

Monticello

3Q/2010 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH TURBINE FLOOR HEAVY LIFT PROCEDURE.

A finding of very low safety significance and associated non cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee, on two occasions during the lift and transfer of the General Electric Zinc Injection Passivation (GEZIP) skid, failing to adhere to the load height restrictions documented in Procedure 8117, "Turbine Maintenance Procedure Heavy Load Movement over Safe Shutdown Equipment on the Turbine Floor," a procedure affecting quality. This resulted in the licensee not evaluating and managing the risk associated with moving a heavy load above and in close proximity to the Division I emergency service water piping. The licensee immediately placed a restriction on moving heavy loads on the turbine floor until the appropriate corrective actions can be implemented. The inspectors determined that the performance deficiency affected the cross cutting area of Human Performance, having work control components, and involving aspects associated appropriately planning work activities by incorporating risk insights. [H.3(a)]

The inspectors determined that the failure to adequately evaluate two deviations from the acceptable heavy load path for the transport and placement of the new GEZIP skid was a performance deficiency, because it was the result of the failure to meet a requirement, and the cause was reasonably within the licensee's ability to foresee and correct, and should have been prevented. The inspectors screened the performance deficiency per IMC 0612, Appendix B, and determined that the issue was more than minor because it could reasonably be viewed as a precursor to a significant event. Specifically, the licensee failed to manage the risk of moving a heavy load above and in close proximity to the Division I emergency service water piping.

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

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

UNACCEPTABLE PRECONDITIONING OF 250 VDC BATTERY CHARGERS.

The inspectors identified a finding of very low safety significance and associated NCV of Technical Specification (TS) 5.4.1 for the licensee's failure to appropriately implement an applicable procedure recommended in Regulatory Guide 1.33, Appendix A, Revision 2, February 1978. Specifically, the licensee approved TS surveillance activities to commence for the 250 Vdc battery chargers in 2008 without ensuring that the equipment was tested in the as-found condition. Due to improper sequencing of preventive maintenance activities for the battery chargers, and subsequent inadequate review of the maintenance and testing order, the 250 Vdc battery chargers were unacceptably preconditioned prior to performing testing to satisfy the 24 month TS Surveillance Requirement 3.8.4.2. These issues were identified by the inspectors prior to the 2010 performance of the same surveillance tests. The licensee took immediate corrective actions and entered the issues into their corrective action program. The inspectors determined that the performance deficiency affected the cross cutting area of Human Performance, having work control components, and involving aspects associated with appropriately coordinating work activities by incorporating actions to address the impact of the work on different job activities. [H.3(b)]

The inspectors determined that the issue was a performance deficiency because it was the result of the failure to meet a requirement, and the cause was reasonably within the licensee's ability to foresee and correct, and should have been

prevented. The inspectors determined that the performance deficiency was more than minor and a finding because, if left uncorrected, it would have had the potential to lead to a more significant safety concern. The inspectors applied IMC 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings" to this finding. Under Column 2 of the Table 4a worksheet, the inspectors answered "Yes" to Question 1 because the finding did not result in loss of operability or functionality. Therefore, the finding was considered to be of very low safety significance. Inspection Report# : [2010003](#) (pdf)

Significance: SL-IV Mar 26, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform 10 CFR 50.59 Evaluation For Isolation of Room Cooler Which Addressed Temperature Limitations

The inspectors identified a finding of very low safety significance associated with an NCV of 10 CFR 50.59, "Changes, Tests, and Experiments," Section (d)1 for the licensee's failure to perform a written evaluation, which provided the bases for the determination that a change did not require a license amendment. Specifically, the licensee failed to provide a basis which addressed room temperature limitations as to why the isolation of a high pressure coolant injection (HPCI) room cooler did not require prior NRC approval. This failure impacted the NRC's regulatory process, and is therefore being assessed for traditional enforcement. The licensee entered this issue into their corrective action program and determined that no immediate corrective actions were necessary because administrative controls were in place to ensure that the HPCI room temperature would not exceed the calculated initial room temperature limitation.

The inspectors determined that the finding was more than minor because they could not reasonably determine that the changes would not have ultimately required NRC prior approval, thus meeting the criteria for a Severity Level IV violation. The finding affected the Mitigating Systems cornerstone attribute of Equipment Performance to ensure the availability and reliability of systems (HPCI) that respond to initiating events to prevent undesirable consequences. This finding has a cross-cutting aspect in the area of human performance within the resources component because the licensee did not ensure that personnel, equipment, procedures, and other resources were available and adequate to assure nuclear safety in that training of personnel was not sufficient. [H.2(b)] (Section 1R17.1.b)

The associated performance deficiency is tracked as item 2010-06-02.

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

Significance:  Mar 26, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform 10 CFR 50.59 Evaluation For Isolation of Room Cooler Which Addressed Temperature Limitations - performance deficiency

The inspectors identified a finding of very low safety significance for the licensee's failure to perform a written evaluation, which provided the bases for the determination that a change did not require a license amendment as required by 10 CFR 50.59. Specifically, the licensee failed to provide a basis which addressed room temperature limitations as to why the isolation of a high pressure coolant injection (HPCI) room cooler did not require prior NRC approval. The licensee entered this issue into their corrective action program and determined that no immediate corrective actions were necessary because administrative controls were in place to ensure that the HPCI room temperature would not exceed the calculated initial room temperature limitation.

The inspectors determined that the finding was more than minor because they could not reasonably determine that the changes would not have ultimately required NRC prior approval. The inspectors determined that the finding was of very low safety significance because the finding did not result in loss of operability or functionality. The finding affected the Mitigating Systems cornerstone attribute of Equipment Performance to ensure the availability and reliability of systems (HPCI) that respond to initiating events to prevent undesirable consequences. This finding has a cross-cutting aspect in the area of human performance within the resources component because the licensee did not ensure that personnel, equipment, procedures, and other resources were available and adequate to assure nuclear safety in that training of personnel was not sufficient. [H.2(b)] (Section 1R17.1.b)

The associated traditional enforcement action is tracked as item 2010-006-01.

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

Significance: SL-IV Mar 04, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure of an NDE Technician to Follow an Ultrasonic Thickness Examination Procedure

A Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," was identified by the inspectors for a contract Non-Destructive Examination (NDE) technician's failure to follow a procedure during an Ultrasonic (UT) examination of the Reactor Core Isolation Cooling (RCIC) barometric condenser shell. Specifically, the technician failed to properly perform a calibration of the UT examination equipment. The underlying performance deficiency (PD) associated with this violation did not result in a finding due to the minor safety-significance of the PD and hence the PD was not evaluated for cross-cutting aspects (i.e., it screened out as minor). Specifically, the PD was similar to Example 4b of IMC 0612, Appendix E, "Examples of Minor Issues," in that, it involved an insignificant procedural error, failure to calibrate UT equipment per procedure. The failure had minimal impact on the UT readings (within UT test equipment tolerances). However, due to the willfulness of the violation, the violation was processed through the traditional enforcement process and assigned a Severity Level IV. Specifically, the NRC Enforcement Policy states that a violation may be considered more significant than the underlying non-compliance if it includes indications of willfulness. As part of its corrective actions, the licensee re-examined the technician's prior UT examinations and found insignificant variation between re-examined UT examination results and the technician's original UT examination results.

Inspection Report# : [2010009](#) (pdf)

Significance:  Dec 04, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Emergency Service Water Piping Supports Did Not Meet Seismic Category 1 Design Basis Requirements

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," having very low safety significance for the failure to restore the emergency service water (ESW) piping supports to their design specifications. Specifically, although the licensee identified the existence of gaps between the ESW piping supports and the baseplates, the licensee failed to recognize that this condition did not meet seismic Category 1 design basis requirements. As a result, corrective actions were not implemented. The licensee entered this issue into its corrective action program and restored the supports to their design specifications.

The finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of protection against external events and affected the cornerstone objective of ensuring the availability of the ESW system, and ultimately the emergency diesel generators (EDGs), to respond to initiating events to prevent undesirable consequences. This finding is of very low safety significance (Green) because the design deficiency was confirmed not to result in loss of operability or functionality. This finding has a cross-cutting aspect in the area of problem identification and resolution because the licensee did not properly prioritize and evaluate an identified problem.

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

Significance:  Dec 04, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Evaluate Minimum Voltage Available at Safety-Related Electrical Components

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance for the failure to adequately evaluate circuit loads in determining design limits in electrical calculations. Specifically, three examples were identified where the licensee (1) failed to perform a calculation for safety-related motor starters that included all control circuit loads in determining the minimum voltage available at 120Vac starter coils, which was used to establish the coil voltage test acceptance criteria; (2) failed to include thermal overload heater and starter contact resistance when calculating the minimum voltage at 480Vac motor terminals; and (3) failed to assure that the minimum voltage at the 120Vac solenoid operated control valves was in conformance with vendor requirements. These issues were entered into the licensee's corrective action program to re-evaluate the voltage available, and to test coils, as required, to verify the pick-up voltage.

The finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of design control and affected the cornerstone objective of ensuring the availability, reliability and capability of safety-

related equipment to respond to initiating events to prevent undesirable consequences. This finding is of very low safety significance (Green) because the design deficiency was confirmed, with the exception of ESW pump P-111B, not to result in loss of operability or functionality. Specifically, the failure to assure adequate voltage was available at the solenoid valves coils; and to perform periodic testing to assure the minimum voltage remained acceptable as the components aged, did not result in an impact on current operability. With respect to the ESW pump, it was determined that the pump would not have started under degraded voltage condition as required such that the ESW pump was considered inoperable. Based on a Phase III analysis, the failure of the pump to start under degraded voltage conditions was determined to be very low safety significance (Green). The inspectors did not identify a cross-cutting aspect associated with this finding because this was a legacy design issue and therefore was not reflective of current performance.

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

Significance:  Dec 04, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Testing for Motor Control Center (MCC) Contactors

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," having very low safety significance for the failure to have adequate testing for safety-related equipment to monitor component degradation. Specifically, the licensee failed to verify that the motor control center contactors would continue to pick-up under degraded voltage conditions with less than the vendors' required minimum voltage. These issues were entered into the licensee's corrective action program to test the 13 contactors as soon as practicable and to revise the maintenance procedures to incorporate the requirements for periodic testing of contactors.

The finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of design control and affected the cornerstone objective of ensuring the availability, reliability and capability of safety-related equipment to respond to initiating events to prevent undesirable consequences. This finding is of very low safety significance (Green) because the testing deficiency was confirmed, with the exception of emergency service water (ESW) pump P-111B, not to result in loss of operability or functionality. Specifically, subsequent testing confirmed for nine contactors that the safety-related starter coils would still function at the calculated degraded voltage values. Although three of the contactors have not been tested, they were of a different size than the failed contactor and there appeared to be reasonable assurance based on the successful tests that these contactors also remained operable. With respect to the ESW pump, the failed test confirmed that the motor starter contactor would not pickup under degraded voltage conditions due to mechanical binding of the contactor arm such that the ESW pump was considered inoperable. Based on a Phase III analysis, the failure of the pump to start under degraded voltage conditions was determined to be very low safety significance (Green). The inspectors did not identify a cross-cutting aspect associated with this finding because this was a legacy design issue and therefore was not reflective of current performance.

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

Significance:  Dec 04, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Pipe Support Design Deficiencies

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance for the failure of two pipe supports to meet their design requirements. Specifically, the calculation for pipe support SR-526 failed to use the minimum yield strength in determination of the allowable bending stress of the pipe support baseplate as required in the American Institute of Steel Construction code. In addition, the calculation for pipe support PS-16 failed to use the design basis concrete compressive strength in determination of the anchor bolt allowable as required in the licensee's design specification. This finding was entered into the licensee's corrective action program and a preliminary analysis performed by the licensee concluded that the pipe supports were operable but nonconforming. This NCV was the result of a Power Uprate sample. The performance deficiency for pipe support SR-526 example was more than minor because it was associated with the Mitigating Systems cornerstone attribute of design control and affected the cornerstone objective of ensuring the availability, reliability, and capability of the safety-related residual heat removal and core spray pumps. This finding is of very low safety significance (Green) because the design deficiency was confirmed not to result in loss of

operability or functionality. The performance deficiency for pipe support PS-16 example was more than minor because it was associated with the Barrier Integrity cornerstone attribute of design control and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. This finding is of very low safety significance (Green) because there was no actual barrier degradation. The inspectors did not identify a cross-cutting aspect associated with this finding because this was a legacy design issue and therefore was not reflective of current performance.
Inspection Report# : [2009007](#) (pdf)

Barrier Integrity

Significance:  Sep 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE ELECTRICAL ISOLATION DURING DEMOLITION ACTIVITY.

A finding of very low safety significance and associated non cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self revealed when the licensee failed to adequately implement the requirements of their fleet tagging procedure, a procedure affecting quality, during the demolition of the 'A' train of the combustion gas control system (CGCS). This failure directly led to workers being unprotected from existing 24 Vdc, and potentially 120 Vac, during the removal of cables C259 SV40008A/1 and C259 SV4009A/1. In addition, cutting of the energized cables resulted in the loss of position indication for three primary containment isolation valves which are required by Technical Specifications. The licensee promptly took actions to restore the affected containment isolation valves to an operable status and entered this event into their corrective action program for further evaluation. The inspectors determined that the contributing cause that provided the most insight into the performance deficiency was associated with the cross cutting area of Human Performance, having work control components, and involving aspects associated with appropriately coordinating work activities by incorporating job site conditions which may impact human performance and plant systems and components. [H.3(a)] The inspectors determined that the licensee's failure to adequately implement their work order planning and tagging processes to protect workers and equipment from existing electrical hazards during the demolition of the 'A' train of the CGCS system was a performance deficiency because it was the result of the failure to meet a requirement; the cause was reasonably within the licensee's ability to foresee and correct; and should have been prevented. The inspectors applied IMC 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," to this finding. Since the finding directly resulted in the loss of position indication for three containment isolation valves which are required by Technical Specifications, the inspectors evaluated the finding under the Containment Barrier Cornerstone. Utilizing Column 4 of the Table 4a worksheet, the inspectors answered "Yes" to question 1. Since the finding only resulted in the degradation of the radiological barrier function provided for the control room, auxiliary building, spent fuel pool, or standby gas treatment (SBGT) system, the finding was screened to be of very low safety significance.

Inspection Report# : [2010004](#) (pdf)

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

SRV LOW LOW SET SURVEILLANCE PROCEDURE IMPLEMENTATION.

The inspectors identified a finding of very low safety significance and NCV of Technical Specification 5.4.1 for the licensee failing to appropriately implement an applicable procedure recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Specifically, when unexpected local alarms were received during the performance of the safety relief valve (SRV) low low set system quarterly test, Instrument and Control (I&C) personnel elected to attempt to clear the alarms prior to notifying operations and without fully understanding which alarms were present. The surveillance procedure provided no guidance on how to clear the unexpected module trip alarms and relay energized lights. The licensee entered this issue into their corrective action program. The inspectors determined that the performance deficiency affected the cross cutting area of Human Performance, having decision-making components, and involving aspects associated with using conservative assumptions in decision making. [H.1(a)]

The inspectors determined that the performance deficiency was more than minor and a finding because it was associated with the Barrier Integrity Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors evaluated the finding using IMC 0609, Appendix A, Attachment 1, "Significance Determination of Reactor Inspection Findings for At Power Situations," using the Phase 1 Worksheet for the Barrier Integrity Cornerstone. Since the inspectors answered 'no' to all four questions in the Containment Barrier column of the Characterization Worksheet for Initiating Events, Mitigating Systems, and Barrier Integrity Cornerstones, the inspectors concluded that the finding was of very low safety significance.

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

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS FOR UNEXPECTED SRV LOW LOW SET TRIPS ENCOUNTERED DURING SURVEILLANCE TESTING.

The inspectors identified a finding of very low safety significance and NCV of 10 CFR 50, Appendix B, Criterion XVI, for the licensee's failure to adequately evaluate and take corrective actions for a condition adverse to quality. Specifically, the licensee failed to appropriately evaluate the implications of the unexpected trips of high/low pressure switches, PSHL 4065A and PSHL 4066A, during the January 28, 2009, performance of the SRV low low set system quarterly tests and implement appropriate corrective actions. The failure to adequately evaluate the unexpected trips and correct the condition adverse to quality directly contributed to a repeat occurrence and subsequent unplanned Technical Specification Action entry during the January 27, 2010, performance of the same surveillance test. The licensee entered the issue into their corrective action program. The inspectors determined that the performance deficiency affected the cross cutting aspect in the area of Problem Identification and Resolution, having corrective action program components, and involving aspects associated with the licensee thoroughly evaluating problems such that the resolutions address causes and extent of conditions, as necessary. [P.1(c)]

The inspectors determined that the performance deficiency was more than minor and a finding because it was associated with the Barrier Integrity Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors evaluated the finding using IMC 0609, Appendix A, Attachment 1, "Significance Determination of Reactor Inspection Findings for At Power Situations," using the Phase 1 Worksheet for the Barrier Integrity Cornerstone. Since the inspectors answered 'no' to all four questions in the Containment Barrier column of the Characterization Worksheet for Initiating Events, Mitigating Systems, and Barrier Integrity Cornerstones, the inspectors concluded that the finding was of very low safety significance.

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

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE MAINTENANCE PROCEDURE FOR 'A' SBTG SYSTEM.

A finding of very low safety significance and associated non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed for the licensee's failure to include acceptance criteria appropriate to the circumstances for a preventive maintenance procedure for the 'A' standby gas treatment (SBGT) subsystem. Due to the lack of a specific caution to avoid over-tightening of bolts for installation of a blocking device on the 'A' SBTG subsystem suction valve (AO-2945), the valve failed to open during return-to-service testing on September 29, 2009. Failure of AO-2945 to open resulted in an inadvertent initiation of the 'B' SBTG subsystem due to a low flow condition. The licensee took immediate corrective actions and entered the issue into their corrective action program. In order to re-perform return to-service testing of the 'A' SBTG subsystem after the AO 2945 issue was resolved, the 'B' SBTG subsystem had to be shutdown, requiring entry into limiting condition for operation (LCO) 3.0.3 due to the inoperability of both SBTG subsystems. The inspectors determined that the performance deficiency affected the cross-cutting area of Problem Identification and Resolution, having corrective action program components, and involving aspects associated with identifying issues completely and accurately commensurate with their safety significance. [P.1(a)]

The inspectors determined that the issue was a performance deficiency because it was the result of the failure to meet a requirement, and the cause was reasonably within the licensee's ability to foresee and correct, and should have been

prevented. The inspectors determined that the performance deficiency was more than minor and a finding because it involved the procedure quality attribute of the Barrier Integrity Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors applied IMC 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings" to this finding. Under Column 4 of the Table 4a worksheet, the inspectors answered "Yes" to Question 1 because the finding only represented a degradation of the radiological barrier function provided by the SBT system. Therefore, the finding was considered to be of very low safety significance.

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

Significance: SL-IV Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MAKE REQUIRED EIGHT HOUR EVENT REPORT PER 10 CFR 50.72(b)(3)(v).

A Severity Level IV non-cited violation (NCV) of 10 CFR 50.72(b)(3)(v)(C) was identified by the inspectors for the failure of the licensee to make an eight hour notification to the NRC for a condition that, at the time of discovery, could have prevented the fulfillment of the SBT system safety function. The licensee entered this issue into their corrective action program as CAP 01210817. The inspectors determined that the contributing cause that provided the most insight into the performance deficiency affected the cross cutting area of Problem Identification and Resolution, having corrective action program components, and involving aspects associated with properly classifying and evaluating for reportability conditions adverse to quality. [P.1(c)]

The inspectors determined that the issue was a performance deficiency because it was the result of the failure to meet a requirement, and the cause was reasonably within the licensee's ability to foresee and correct, and should have been prevented. The inspectors determined that the performance deficiency was more than minor and a finding because the failure to report the condition that could have prevented the fulfillment of the SBT system safety function affected the NRC's ability to perform its regulatory function. Because violations of 10 CFR 50.72 are considered to be violations that potentially impede or impact the regulatory process, they are dispositioned using the traditional enforcement process instead of the SDP. Per NRC Enforcement Policy, Supplement I, Example D.4, a failure to make a required Licensee Event Report is categorized as a Severity Level IV violation. The inspectors considered the failure to make a required 50.72 report to meet the intent of this example. Because the violation was not repetitive or willful, and it was entered into the licensee's corrective action program, this violation is being treated as a Severity Level IV NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy.

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

Significance:  Dec 04, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Calculation Errors Associated With the Pneumatic Pressure Requirements for the Inboard Main Steam Isolation Valves

The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance for the failure to incorporate the actual physical configuration of the inboard main steam isolation valves (MSIVs) and the correct pneumatic system pressure drop into the pneumatic pressure requirement calculation for the inboard MSIVs. Specifically, the licensee failed to adjust the actuator moving part weight to reflect that the actuator was offset by 45 degrees instead of being mounted vertically and to correctly compute the system pressure drop. This finding was entered into the licensee's corrective action program and a preliminary calculation performed by the licensee concluded that the valves were operable.

The finding was more than minor because it was associated with the Barrier Integrity cornerstone attribute of structures, systems, components and barrier performance, and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. This finding is of very low safety significance (Green) because there was no actual barrier degradation. The inspectors did not identify a cross-cutting aspect associated with this finding because this was a legacy design issue and therefore was not reflective of current performance.

Inspection Report# : [2009007](#) (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

Last modified : November 29, 2010