

Duane Arnold

4Q/2010 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

INADEQUATE PROCEUDRE RESULTS IN A LOSS OF SHUTDOWN COOLING.

A finding of very low safety significance and associated non-cited violation of Technical Specification Section 5.4.1.a was self revealed because procedure “OI 358, Reactor Protection System, Revision 58” was inadequate. Specifically, while transferring power for the ‘B’ Reactor Protection System to the alternate power supply, the common suction isolation valve for both trains of Shutdown cooling (SDC) went shut causing a loss of shutdown cooling. The licensee entered the issue into the CAP as CR 593949 and revised their procedure to prevent a similar condition in the future.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, shutdown cooling could be lost with different initial conditions, such as having a time-to-boil less than 2 hours and RCS level less than 23 feet above the reactor vessel flange. The inspectors concluded this finding was associated with the Initiating Events Cornerstone. The significance of this finding was evaluated as Green using IMC 0609 Appendix G, “Shutdown Operations Significance Determination Process,” Table 1, “Losses of Control,” and Checklist 7 of Attachment 1, “BWR Refueling Operation with RCS Level >23’.” No cross cutting aspect was identified for this violation since it did not reflect current performance.

Inspection Report# : [2010005](#) (*pdf*)

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY DEFINE REQUIREMENTS AND PRESCRIBE A PROCEDURE APPROPRIATE FOR PLANT CONDITIONS.

A finding of very low safety significance and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors for the licensee’s failure to prescribe a procedure appropriate to the circumstances when Surveillance Test Procedure (STP) 3.0.0-01, Attachment 3, “Reactor Coolant Leakage,” was implemented on April 8, 2010 to meet the Technical Specification (TS) definition of identified leakage. Specifically, STP 3.0.0-01 did not include a requirement to verify that leakage inside the drywell did not interfere with the leakage detection system prior to reclassifying unidentified leakage as identified leakage. The licensee entered the issue into their corrective action program. 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 the licensee assessing information from the corrective action program in aggregate to identify common cause problems. [P.1(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 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 Table 2, all RCS Boundary issues that are not a result of a plant upset will be considered using the Initiating Events Cornerstone. Under Table 4a for the Initiating Events Cornerstone, the finding screened as Green because there was no actual RCS leakage that would have exceeded the TS limit, and the finding did not affect other mitigation systems resulting in a total loss of safety function.

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

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE EVALUATIONS FOR CRANE AND SPECIAL LIFTING DEVICES.

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for deficiencies in the design documents for the reactor building crane and the special lifting devices. Specifically, the crane bridge girder rails supporting the trolley were not evaluated for the design basis seismic loads. In the reactor vessel head special lifting device calculation, the licensee did not evaluate the hook pins and the calculated safety factors did not meet the design criteria. In the dryer/separator special lifting device calculation, the licensee used incorrect stress allowable values. The licensee documented the condition in their Corrective Action Programs (CAPs) as CAPs 072917, 072568, 072885 and 072880, and initiated actions for calculation revisions and/or modifications.

The inspectors determined that not evaluating bridge girder rails for seismic loads in accordance with NUREG 0554, not evaluating the hook pins and accepting safety factors not meeting the design criteria and American National Standards Institute (ANSI) Standard N14.6 on the reactor vessel head special lifting device, and the inadequate calculation of safety factors on the dryer/separator special lifting device in accordance with ANSI N14.6 was a performance deficiency. The finding was more than minor because it was associated with the Initiating Events Cornerstone attribute of Equipment Performance and affected the cornerstone objective to limit the likelihood of those events that upset the plant stability and challenge critical safety functions during shutdown as well as power operations. For the item associated with the crane rail, the Region III Senior Risk Analyst (SRA) performed an SDP Phase 3 risk assessment for estimating the frequency of occurrence of an Operating Basic Earthquake (OBE) or higher seismic event during use of reactor building crane and concluded that the issue was of very low risk significance (Green). For the item associated with the special lifting devices, the inspectors evaluated the finding using IMC 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," and based on a "No" answer to all the questions in the Initiating Events column of Table 4a, as the licensee demonstrated adequate safety factors on all components through subsequent evaluations, determined the finding to be of very low safety significance (Green). The inspectors did not identify any cross cutting aspects associated with this finding because, based on the age of the performance deficiencies, it was not reflective of the current licensee performance.

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

Mitigating Systems

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY WATER INTRUSION INTO CABLE VAULTS CONTAINING SAFETY RELATED CABLES.

A finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the licensee's failure to promptly identify and correct a condition adverse to quality. Specifically, the licensee failed to identify that conduits containing safety related cables were subject to water intrusion following the discovery of water filling an adjacent conduit containing non-safety related cables in the same cable vault. The licensee entered the issue into the CAP as CR 582215, implemented shiftly inspections of the cable vault, and planned inspections and dewatering of the safety related cable conduits.

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 had the potential to lead to a more significant safety concern. The finding was of very low safety significance because the finding was a qualification deficiency that did not result in a loss of operability. 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 thoroughly evaluating problems such that the resolutions address causes and extent of conditions, as necessary.

Inspection Report# : [2010005](#) (pdf)

Significance:  Oct 01, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM TECHNICAL SPECIFICATION SURVEILLANCE REQUIREMENT 3.8.1.6.

The inspectors identified a finding of very low safety significance and associated NCV of Technical Specification (TS) 3.8.1 for the licensee failing to perform TS Surveillance Requirement (SR) 3.8.1.6, which verifies the fuel oil transfer system operates to transfer fuel oil from storage tank to the day tank. Specifically, the licensee failed to perform Inservice Testing (IST) of the diesel fuel transfer pumps as intended by TS SR 3.8.1.6.

The inspectors determined that failure to perform IST of the diesel fuel transfer pumps as intended by TS SR 3.8.1.6 was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems attribute of Equipment Performance and it 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). 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 Mitigation Systems Cornerstone. All four questions on this table were answered "no." Specifically, the licensee had still performed functionality tests of the pumps at the required frequency, and if the pumps had exhibited lower than expected flow during a demand period, the fuel day tanks had adequate margin to compensate to allow for operator action. Therefore, the issue screened as having very low safety significance. This finding has a cross-cutting aspect in the area of Human Performance, Work Control because the licensee did not appropriately assess the impact of changes to the work scope or activity on the plant and human performance. Specifically, the licensee failed to recognize that deleting the section of STP 3.8.1-11 that pertained to IST testing of the fuel oil transfer pump would delete steps in the procedure that were required by TS SR 3.8.1.6. (IMC 0302 (H.3(b)))

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

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

SURVEILLANCE TEST PROCEDURE DID NOT INCLUDE APPROPRIATE ACCEPTANCE CRITERIA.

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to include appropriate acceptance criteria within Surveillance Test Procedure (STP) NS540002A, "A Emergency Service Water Operability Test," Revision 6; and, NS540002B, "B Emergency Service Water Operability Test," Revision 5. Specifically, STP NS540002A and B did not include appropriate as-found and as-left acceptance criteria to demonstrate prior and ongoing equipment functionality or operability. The licensee entered the issue into the corrective action program (CAP) as condition report (CR) 576584 and significantly revised STP NS540002A and B to include appropriate acceptance criteria.

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 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 Table 4a, the inspectors answered "No" to all five questions under the Mitigating Systems Cornerstone Column, and screened the

finding as Green. The inspectors determined that the contributing cause that provided the most insight into the performance deficiency affected the cross-cutting area of Human Performance, having resource components, and involving aspects associated with complete, accurate, and up-to-date procedures. [H.2(c)].

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

Significance: **G** Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

CONDITION ADVERSE TO QUALITY NOT PROMPTLY IDENTIFIED AND CORRECTED.

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the licensee's failure to promptly identify and correct a condition adverse to quality on August 6, 2010. Specifically, during the performance of STP NS540002B, "B Emergency Service Water Operability Test," the licensee did not identify abnormal, elevated Emergency Service Water (ESW) flow to the "B" Standby Diesel Generator (SBDG), and the impact on other ESW system Technical Specification (TS) and TS support equipment. The licensee entered the issue into the CAP as CR 582068.

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 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 Table 4a, the inspectors answered "No" to all five questions under the Mitigating Systems Cornerstone Column, and screened the finding as Green. 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 implementing a corrective action program with a low threshold for identifying issues. [P.1(a)].

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

Significance: **SL-IV** Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Completeness and Accuracy of Information.

A non-cited violation (NCV) of 10 CFR 50.9, "Completeness and Accuracy of Information," was identified due to the submittal of inaccurate medical information for licensed operators. The submittals to the NRC were inaccurate because they certified that the operators had been medically examined and had met all medical qualifications, when in fact, olfactory testing to detect odor of products of combustion had not been performed. The licensee planned corrective actions to administer an olfactory test for products of combustion to all on-shift licensed operators.

The licensee's medical physician failed to adequately test all licensed operators (both initial and renewal licensees) in accordance with 10 CFR 55.21 and 55.33 with respect to American National Standards Institute/American Nuclear Society (ANSI/ANS) 3.4-1983. The licensee submitted medical information for its licensed operators and applicants that was incomplete and incorrect in its assessment of the medical condition and general health of its licensed operators and initial applicants. Because violations of 10 CFR 50.9 are considered to be violations that potentially impede or impact the regulatory process, they are dispositioned using the Traditional Enforcement process. The licensee's failure to provide complete and accurate information to the NRC, which could have resulted in an incorrect licensing action, is also a performance deficiency because the licensee is expected to comply with 10 CFR 50.9 and because it was within the licensee's ability to foresee and prevent. This was also considered a performance deficiency and was more than minor as determined by IMC609, Appendix I, "Licensed Operator Requalification Significance Determination Process." The inspectors determined that this finding had a cross-cutting aspect in the area of Problem Identification & Resolution associated with the component of operating experience, to implement and institutionalize Operating Experience through changes to station processes, procedures, equipment, and training programs. [P.2(b)].

Associated Performance Deficiency is 2010-004-04.

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

Significance: **G** Sep 30, 2010

Identified By: NRC

Item Type: FIN Finding

ANSI STANDARDS FOR LICENSED OPERATORS NOT MET.

A non-cited violation (NCV) of 10 CFR 50.9, "Completeness and Accuracy of Information," was identified due to the submittal of inaccurate medical information for licensed operators. The submittals to the NRC were inaccurate because they certified that the operators had been medically examined and had met all medical qualifications, when in fact, olfactory testing to detect odor of products of combustion had not been performed. The licensee planned corrective actions to administer an olfactory test for products of combustion to all on shift licensed operators. The licensee's medical physician failed to adequately test all licensed operators (both initial and renewal licensees) in accordance with 10 CFR 55.21 and 55.33 with respect to American National Standards Institute/American Nuclear Society (ANSI/ANS) 3.4 1983. The licensee submitted medical information for its licensed operators and applicants that was incomplete and incorrect in its assessment of the medical condition and general health of its licensed operators and initial applicants. Because violations of 10 CFR 50.9 are considered to be violations that potentially impede or impact the regulatory process, they are dispositioned using the Traditional Enforcement process. The licensee's failure to provide complete and accurate information to the NRC, which could have resulted in an incorrect licensing action, is also a performance deficiency because the licensee is expected to comply with 10 CFR 50.9 and because it was within the licensee's ability to foresee and prevent. This was also considered a performance deficiency and was more than minor as determined by IMC609, Appendix I, "Licensed Operator Requalification Significance Determination Process." The inspectors determined that this finding had a cross cutting aspect in the area of Problem Identification & Resolution associated with the component of operating experience, to implement and institutionalize Operating Experience through changes to station processes, procedures, equipment, and training programs. [P.2(b)]. (Section 1R11.8)

Traditional Enforcement portion of above is tracked as 2010-004-03.

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

Significance: **G** Jun 09, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE THE PAST OPERABILITY OF THE 'B' CONTROL BUILDING CHILLER CONDENSER.

The inspectors identified a NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," having very- low-safety significance for the failure to evaluate the past operability of the 'B' control building chiller condenser following the discovery of an unanalyzed condition. Specifically, an operability evaluation was not performed when about 45 percent of the heat exchanger tubes were found to be either plugged or heavily fouled due to silt accumulation. No acceptance criteria for tube plugging existed at the time of this discovery. The licensee entered this issue into its corrective action program.

The performance deficiency was determined to be more than minor because it affected the cornerstone objective of ensuring the capability of systems. Due to the extensive number of plugged or heavily fouled tubes, there was reasonable doubt on the past operability of the control room chillers condenser. The finding screened as very-low-safety significance because the licensee was able to demonstrate the cooler had sufficient flow such that the finding did not represent an actual loss of safety function of a single train for duration greater than its Technical Specification allowable outage time. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.

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

Significance: **G** Jun 09, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO UPDATE THE UFSAR TO REFLECT REQUIRED COOLING TO THE RHR PUMP SEALS.

The inspectors identified a NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," having very-

low-safety significance for the failure to take corrective actions in response to a previous NCV concerning the residual heat removal pump seal water cooling requirements. Specifically, the licensee had not performed a new evaluation under 10 CFR 50.59 to address the previous NRC concerns associated with a change to eliminate the need for residual heat removal pump seal water cooling; had not corrected the updated final safety analysis after learning that the previous 10 CFR 50.59 evaluation was not technically adequate to support the change; and had not replaced the seal with ones designed for higher temperatures. The licensee entered this issue into its corrective action program.

The performance deficiency was determined to be more than minor because, if left uncorrected, it had the potential to lead to a more significant safety concern. Specifically, termination of flow to the RHR pump seal water coolers would result in operation outside the seal's design. The finding screened as very-low-safety significance because cooling water had been provided to the seals for the residual heat removal pumps. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.

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

Significance:  Jun 09, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENSURE THE OPERABILITY OF LPCI IN MODE 3.

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," having very-low-safety significance for the failure to correct the lack of barriers to prevent low pressure core injection (LPCI) from becoming inoperable in Mode 3. Specifically, the licensee allowed the possibility of LPCI becoming inoperable in Mode 3 due to pressure locking of the residual heat removal crosstie valves when operating the system in shutdown cooling mode. The licensee entered this issue into its corrective action program.

The performance deficiency was determined to be more than minor because it was associated with the mitigating system cornerstone attribute of equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding screened as very-low-safety significance because a review of the operators' log demonstrated that the Technical Specification allowable outage time of LPCI was never exceeded. Therefore, the finding did not represent an actual loss of safety function of a single train for duration greater than its Technical Specification allowable outage time. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.

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

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: FIN Finding

LIFT HEIGHT ASSUMPTIONS IN DROP LOAD ANALYSES NOT REFLECTED IN RIGGING PROCEDURES.

A finding of very low safety significance was identified by the inspectors for deficiencies in the design documents for failure to translate the lift height assumptions used in drop load evaluations into field instructions in appropriate rigging procedures. Specifically, calculations for accidental drop during handling of the fuel pool area demineralizer shield plug and of the reactor feed pump motor were based on specific lift heights during rigging; however, no field instructions were provided for limiting the rigging to the specified heights. The licensee documented the condition in CAPs 072551 and 072811 and initiated actions for calculation/procedure revisions.

The inspectors determined that lack of field instructions or procedures restricting the lift heights was inconsistent with the assumptions used in the drop load analyses and was a performance deficiency. 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 to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The inspectors evaluated the finding using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04,

“Phase I Initial Screening and Characterization of Findings,” Table 4a for the Mitigating Systems. Using the screening questions in Table 4a, the inspectors determined that the finding was of very low safety significance because the deficiency did not result in loss of operability or function. This finding has a cross cutting aspect in the area of Problem Identification and Resolution because the licensee did not perform a thorough evaluation of CAP 053197 in October 2007 which identified that the lift height assumptions used in the calculation for the stud tensioner load drop were not translated into field instructions or procedures [P.1(c)].

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

Barrier Integrity

Significance:  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW THE PROCEDURES FOR PERFORMING OPERABILITY DETERMINATIONS.

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors for the failure of the licensee to follow procedure EN-AA-203-1001, “Operability Determinations/Functionality Assessments,” and Administrative Control Procedure (ACP) 110.1, “Conduct of Operations.” The Shift Manager failed to make an immediate operability determination which addressed the impact of the degraded conditions in the drywell cooling system on primary containment and to provide sufficient detail for an independent person to understand the basis for the decision was contrary to step 4.3 of EN-AA-203-1001 and Attachment 10 of ACP 110.1, and was a performance deficiency. The licensee entered the item into their Corrective Action Program as CAP074069, and performed a Prompt Operability Determination (OPR000427) that determined their Primary Containment was operable with the degraded condition in the Drywell Cooling system.

The performance deficiency was determined to be more than minor because if left uncorrected, failure to properly implement the operability procedures could result in safety-related components being incorrectly declared operable rather than inoperable or operable but non-conforming (a more significant safety concern). The inspectors evaluated the finding using the SDP in accordance with IMC 0609, Table 4a for the Containment Barrier Cornerstone. The finding screens as very low safety significance (Green) because the finding does not represent an actual open pathway in the physical integrity of reactor containment. This finding has a cross-cutting aspect in the area of Human Performance, Decision Making, because the licensee did not use conservative assumptions in decision making and adopt 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, not evaluating the breach of the closed system on a primary containment penetration to determine its effect on primary containment operability was a non-conservative assumption in the IOD.

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

Emergency Preparedness

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONDUCT AN ADEQUATE CRITIQUE FOR THE MAY 20, 2009, DRILL.

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix E, Section IV.F.2.g, and of the emergency planning standard 10 CFR 50.47(b)(14) was identified by the inspectors for the failure of the critique to identify a planning standard weakness. Specifically, during the 2009 Emergency Response Organization (ERO) Training Drill #2 conducted on May 20, 2009, the licensee’s critique process failed to identify a performance problem associated with communications between the Control Room/Simulator (CRS) and the Technical Support

Center (TSC) and, as a result, the deficiency was not corrected. The CRS provided inaccurate information necessary for an Emergency Action Level (EAL) classification to the TSC concerning the reactor water level which prompted a controller injection to stop a potential inaccurate classification. The licensee entered the finding into their corrective action program (CAP 068506 and CE 007572).

The performance deficiency was determined to be more than minor because the deficiency adversely affected the Emergency Preparedness Cornerstone objective to ensure the licensee is capable of implementing adequate measures to protect the health and safety of the public in a radiological emergency, as demonstrated by the ERO performance in a drill. The inspectors used IMC 0609, Appendix B, and determined the deficiency was similar to the Green example of the drill critique process not properly identifying a weakness resulting from a performance problem associated with a risk significant planning standard 10 CFR 50.47(b)(14). Therefore, the finding was screened to be of very low safety significance (Green). The cause of the finding had a cross cutting component in the problem identification and resolution area of self and independent assessments.

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

Occupational Radiation Safety

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH REQUIREMENTS OF RWP.

A finding of very low safety significance and an associated Non-Cited-Violation (NCV) of Technical Specification 5.4.1(a) was identified by the inspectors for the failure to implement adequate written procedures regarding the radiation safety program. Specifically, the licensee failed to comply with the requirements of the radiation work permit (RWP) when retrieving a piece of a highly irradiated boron tube from the reactor cavity to moisture separator/dryer weir wall. Immediate corrective actions included lessons learned being shared with the RP staff to ensure congruency with radiological pre-job briefings and RWP requirements.

The inspectors reviewed the guidance in IMC 0612, Appendix E, "Examples of Minor Issues," and did not identify any similar performance issues. The inspectors then compared the issue to the minor screening questions in IMC 0612 Appendix B "Issue Screening" and determined that the issue was more than minor because if left uncorrected the performance deficiency had the potential to lead to a more significant radiological safety concern and could result in unplanned radiological exposures. The finding was determined to be of very low safety significance because the problem was not an ALARA planning issue, there were no overexposures, nor substantial potential for overexposures, and the licensee's ability to assess dose was not compromised. The inspectors determined that the cause of the incident involved a cross-cutting component in the human performance area for work practices. Specifically, personnel work practices did not support human performance because the licensee did not effectively communicate expectations regarding procedural compliance and personnel failed to follow procedures.

Inspection Report# : [2010005](#) (pdf)

Significance:  Mar 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

AN INTERNAL CONTAMINATION OCCURRED WHILE CLEANING RPV STUDS AND WASHERS ON THE REFUEL FLOOR AT DUANE ARNOLD.

A self revealed finding of very low safety significance and associated NCV of Technical Specification (TS) 5.4.1(a) was identified for failure to establish and implement a procedure for performing decontamination activities associated with a potentially significant decontamination activity. The issue resulted in an event where a radworker became internally contaminated. The event was entered in the licensee's CAP. Additionally, the licensee completed a Human Performance Review Worksheet. The licensee also initiated long term corrective actions including refuel floor procedure augmentations.

The finding is more than minor because it affected the Occupational Radiation Safety Cornerstone objective to ensure adequate protection of worker health and safety from exposure to radiation and the corresponding attributes associated with the occupational radiation safety program and processes. The finding was determined to be of very low safety significance because it was not an as low as is reasonably achievable (ALARA) planning issue, there was no over exposure or substantial potential for an overexposure, and the licensee's ability to assess worker dose was not compromised. The finding involved a cross cutting aspect in the area of human performance related to work control in that the licensee did not coordinate work activities by incorporating actions to address keeping personnel apprised of the operational impact on work activities.

Inspection Report# : [2010002](#) (*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 LER PER 10 CFR 50.73 (a) (2)(v)(A) AND (D).

A Severity Level IV non-cited violation of 10 CFR Part 50.73(a)(2)(v)(A) and (D) was identified by the inspectors for the failure of the licensee to report an event or condition that could have prevented the fulfillment of the Turbine Stop Valve Closure and Turbine Control Valve Fast Closure reactor protection system (RPS), and the End-of-Cycle Recirculation Pump Trip (EOC-RPT) safety functions, which are relied upon to shutdown the reactor and maintain it in a shutdown condition, and mitigate the consequences of an accident. The licensee entered the violation into their corrective action program as AR 392462.

Violations of 10 CFR 50.73 are considered to be violations that potentially impact the regulatory process and they are dispositioned using the traditional enforcement process instead of the ROP SDP. Because the performance deficiency was minor and not a finding per Inspection Manual Chapter 0612, Appendix B, "Issue Screening," a cross-cutting aspect was not assigned and the performance deficiency not tracked.

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

Last modified : March 03, 2011