human performance – resources. (H.2.c)

Inspection Report# : 2009005 *(pdf)*

**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. (H.3.b)
Inspection Report# : 2009002 *(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)*

Last modified : March 01, 2010