

Dresden 2

1Q/2010 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: FIN Finding

Failure to Identify and Replace CR120A Relays as Recommended by GE SIL 229 Supplement 1

A finding of very low safety significance was identified by NRC Inspectors for the licensee's failure to identify and replace several CR120A relays as recommended by GE SIL 229 Supplement 1. Specifically, the licensee failed to replace several CR120A relays associated with primary containment valve isolation logic which eventually resulted in a partial Group 2 logic isolation event. The licensee entered this issue into the corrective action program (CAP) as Issue Report 923691. The licensee plans to replace these CR120A relays. There was no enforcement action associated with this finding.

This finding was determined to be more than minor because it was associated with the Equipment Performance attribute of the Initiating Events Cornerstone and affected the cornerstone's objective to limit the frequency of those events that upset plant stability and challenge critical safety functions during power operations. The relay failure caused an unplanned partial Group II primary containment isolation that impacted plant operations for several days. This issue was determined to be of very low safety significance since it did not contribute to both a reactor scram and loss of a mitigating function when evaluated as a Transient Initiator.

Inspection Report# : [2009004](#) (*pdf*)

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Instrument Air Isolation Valve Mispositioning on April 26, 2009

A finding of very low safety significance and associated Non Cited Violation of Technical Specification Section 5.4.1 was self revealed when the Unit 2 instrument air system had a significant pressure drop because a non licensed operator failed to follow procedure DOP 4700 01, "Instrument Air System Startup," Revision 46. The violation was placed into the licensee's corrective action program (CAP) in Issue Reports 911794 and 893376. The non licensed operator was relieved from duty. Both the non licensed operator and the unit supervisor were counseled for the failure to perform expected work practices. The licensee also found that this event was similar to other problems discussed in the licensee's Root Cause Report 893376, "Operations Cyclic Performance." Multiple corrective actions were assigned in Root Cause Report 893376 to address a lack of operations supervision enforcing department standards. Using the guidance contained in IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening," dated December 4, 2008, the inspectors determined that the finding was more than minor because the finding could be reasonably viewed as a precursor to a significant event. Specifically, the failure to follow procedure resulted in an instrument air (IA) transient that could have resulted in a unit scram if the IA system had not been recovered in a timely manner. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 Initial Screening and Characterization of findings," Table 4a, for the Initiating Event Cornerstone. The inspectors determined that the finding represented an increase in the likelihood of a reactor trip and the likelihood that mitigation equipment would be unavailable because the finding increased the likelihood of a loss of instrument air (LOIA) event. Therefore, the finding required a phase 2 SDP evaluation. The duration of the condition was less than three days. Using the SDP usage rules from IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At Power Situations", the inspectors increased the initiating event frequency for the LOIA event by one order of magnitude for the three day exposure period. The result was an estimated change in core damage frequency of less than 1.0E 6/yr. As a result, the finding was determined to be of very low safety significance (Green) based on the phase 2 SDP evaluation. This finding had a cross cutting aspect in the area of Human Performance, Work Practices because the operator did not use the expected human performance techniques.

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

Mitigating Systems

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Significance of Potentially Submerged Safety and Non safety-related Low Voltage Power and Control Power Cables

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." Specifically, licensee personnel failed to maintain safety related cables in underground manholes from becoming repeatedly submerged, which resulted in subjecting the cables to an environment for which they were not qualified. As corrective action, the licensee generated work order (WO) 01271108 on September 24, 2009, to remove the seals on the conduit which contained the cables and which kept water from draining out of the conduit. This issue was entered into the licensee's corrective action program as Issue Report (IR) 975308.

The finding was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance because it was a qualification deficiency that did not result in a loss of operability. The inspectors concluded that there was not a cross cutting issue associated with this violation.

Inspection Report# : [2010002](#) (*pdf*)

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Operating Personnel Incorrectly Placed Clearance Tags

A finding of very low safety significance and associated NCV of Technical Specification 5.4.1 was self-revealed for the failure to meet the requirements of Clearance Order (CO) 69631 by removing shorting links instead of fuses as required by the CO on November 12, 2009. As a result, protective relaying was unintentionally removed from the Unit 2 main power transformer TR-2, the unit auxiliary transformer TR 21, and the reserve auxiliary transformer TR-22. This issue was entered into the licensee's CAP as Issue Report 992290. Corrective actions included: coaching of the individuals involved with the incorrect placing of the out-of-service and a placard on the device that was incorrectly repositioned was changed to include the specific equipment part number of the shorting links.

The finding was determined to be more than minor because the finding could reasonably be viewed as a precursor to a significant event. The finding was evaluated using the SDP in accordance with IMC 0609, Appendix G, Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Operational Checklists For Both PWRs and BWRs," Checklist 6, dated May 25, 2004. This checklist stated that for a finding to require a Phase 2 or 3 determination, it would require an increase in the likelihood of a loss of offsite power or degrade the licensee's ability to cope with a loss of offsite power. The ability of the licensee to cope with a loss of offsite power was not impacted because at least one emergency diesel generator was operable during the entire period. The inspectors determined that neither of these conditions were met so the finding screened as Green. This finding had a cross-cutting aspect in the area of Human Performance, Work Practices. H.4(a)

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

NRC Inspector-Identified Control Room Alarm Isolation Valve Out-of-Position

The inspectors identified a finding of very low safety significance and associated NCV of Technical Specification 5.4.1 for the licensee failing to follow Dresden procedure DOP 2-1500-M1, "LPCI System Mechanical Checklist," Revision 39. On September 24, 2009, the inspectors identified valve 2-1501-42A, U2 low pressure coolant injection (LPCI) A pump gland leak-off valve, was closed instead of open as required by DOP 2-1500-M1. With this valve closed instead of open, the control room alarm for LPCI pump seal leakage would not have been able to fulfill its

function. The issue was entered into the licensee's CAP as IR 969490. The licensee's corrective actions included changing maintenance procedure DMP 1500 05, "LPCI Pump Maintenance," step G.25.d to include the case drain valve equipment numbers and sign offs to position and verify the valves; and Operations Department Management addressed the operations department personnel about this issue.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, the valve isolated an alarm in the control room. The inspectors concluded this finding was associated with the Mitigating Systems Cornerstone using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 Initial Screening and Characterization of Findings," Table 4a, dated January 10, 2008. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices because the licensee did not have any documentation as to how or when the valve was placed into the position it was in. The design and location of the valve precluded that the valve was accidentally placed into the position it was found in. Therefore, the inspectors concluded that either the failure to use human error prevention techniques or maintaining proper documentation of activities caused the mispositioning of valve 2-1501-42A. H.4.(a) (Section 1R15)

Inspection Report# : [2009005](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Preconditioning the Unit 2 Emergency Diesel Generator Prior to Performing TS Surveillance Requirements

The inspectors identified a finding of very low significance and associated NCV of 10 CFR 50 Appendix B, Criterion XI, "Test Control", because the licensee unacceptably preconditioned the Unit 2 Emergency Diesel Generator (EDG) prior to performing Technical Specification (TS) Surveillance Requirements (SR) 3.8.1.19.c.4, 3.8.1.12.c.3, and 3.8.1.10. These TS SRs involved verifying that the EDG supplied steady state frequency would be acceptable following a loss of offsite power coincident with and without a loss of coolant accident, and following the loss of the largest post accident load. Specifically, the inspectors identified that the licensee routinely performed governor oil change outage maintenance activities which involved a section that tuned the Unit 2 diesel governor's response to a load change just prior to performing these TS SRs. This issue has been entered into the licensee's CAP as IR 1000609. The licensee had not reached a conclusion on corrective actions by the end of the inspection period.

This finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Unacceptable preconditioning the EDG could mask latent performance issues and affect the ability of the EDG to supply safety-related power to vital loads during an event. The inspectors performed a Phase 1 SDP evaluation and determined that this issue was Green because it did not result in an inoperable Unit 2 EDG. The failure to adequately coordinate the work activity of the preventive maintenance and post-maintenance testing with the TS SR activities was the principal contributor to this finding and was reflective of recent performance. This finding had a cross-cutting aspect in the area of Work Control. Specifically, the licensee did not appropriately coordinate work activities by incorporating actions to address the impact of the work as different job activities. The scheduling of the work activities resulted in the pre conditioning of the EDG prior to performing the surveillance tests. H.3(b) (Section 1R19)

Inspection Report# : [2009005](#) (pdf)

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Ensure a Safety-related Plus was Ordered and installed in the 2/3 Emergency Diesel Generator Turbo Lube Oil "Y" Strainer

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion IV, "Procurement Document Control," was self-revealed for the licensee's failure to ensure a safety-related plug was ordered and installed where required in the 2/3 EDG turbo lube oil "Y" strainer. Instead, a non-conforming part was installed, which resulted in a one-half gallon per minute oil leak and removal of the diesel generator from service. The issue was entered into the licensee's CAP as IR 926605. Corrective actions included inspection of all other diesel generators to ensure the non-conforming condition did not exist on another machine, revising the procurement documents to ensure that future parts include a pressure retaining pipe plug with approved material, and adding a requirement for a quality inspection to be performed to "inspect the strainer for metallic pipe plug in blow down port." Individual procedure compliance issues were addressed through the station's performance improvement initiatives. The finding was determined to be more than minor because the finding was similar to IMC 0612, Appendix E,

Example 5 c because an incorrect and inadequate part was installed and the system was returned to service. This performance deficiency impacted the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. A Phase 3 SDP risk evaluation was performed by the regional Senior Risk Analyst who determined the risk significance of the finding to be less than 1.0E-6/yr delta core damage frequency (CDF) and less than 1.0E-7/yr delta LERF, which represents a finding of very low safety significance. Failure of plant personnel to question the plastic shipping plug before the equipment was installed and returned to service was not in compliance with MA-AA-716 008, "Foreign Material Exclusion Program," and, therefore, inspectors determined that this event was cross-cutting in Human Performance, Work Practices, Procedural Compliance for failure of personnel to follow the procedure. H.4(b) (Section 4OA3.3) Inspection Report# : [2009005](#) (pdf)

Significance:  Nov 18, 2009

Identified By: NRC

Item Type: FIN Finding

Ventilation System One-Time Inspection Results (4OA5.1.b(1))

A finding of very low safety-significance (Green) was identified by the inspectors for the licensee's failure to adequately evaluate and address an aging effect identified by the ventilation system one-time inspection program in accordance with the license renewal Program Basis Document B.1.23C. The licensee entered this issue into the corrective action program, and initiated periodic inspections to manage the aging effect.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, failure to address the aging effect would not provide assurance that the intended function of in scope ventilation systems would be maintained consistent with the current licensing basis through the period of extended operation. This finding is of very low safety-significance (Green) because it did not result in a loss of operability, did not represent an actual loss of safety function, and is not potentially risk-significant due to external events. The cause of this finding is related to the cross-cutting aspect in the area of Human Performance, Work Practices, because the licensee did not ensure proper supervisory and management oversight of work activities, such that nuclear safety is supported. Specifically, supervisory expectations for follow-up were not adequately conveyed prior to the completion of the program.

Inspection Report# : [2009007](#) (pdf)

Significance:  Nov 18, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Unit 2 SBLC Tank Thickness Calculation Errors (4OA5.1.b(2))

A finding of very low safety-significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the failure to accurately translate the design bases for the Standby Liquid Control (SBLC) tank into specifications, drawings, procedures, and instructions.

Specifically, the SBLC tank wall thickness used in a design basis calculation was incorrect. The licensee initiated IR 983037 to address deficiencies in the calculation.

The finding was determined to be more than minor because the finding was associated with the mitigating systems cornerstone attribute of design control 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 design basis calculations did not demonstrate that the tank will remain available following design basis seismic events. This finding is of very low safety-significance (Green) because it did not result in a loss of operability. The inspectors did not identify a cross-cutting aspect associated with this finding as it was not indicative of current performance.

Inspection Report# : [2009007](#) (pdf)

Significance:  Nov 18, 2009

Identified By: NRC

Item Type: FIN Finding

Failure to Inspect the Non-EQ Electrical Connections Subject to Localized Adverse Environment

A finding of very low safety-significance was identified by the inspectors for the licensee's failure to implement a program in accordance with the license renewal program basis Document B.1.33. Specifically, the licensee failed to develop and implement a program to perform visual inspections of the accessible non environmentally-qualified electrical connections located in adverse localized environments. The licensee subsequently entered the issue into their corrective action program as AR00977284 to re-perform the inspection and revise documentations as required. The finding was not associated with violation of regulatory requirements.

The finding was determined to be more than minor because, if left uncorrected, the finding would become a more safety-significant concern. The failure to perform a visual inspection of the subject connections did not assure that the intended functions of these connections would be maintained consistent with the current licensing basis through the extended period of operation. The finding was of very low safety-significance based on a Phase 1 screening in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." This finding has a cross-cutting aspect in the area of Human Performance for the resources component because implementing procedures did not include sufficient guidance defining the parameters of the program.

Inspection Report# : [2009007](#) (pdf)

Significance:  May 22, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Diesel-Driven Fire Pump Discharge Valve Found Out of Position

A finding of very low safety significance and associated non-cited violation of license conditions 2.E and 3.G for Units 2 and 3, respectively, was identified by the inspectors for the failure to restore the Unit 1 diesel-driven fire pump to an operable condition within 7 days as required by Technical Requirements Manual (TRM) 3.7.i.A.1. Specifically, the Unit 1 fire pump discharge valve was found closed rendering the pump inoperable for greater than 7 days. Upon discovery of the valve in the closed position the licensee repositioned the valve in the correct locked open position and initiated Action Requests (AR) 922581 and 922585.

This finding is more than minor because the failure to provide the two required fire pumps could have resulted in a failure of the station's water based fire protection system should the Unit 2/3 fire pump have been out of service at the same time. The finding screened as very low safety significance because the performance of the system was not affected by the closed valve as the Unit 2/3 diesel-driven fire pump remained operable to provide water to the station's fire protection system, if required. This finding has a cross-cutting aspect in the area of human performance, work control because the licensee did not properly plan and coordinate activities consistent with nuclear safety.

Specifically, the licensee failed to restore the Unit 1 diesel-driven fire pump to an operable condition within 7 days as required by TRM 3.7.i.A.1 as a result of ineffective communications between licensee personnel to verify that valve 1-4199-109 was in its correct locked open position prior to declaring the pump operable [H.3(b)].

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

Barrier Integrity

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Technical Specification 5.5.4 Implementing Procedure

- The inspectors identified a finding of very low safety significance and associated Non Cited Violation of Technical Specification 5.5.4 for the licensee failing to follow Step I.2.a and b of Procedure DOS 1500 08, "Discharge of Containment Cooling Service Water (CCSW) From Low Pressure Coolant Injection (LPCI) Heat Exchanger (Hx) During CCSW Pump Operations," Revision 16. Specifically, the licensee failed to perform a tube leak test as required by DOS 1500 08 when activity exceeded 1.5E 6 microcuries/milliliter. The licensee's corrective actions included a change to DOS 1500 08 to ensure personnel do not waive performance of the test procedure until tube leak checks are considered during non routine samples of CCSW and revising the chemistry sampling procedure CY DR 110 220, "LPCI Service Water (CCSW) and Torus Water Sampling," to notify operations to evaluate performance of a tube leak check if activity exceeds 1.5E 6 microcuries/milliliter.

The inspectors determined that the failure to perform a tube leak test or perform Calculated CCSW Sample Activity

Limit and Canal Activity Calculations was contrary to DOS 1500 08, and was a performance deficiency. The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, had there been an actual LPCI Hx tube leak radioactivity could have been released. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 Initial Screening and Characterization of Findings," Table 4a for the Containment Barrier Cornerstone. All four questions on this table were answered "no." There was no actual degradation of the containment barrier. Therefore, the issue screened as having very low safety significance. This finding had a cross cutting aspect in the area of Human Performance, Decision Making because the licensee did not demonstrate that the proposed action was safe in order to proceed rather than a requirement to demonstrate that it was unsafe in order to disapprove the action. Specifically, the licensee assumed the activity in the sample was coming from the floor drain system with no valid proof that was the case.

Inspection Report# : [2010002](#) (pdf)

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow the master Refueling Procedure During Movement of Fuel Assembly JLU569

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, was self-revealed for the failure to properly move a fuel assembly to its specified location, in accordance with DFP 0800-01, "Master Refueling Procedure." Specifically, on November 5, 2004, fuel assembly JLU569 was placed in position C4-E5, instead of C4-F5, as required by the procedure. The violation was placed into the licensee's CAP in IR 990180. As corrective action, the licensee temporarily suspended all fuel handling activities, conducted a piece count of the spent fuel and stationed a second Senior Reactor Operator on the refueling bridge as additional oversight for follow-on fuel movements. Additionally the fuel handling crew associated with the event was suspended from future fuel moves, pending remedial training.

Using the guidance contained in IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening," dated December 4, 2008, the inspectors determined that the finding was more than minor because the finding was associated with the configuration control and human performance attributes of the Barrier Integrity Cornerstone and impacted the Barrier Integrity Cornerstone objective to provide reasonable assurance that physical design barriers (i.e., fuel cladding) protect the public from radionuclide releases caused by an accident or event. Specifically, the shutdown margin and thermal management of the spent fuel pool(s) is affected by fuel assembly placement inside the pool(s). The inspectors determined the finding could be evaluated using the significance determination process in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 3b, question 6, which directed the inspectors to Appendix M, "Significance Determination Process Using Qualitative Criteria." Because probabilistic risk assessment tools were not well suited for this finding, the criteria for using IMC 0609, Appendix M, were met. In determining the significance of this finding, regional management reviewed the licensee's bounding analysis in the UFSAR, which demonstrated that regardless of the incorrect bundle position in the fuel pool, the design of the pool still maintained pool Keff less than .95. Based on the additional qualitative circumstances associated with this finding, regional management concluded the finding was of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Human Performance, Work Practices. Specifically, neither the Senior Reactor Operator (SRO), nor either of the two members of the fuel handling crew, adequately performed independent verification techniques that ensured the fuel assembly move was made in accordance with the Nuclear Component Transfer List, as required by DFP 0800-01. H.4(a) (Section 1R20)

Inspection Report# : [2009005](#) (pdf)

Significance:  Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Technical Specification 5.5.2 Implementing Procedures

The inspectors identified several examples of failure to follow the procedures that implemented Technical Specification (TS) 5.5.2, "Primary Coolant Sources Outside Containment." These failures were determined to represent a Green finding and a non cited violation. Planned corrective actions associated with this violation included, but were not limited to: a revision to DTP 09, "Leak Detection and Reduction Program," to restore commitments made to the NRC; changes to the work control program to ensure that leaks identified by the Leakage Reduction

Program are given a high priority; assignment of a program owner; revising operating surveillances to ensure they meet the requirements of TS 5.5.2; initiating a training program for operations and engineering personnel on TS 5.5.2; and developing an administrative limit on emergency core cooling system leakage outside the primary containment. The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, the failure to track, trend, and repair leakage outside primary containment could lead to exceeding radiation exposure limits in the event of an accident. This finding was determined to have very low safety significance because the actual emergency core cooling system leakage outside the primary containment was low. This finding had a cross cutting aspect in the area of Human Performance, Work Practices because the licensee did not effectively communicate expectations regarding procedural compliance with regard to TS 5.5.2, "Primary Coolant Sources Outside Containment." Specifically, licensee personnel failed to follow several procedural requirements because they were unaware of the requirements.

Inspection Report# : [2009004](#) (*pdf*)

Emergency Preparedness

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: FIN Finding

Failure to Meet Regulatory Commitment to Maintain Contingency Plans for Post-Accident Sampling

The inspectors identified a finding of very low safety significance for the failure to meet a regulatory commitment to maintain a contingency plan for obtaining highly radioactive samples of reactor coolant, the suppression pool, and drywell atmosphere for post accident plant recovery planning. Specifically, the licensee's contingency plan was not adequately maintained to ensure the High Radiation Sampling System (HRSS) functioned adequately or otherwise was demonstrated to be in a state of readiness to allow samples to be obtained within a two week window. No violations of regulatory requirements were identified related to this finding. Corrective actions were being developed to ensure the licensee's contingency plan commitments would be met. Those actions included a means to improve system ownership and establishment of an effective process for HRSS equipment maintenance and repair at a priority consistent with its intended use.

The finding was more than minor because it impacted the facilities and equipment attribute of the Emergency Preparedness Cornerstone and adversely affected the cornerstone objective of ensuring capability to implement adequate measures to protect health and safety of the public in the event of a radiological emergency. Specifically, equipment intended to obtain highly radioactive samples that are used to assess reactor core condition as part of post accident recovery activities was not demonstrated to be in a readiness condition consistent with the licensee's contingency plan. The finding was determined to be of very low safety significance because it involved equipment, which supplements the licensee's emergency plan for reentry and recovery activities as provided in the planning standard of 10 CFR 50.47(b)(8), and represented a planning standard problem associated with demonstrating functional readiness of that equipment. The finding was determined to be associated with a cross cutting aspect in the area of human performance in the resources component, in that, the licensee failed to ensure that equipment to support its emergency plan was functional or otherwise was demonstrated to meet a defined status of operational readiness.

Inspection Report# : [2010002](#) (*pdf*)

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 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Record the Identity of Personnel Performing Post Maintenance Tests

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion XVII, "Quality Assurance Records," was identified by the inspectors for the licensee's failure to record the identity of various personnel who performed seven post-maintenance tests (PMTs) related to Unit 3 EDG maintenance. Despite the PMTs being related to work on safety related components, an activity affecting quality, neither the licensee's procedure MA AA 716 012, "Post-Maintenance Testing," nor DAP 15 10, "Post-Maintenance Testing Program," required the identity of the inspector or tester to be recorded. Completed corrective actions included adding PMT documentation requirements to DAP 15 10 and briefing individuals who perform PMTs.

This finding was determined to be more than minor because the finding was similar to IMC 0612, Appendix E examples 1b since a portion of required records were irretrievably lost, and 2h since multiple examples were identified as failures to properly implement the same regulatory requirement. Following IMC 0612, Appendix B, it was apparent that this issue did not fall directly under a cornerstone and that incomplete information was recorded in the seven PMTs. Therefore, the Enforcement Policy was used to screen the severity in conjunction with the IMC 0612, Appendix E, Examples 1b and 2h. Since MA AA 716 012, "Post-Maintenance Testing," did not properly implement regulatory requirements, this finding has a cross-cutting aspect in the area of Human Performance, Resources because the licensee did not provide complete, accurate, and up-to-date procedures to plant personnel.

Inspection Report# : [2010002](#) (*pdf*)

Last modified : May 26, 2010