

# Fort Calhoun

## 3Q/2010 Plant Inspection Findings

---

### Initiating Events

**Significance:** SL-IV Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Update Intake Structure Design**

SL-IV. The team identified a Severity Level IV, noncited violation for failure to update the final (updated) safety analysis report in accordance with 10 CFR 50.71(e). Specifically, the licensee failed to update Section 9.8, "Raw Water Systems," of the Fort Calhoun Station Updated Safety Analysis Report after constructing a sheet pile alignment wall alongside the intake structure in 1982. Furthermore, this modification removed the slope from the river bottom. Additionally, recent sounding records indicate the river bottom near the intake structure is approximately the same depth as the center of the channel, thus, invalidating the updated safety analysis report statement. The licensee entered this condition into the corrective action program as CR 2009-3927.

The finding is more than minor because the finding is determined to have a material impact on safety. Specifically, with the new sheet pile alignment wall, it could lead to a barge strike that is different than described in the updated safety analysis report. Using Supplement I of the NRC Enforcement Policy, this finding will be treated as a Severity Level IV violation. This finding was not assigned a crosscutting aspect because the underlying cause was not indicative of current performance (Section 4OA5.1).

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

---

### Mitigating Systems

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **FAILURE TO PROVIDE ADEQUATE LIMITING CONDITION FOR OPERATIONS FOR HIGH RIVER LEVEL**

The inspectors identified a noncited violation of 10 CFR 50.36(c)(2)(ii)(B) for the failure to include an adequate limiting condition for operation in the technical specification. Specifically, the reactor cannot be placed in a cold shutdown condition using normal operating procedures when the river level exceeds 1009 feet mean sea level, as required by Technical Specification 2.16. This violation has been entered into the licensee's corrective action program to determine the appropriate limiting condition for operation.

The inspectors determined that the licensee's failure to include an adequate limiting condition for operation in the technical specification was a performance deficiency. This finding is more than minor because it affected the protection against external events attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, in that the reactor cannot be placed in a cold shutdown condition using normal operating procedures when the river level exceeds 1009 feet mean sea level. Because this finding occurred while the unit was operating at full power, the inspectors used Inspection Manual Chapter 0609, Appendix A, to determine its significance. Using Attachment 1 of that appendix, the inspectors determined that this finding had very low risk significance because the finding did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event, using the criteria included in Exhibit 1 of Inspection Manual Chapter 0609 Attachment 4. Since the finding is not indicative of current licensee performance, there is no crosscutting area assigned to this finding.

Inspection Report# : [2010003](#) (pdf)

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to Correct Adverse Condition Trips Turbine Driven Auxiliary Feedwater Pump**

A self-revealing noncited violation of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," occurred for the licensee's failure to assure that a condition adverse to quality was corrected. Specifically, the licensee identified five instances of the turbine driven auxiliary feedwater pump FW-10 reset lever being bumped and unlatching, which would prevent FW-10 from starting if required, and failed to correct the adverse configuration condition allowing the reset lever to be bumped. The failure to correct this adverse condition was demonstrated when the turbine driven auxiliary feedwater pump FW-10 reset lever apparently partially unlatched due to bumping, tripped during a surveillance test start attempt February 17, 2010. The licensee entered this issue in their corrective action program as CR-2010-0813.

The finding is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the issue screened as potentially risk significant since the finding represented a loss of system safety function of a single train for greater than the technical specification allowed outage time. The finding required a Phase 2 analysis. When evaluated per Manual Chapter 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations," and the Fort Calhoun Phase 2 pre-solved table item "Turbine Driven Auxiliary Feedwater Pump Fails to Start," the inspectors determined this finding to be potentially risk significant. The finding was forwarded to a senior reactor analyst for review. The senior reactor analyst performed the Phase 3 analysis, Attachment 4, and determined that the finding was of very low risk significance. This finding has a crosscutting aspect in the corrective action program component of the Problem Identification and Resolution area because the licensee's periodic trends and assessments did not recognize the significance of precursor events related to bumping the reset lever and prompt action to prevent further problems with the turbine driven auxiliary feedwater pump FW-10 [P.1(b)].

Inspection Report# : [2010006](#) (pdf)

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Verify Trip Fully Latched results in Turbine Driven Auxiliary Feedwater Pump Trip**

The team identified a noncited violation of Technical Specification 5.8.1.a that requires written procedures be implemented as recommended in Regulatory Guide 1.33, Revision 2, Appendix A, that requires procedures for startup, shutdown and operation of the auxiliary feedwater system. Specifically, the licensee having no procedural guidance to verify full engagement of the turbine driven auxiliary feedwater pump FW-10 high exhaust back pressure trip when latched. This resulted in the partially latched high exhaust trip mechanism vibrating loose and a failure to start of FW-10, on February 17, 2010. The licensee entered this deficiency in their corrective action program as CR 2010-0813.

This finding is greater than minor because it was associated with the Mitigating Systems cornerstone attribute of procedural quality and it affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the issue screened as very low safety significance because it was not a design or qualification deficiency that resulted in a loss of operability or functionality, did not create a loss of system safety function of a single train for greater than the technical specification allowed outage time and did not affect seismic, flooding, or severe weather initiating events. The finding has a crosscutting aspect in the area of problem identification and resolution associated with operating experience because the licensee failed to implement and institutionalize operating experience through changes to station operating procedures when they failed to incorporate industry information to verify the turbine driven auxiliary feedwater pump is fully latched [P.2(b)].

Inspection Report# : [2010006](#) (pdf)

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Inadequate Procedure Results in Failure of Turbine Driven Auxiliary Feedwater Pump to Start.**

A self-revealing non-cited violation of Technical Specification 5.8.1.a was identified regarding the licensee's failure to implement and maintain the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Paragraph 9.a of Appendix A requires that such maintenance that can affect the performance of safety-related equipment be properly pre-planned and performed in accordance with documented instructions. Specifically, the licensee failed to have an adequate procedure for ensuring air was vented from the auxiliary feedwater pump control oil system following maintenance. As a result, the turbine-driven auxiliary feedwater pump failed to start during an operability test. The licensee has entered this issue into their corrective action program as condition report CR-2009-0905

The finding is more than minor because it is associated with mitigating system cornerstone attribute of procedure quality and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Using Manual Chapter 0609.04, "Phase 1 Initial Screening and Characterization of Findings," the finding was found to have very low safety significance (Green) because it was not a design deficiency; did not represent loss of a safety function, loss of a single train for greater than its allowed outage time, or loss of a non technical specification train of equipment; and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The finding has a crosscutting aspect in the area of problem identification and resolution associated with operating experience because the licensee failed to implement and institutionalize operating experience through changes to station work instructions when they failed to incorporate industry information on control and hydraulic oil system failures due to air introduced during maintenance [P.2(b)].

Inspection Report# : [2010006](#) (pdf)

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Turbine Driven Auxiliary Feedwater Pump Trip Due to Inadequate Design Margin**

A self-revealing non-cited violation of 10 CFR, Part 50, Appendix B, Criterion III, "Design Control," occurred when the licensee failed to ensure that the design basis of certain structures, systems and components were translated into specifications, drawings, procedures, and instructions when implementing Engineering Change 45105. Specifically, this design change reduced the turbine driven auxiliary feedwater pump's margin between the pump discharge pressure and the pump's high discharge pressure trip set-point resulting in a April 6, 2009, high pump discharge pressure trip during a scheduled surveillance test start. The licensee entered this issue in their corrective action program as CR 2009-1611.

The inspectors determined the finding is more than minor because it is associated with the design control attribute of the mitigating systems cornerstone, and adversely affected the cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the issue screened as potentially risk significant since the finding represented a loss of system safety function of a single train for greater than the technical specification allowed outage time. The finding required a Phase 2 analysis. When evaluated per Manual Chapter 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations," and the Fort Calhoun Phase 2 pre-solved table item "Turbine Driven Auxiliary Feedwater Pump Fails to Start," the inspectors determined this finding to be potentially risk significant. The finding was forwarded to a senior reactor analyst for review. The senior reactor analyst performed the Phase 3 analysis, Attachment 4, and determined that the finding was of very low risk significance. The finding has a crosscutting aspect in the area of human performance because the licensee failed to use conservative assumptions in decision making when a non conservative design margin was approved and implemented on the turbine driven auxiliary feedwater pump [H.1(b)].

Inspection Report# : [2010006](#) (pdf)

**Significance:** Y Jun 21, 2010

Identified By: NRC

Item Type: AV Apparent Violation

### **Failure to Maintain External Flood Procedures**

Yellow. The inspectors identified an apparent violation of Technical Specification 5.8.1.a, "Procedures," for failure to establish and maintain procedures that protect the intake structure and auxiliary building during external flooding events. The inspectors determined that the procedural guidance of GM-RR-AE-1002, "Flood Control Preparedness for Sandbagging," was inadequate because stacking and draping sandbags at a height of four feet over the top of floodgates would be insufficient to protect the vital facilities to 1014 feet mean sea level, as committed to in Updated Safety Analysis Report and station procedures. The licensee has entered this condition into their corrective action program as Condition Report 2010-2387. As result of this violation, the licensee has implemented a corrective action plan to correct identified deficiencies and ensure site readiness.

This performance deficiency is more than minor because it adversely affected the Mitigating Systems Cornerstone attribute of external events and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined the finding resulted in the degradation of equipment and functions specifically designed to mitigate a flooding initiating event. In addition, an external flood event would degrade two or more trains of a multi-train safety system. Therefore, the finding was potentially risk significant to flood initiators and a Phase 3 analysis was required. The preliminary change in core damage frequency was calculated to be  $3.1E-5$ /year indicating that the finding was of substantial safety significance (Yellow). The finding was determined to have a crosscutting aspect in the area of problem identification and resolution, corrective action program, for failure to take appropriate corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity. Specifically, from 2003 to 2008, the licensee failed to initiate appropriate corrective actions to ensure regulatory compliance of the external flooding design basis was maintained. [P.1(d)] (Section 4OA5.1)

ERRATA - 10/19/10 issued IR 05000285/2010008-01 to document final significance determination process letter.

Inspection Report# : [2010007](#) (pdf)

Inspection Report# : [2010008](#) (pdf)

**Significance:** G Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Assessment of Seismic Qualification of Raw Water Pumps**

Green. The team identified a Green, noncited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." Specifically, from February 1992 to September 8, 2009, the licensee failed to adequately evaluate the seismic qualification of the raw water pumps to ensure that the pumps' anchor bolts imbedded in the floor would meet Seismic Class I standards. The team determined that the February 1992 seismic analysis was not conservative for the following reasons: (1)The weight distribution of the pump/motor assembly in the analysis did not correctly apply the center of gravity of the pump to the loading analysis. (2)The stress analysis of the anchors did not include the weight of the water in the piping. (3)The stress analysis did not include the nozzle loads applied to the pump due to the weight of the discharge piping. The licensee entered the issue into their corrective action program as CR 2009-3977, and performed a preliminary operability evaluation of the support components which determined that the pumps would remain operable following a safe shutdown earthquake. The team reviewed the evaluation, and concurred with the operability evaluation. The finding is more than minor because it adversely affected the design control 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 was of very low safety significance (Green) because it was a design deficiency that did not result in actual loss of safety function. This finding was not assigned a crosscutting aspect because the underlying cause was not indicative of current performance (Section 1R21.2.15).

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

**Significance:**  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Flood Protection for the Intake Structure**

Green. The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings.” Specifically, from August 9, 1973, to September 8, 2009, the licensee failed to prescribe instructions into procedures that would ensure that the plant could be safely shutdown at the probable maximum flood elevation of 1009.3 feet mean sea level. The licensee’s updated safety analysis report, technical specifications, and station procedures state that protection of the raw water pumps against flooding up to the probable maximum flood height of 1009.3 feet mean sea level is accomplished by sandbag berms and flood gates. During an intake structure walkdown, the team observed two unsealed, 14 inch diameter fire protection piping penetrations in the outer wall, with the bottom of the penetration at elevation 1008.5 feet mean sea level. The penetrations had an air gap of about ½ inch between the wall and the pipe. After reviewing station procedures, the team determined that the unsealed penetrations would not be sealed during flooding conditions.

As a result of the team’s concern, the licensee entered the issue into their corrective action program as CR 2009-4166 and CR 2009-6195, and verified that there are no other open penetrations in the building walls below the flood level of 1009.3 feet mean sea level. The licensee changed procedure GM-RR-AE-1002 to provide temporary sealing of the penetrations if predicted floods occurred before the permanent seals were installed. The licensee stated that the penetrations will be permanently sealed before the spring 2010 flood season.

This performance deficiency is more than minor because it adversely affected the Mitigating Systems Cornerstone attribute of external events and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. The finding affected the Mitigating Systems Cornerstone because flood protection was degraded. The team determined that the finding resulted in the degradation of equipment and functions specifically designed to mitigate a flooding initiating event and that during a flooding event the loss would degrade two or more trains of a multi-train safety system. Therefore, the finding was potentially risk significant to flood initiators and a Phase 3 analysis was required. The final change in core damage frequency was calculated to be  $8.2 \times 10^{-7}$  indicating that the finding was of very low safety significance (Green). This finding was not assigned a crosscutting aspect because the underlying cause was not indicative of current performance (Section 1R21.2.15).

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

**Significance:**  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Corrective Actions to Ensure the Reliability of the Raw Water Pump Power Cables**

Green. The team identified a Green, noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action” for failure to take adequate corrective action following the discovery of water intrusion in manholes MH-5 and MH-31 in 1998, 2005, and 2009. Specifically, from 1998 to September 11, 2009, the licensee failed to take corrective action to establish an appropriate monitoring frequency that would mitigate potential common mode failure of raw water 5kV motor cables in underground ducts and manholes. The licensee entered the condition into the corrective action program as CR 2009-4216. The corrective action changed the manhole inspection schedule from an 18 month schedule to a quarterly schedule.

The finding is more than minor because it adversely affected the Mitigating Systems Cornerstone attribute of design control for 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 (Green) because it was a design deficiency that did not result in actual loss of safety function. This finding has a crosscutting aspect in the area of human performance, decision making, because the licensee failed to use conservative assumptions in decision making and

adopts a requirement to demonstrate that the proposed action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action. Specifically, since 2005, the licensee decided to postpone installation of proposed level corrective actions and failed appropriately monitor water intrusion in MH-5 and MH-31 multiple times [H.1(b)](Section 1R21.3.4).

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

**Significance:** SL-IV Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Maintain Quality Records of the Intake Structure Design**

SL-IV. The team identified a Severity Level IV, noncited violation of 10 CFR Part 50, Appendix B, Criterion XVII, "Quality Assurance Records," for failure to maintain original records of the seismic and tornado analysis of the intake structure. Specifically, in 2005, the licensee could not retrieve the original design documentation of the seismic and tornado analysis of the intake structure. This condition was documented in CR 200504345. After the licensee determined the documentation was not retrievable, the licensee reconstituted the seismic and tornado analysis of the intake structure. These analyses were available during the team's inspection.

This finding is assessed through traditional enforcement because the finding has the potential for impacting the NRC's ability to perform its regulatory function. Using Inspection Manual Chapter 0612, Appendix E, the finding is more than minor because the records were not retrievable. Using Supplement I of the NRC Enforcement Policy, this finding will be treated as a Severity Level IV violation. This finding was not assigned a crosscutting aspect because the underlying cause was not indicative of current performance (Section 4OA5.1).

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

---

## Barrier Integrity

---

## Emergency Preparedness

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Conduct an Adequate Audit of Emergency Preparedness Interfaces with Offsite Authorities**

The inspectors identified a noncited violation of 10 CFR 50.54(t)(2) for the failure to conduct an evaluation of the adequacy of interfaces between the licensee and state and local governments during a periodic review of the site emergency preparedness program. Specifically, the quality assurance audit team, for the February 2010 emergency preparedness audit, did not evaluate the adequacy of interfaces with offsite agencies and did not contact state or local emergency management or radiological health agencies during the audit to obtain information about their working relationships with the licensee. The licensee has placed this violation in their corrective action program as Condition Report 2010-2078.

This finding is more than minor because it affected the offsite emergency preparedness attribute of the Emergency Preparedness Cornerstone objective. This finding was determined to be of very low safety significance because it was a failure to comply with an NRC requirement and was not associated with the planning standards of 10 CFR 50.47(b). This finding is associated with the resources component of the human performance crosscutting area [H.2(b)]

Inspection Report# : [2010003](#) (*pdf*)

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO CONDUCT DRILLS TO MAINTAIN ENVIRONMENTAL MONITORING SKILLS**

The inspectors identified a noncited violation of 10 CFR 50.47(b)(14) for the failure to conduct drills that were adequate to maintain key skills. Specifically, environmental monitoring teams were not required to collect environmental samples during the 2008 and 2009 annual environmental monitoring drills. The licensee has placed this violation in their corrective action program as Condition Report 2010-2055.

This finding is more than minor because it affected the emergency response organization performance and procedure quality cornerstone attributes of the Emergency Preparedness Cornerstone objective. The finding is of very low safety significance because it is a failure to comply with NRC requirements, was associated with nonrisk significant planning standard 10 CFR 50.47(b)(14), and was not a functional failure of the planning standard. This finding is associated with the resources component of the human performance crosscutting area

Inspection Report# : [2010003](#) (*pdf*)

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

### **PROTECTIVE ACTION RECOMMENDATION PROCESSES ALLOW FOR THE UNNECESSARY EVACUATION OF THE PUBLIC**

The inspectors identified a noncited violation of 10 CFR 50.47(b)(10) and 50.54(q) for the failure to develop and put into place guidelines for the choice of protective actions during an emergency that were consistent with federal guidance. Specifically, the licensee's methodology for determining protective action recommendations could result in recommendations to evacuate members of the public in areas where dose projections did not exceed EPA protective action guides. The licensee has placed this violation in their corrective action program as Condition Report 2010-2174.

This finding is more than minor because it adversely affected the emergency response organization performance and procedure quality cornerstone attributes of the Emergency Preparedness Cornerstone objective. This finding was determined to be of very low safety significance because it was a failure to comply with NRC requirements, is a finding associated with a risk significant planning standard, and is not a risk significant planning standard functional failure or degraded function. This finding was associated with the operating experience component of the problem identification and resolution crosscutting area [P.2(a)]

Inspection Report# : [2010003](#) (*pdf*)

---

## **Occupational Radiation Safety**

**Significance:**  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Provide Adequate Instruction to Pregnant Workers**

The inspectors identified a noncited violation of 10 CFR 19.12 for failure to provide adequate instruction to declared pregnant workers. Specifically, the licensee did not provide adequate information concerning the potential health protection problems and risk associated with exposure of an embryo/fetus to radiation and/or radioactive materials. The licensee entered this issue into their corrective action program as Condition Report CR 2009-5854.

The inspectors determined that the failure to provide adequate instruction to declared pregnant workers is a performance deficiency. The finding is more than minor because it is associated with the occupational radiation safety cornerstone attribute and adversely affects the objective to ensure adequate protection of worker health and safety from exposure to radiation during routine civilian nuclear reactor operation. Using the Occupational Radiation Safety Significance Determination Process, the inspectors determined this finding to be of very low safety significance because the finding did not involve ALARA planning and work controls, did not result in an overexposure, did not present a substantial potential for overexposure, and did not compromise the licensee's ability to assess dose.

Additionally, the finding had a crosscutting aspect in the area of human performance, resources component, because the licensee failed to ensure the procedures related to declared pregnant workers included adequate instructions concerning the increased health concerns related to radiation exposure to the embryo/fetus [H.2.(c)].

Inspection Report# : [2009005](#) (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:** SL-IV Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **FAILURE TO SUBMIT A REQUIRED LICENSEE EVENT REPORT**

The inspectors identified a noncited violation for the failure to submit a licensee event report within 60 days of discovery of an event as required by 10 CFR 50.73. Specifically, the turbine-driven auxiliary feedwater pump, FW 10, was inoperable from February 26 until April 6, 2009, which is a reportable condition required by 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by technical specifications. On March 11, 2009, the electric motor-driven auxiliary feedwater pump, FW-6, was inoperable for approximately four hours when diesel generator 1 was inoperable. With both auxiliary feedwater pumps simultaneously inoperable, this was a reportable condition required by 10 CFR 50.73(a)(2)(v) as an event that could have prevented fulfillment of a safety function. The licensee entered this violation into their corrective action program, completed a reportability evaluation and determined that a licensee event report was required to be submitted within 60 days of April 6, 2009, and had not been submitted. The licensee event report will be submitted prior to August 10, 2010.

The inspectors determined that the licensee's failure to submit a Licensee Event Report was a performance deficiency. The inspectors reviewed this issue in accordance with NRC Inspection Manual Chapter 0612 and the NRC Enforcement Manual. Through this review, the inspectors determined that traditional enforcement was applicable to this issue because the NRC's regulatory ability was potentially affected. Specifically, the NRC relies on licensees to identify and report conditions or events meeting the criteria specified in regulations in order to perform its regulatory function, and when this is not done the regulatory function is impacted, and is therefore a finding. The inspectors determined that this finding was not suitable for evaluation using the significance determination process, and as such, was evaluated for traditional enforcement only in accordance with the NRC Enforcement Policy. This is a Severity Level IV noncited violation consistent with Section IV.A.3 and Supplement I, Paragraph D.4, of the NRC Enforcement Policy.

Inspection Report# : [2010003](#) (pdf)

**Significance:** SL-IV Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Inadequate Reportability Guidance**

Severity Level IV. The inspectors identified a Severity Level IV noncited violation of Fort Calhoun Technical Specification 5.8.1 for inadequate corrective action documents. Specifically, the documents do not adequately address

assigning reportability evaluations. As a result, the licensee failed to evaluate the reportability of a condition that was determined to be reportable until questioned by the inspectors.

The inspectors determined that the licensee's inadequate corrective action documents were a performance deficiency. The inspectors reviewed this issue in accordance with NRC Inspection Manual Chapter 0612 and the NRC Enforcement Policy. Through this review, the inspectors determined that traditional enforcement was applicable to this issue because the NRC's regulatory ability was potentially affected. Specifically, the NRC relies on the licensees to identify and report conditions or events meeting the criteria specified in regulations in order to perform its regulatory function, and when this is not done the regulatory function is impacted, and is therefore a finding. The inspectors determined that this finding was not suitable for evaluation using the significance determination process, and as such, was evaluated in accordance with the NRC Enforcement Policy. The finding was reviewed by NRC management and due in part to its repetitive nature the violation was determined to be of more than minor significance, however since it was not found to be willful, and was entered into the corrective action program, this violation is being treated as a Severity Level IV noncited violation consistent with the NRC Enforcement Policy. Inspection Report# : [2010002](#) (*pdf*)

Last modified : January 06, 2011