

Palisades

4Q/2010 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Examination of Head Penetration Nozzles Nos. 1 and 3

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” were identified by the inspectors for the licensee’s failure to follow Procedure CEP-NDE-0955, “Visual Examination of Bare-Metal Surfaces,” and perform a bare metal visual examination of vessel head penetration nozzles Nos. 1 and 3 within 4 feet. Instead, the licensee performed the examination at approximately 5 feet and the illumination level at this distance had not been demonstrated as adequate to detect primary coolant system leakage. As a corrective action, the licensee’s examiner repeated the bare metal visual examination of nozzles Nos. 1 and 3 and surrounding head surfaces at a distance of less than 4 feet. The violation was entered into the licensee’s corrective action program as condition report (CR) PLP-2010-05188.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Absent NRC identification, the licensee would have continued to perform inadequate examinations of the surfaces of the vessel head near nozzles Nos. 1 and 3, which could allow through-wall nozzle cracks to go undetected. Undetected cracks returned to service would place the vessel head at increased risk for leakage and/or nozzle failure, which affected the Initiating Events Cornerstone attribute of Equipment Performance (barrier integrity). The licensee promptly corrected this issue by repeating the examination of nozzles Nos. 1 and 3 in accordance with the procedure to confirm that no evidence of nozzle leakage existed. The inspectors answered “No” to the Significance Determination Process Phase I screening question “Assuming worst case degradation, would the finding result in exceeding the Technical Specification (TS) limit for any Primary Coolant System (PCS) leakage or could the finding have likely affected other mitigation systems resulting in a total loss of their safety function assuming the worst case degradation”? Therefore, the finding screened as having very low safety significance. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices because the licensee did not effectively communicate expectations regarding procedural compliance and personnel following procedures. Specifically, the failure to perform a bare metal visual examination of vessel head penetration nozzles Nos. 1 and 3 within four feet occurred because the licensee’s management staff did not adequately stress or enforce procedure adherence for this activity. In particular, procedure CEP-NDE-0955 was issued as an “Informational Use” type procedure that was not required to be present at the worksite and thus allowed licensee staff to rely on memory to perform the procedural steps.

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

Significance:  Dec 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Low Pressure Alarms During Reduced Inventory Operations

A finding of very low safety significance and associated NCV of 10 CFR 50.65a(4) was self-revealed for the failure to properly assess and manage risk when service water low pressure alarms were received during orange risk reduced inventory operations. The work control center authorized a non-critical service water valve to be stroked with the belief that the system was filled and vented thus precluding an impact on the service water system. However, that portion of the system had not been filled yet. As a result, opening the valve caused a pressure drop in the system. The licensee started a standby service water pump to restore pressure. The issue was also entered into the corrective action program.

The inspectors determined the finding was more than minor based in-part on example 7g of IMC 0612, Appendix E, which describes a condition where a safety function is significantly degraded without sufficient compensation.

Additionally, as described in IMC 0612 Appendix B, the issue is associated with the configuration control attribute and impacted the Initiating Events Cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions in that proper configuration control was not maintained over the shutdown equipment lineup. Utilizing IMC 0609 Appendix G, Shutdown Operations Significance Determination Process, the inspectors determined the issue was Green in Phase I screening since there was adequate mitigation capability and there was no loss of control. The finding had a cross cutting aspect in the area of Human Performance, Work Control, because the licensee did not appropriately coordinate work activities by incorporating actions to address the impact of work on different job activities to assure plant performance. Specifically, the licensee failed to determine the current status of the service water system and did not evaluate potential impacts during a period of elevated plant risk.

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

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Daily Crane Checks

The inspectors identified a NCV of TS 5.4 for the licensee's failure to implement procedures specified by Regulatory Guide 1.33. Specifically, the licensee failed to perform a check of the main hook in preparations for the head lift. The procedure used to perform checks lacked details regarding the polar crane for features to be tested on a daily basis. The individual who performed the initial daily check was not familiar with the features to be checked. After the inspectors brought this condition to the attention of the licensee, the licensee delayed the head lift and performed the daily check on the main hook. The licensee has entered this condition into their corrective action program. The inspectors concluded that the finding was more than minor, because it revealed programmatic weaknesses that could lead to more significant safety concerns if left uncorrected. Daily crane checks provide assurance that the probability of a heavy load drop is extremely small as discussed in Generic Letter 85-11, the Operating Requirements Manual, and NUREG-0612. The issue impacts the Initiating Event Cornerstone in that load drops could result in a failure of the primary coolant system boundary. Since no load drop occurred and no significant issues were identified with the polar crane, the inspectors concluded the finding was of very low safety significance in accordance with Appendix M. Since the failure to perform the daily check on the main hook resulted, in part, from ineffective coordination between personnel performing load moves, the inspectors concluded that there is an associated cross-cutting aspect in human performance, work control, appropriate coordination of work activities. (H.3(b))

The inspectors identified a NCV of TS 5.4 for the licensee's failure to implement procedures specified by Regulatory Guide 1.33. Specifically, the licensee failed to perform a check of the main hook in preparations for the head lift. The procedure used to perform checks lacked details regarding the polar crane for features to be tested on a daily basis. The individual who performed the initial daily check was not familiar with the features to be checked. After the inspectors brought this condition to the attention of the licensee, the licensee delayed the head lift and performed the daily check on the main hook. The licensee has entered this condition into their corrective action program.

The inspectors concluded that the finding was more than minor, because it revealed programmatic weaknesses that could lead to more significant safety concerns if left uncorrected. Daily crane checks provide assurance that the probability of a heavy load drop is extremely small as discussed in Generic Letter 85-11, the Operating Requirements Manual, and NUREG-0612. The issue impacts the Initiating Event Cornerstone in that load drops could result in a failure of the primary coolant system boundary. Since no load drop occurred and no significant issues were identified with the polar crane, the inspectors concluded the finding was of very low safety significance in accordance with Appendix M. Since the failure to perform the daily check on the main hook resulted, in part, from ineffective coordination between personnel performing load moves, the inspectors concluded that there is an associated cross-cutting aspect in human performance, work control, appropriate coordination of work activities.

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

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Ensure Code Requirements Met When Performing VT-2 Exams

The inspectors identified a finding of very low safety significance (Green) and associated NCV of Technical Specification (TS) 5.4.1, Procedures, for the failure to ensure that American Society of Mechanical Engineers

(ASME) Code and site procedural requirements were understood and incorporated during the performance of VT 2 in service inspections. Specifically, the illumination requirements specified in the Code had not been properly incorporated into all site examination procedures, nor were Operations personnel aware of the specific requirements. The licensee disseminated guidance clarifying the requirements and entered the issue into corrective action program (CAP) as CR PLP 2010 03756.

The issue was more than minor because it adversely affected the Equipment Performance attribute of the Initiating Events cornerstone, whose objective is to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, VT 2 exams performed without fundamental knowledge of Code and procedural requirements could lead to erroneous examination results. The finding screened as Green because no known actual component degradation went undetected as a result of improperly performed exams. The finding had an associated cross cutting aspect in the area of Human Performance (Procedures), in that the licensee failed to have complete, accurate, and up to date procedures and work packages for the VT 2 examinations.

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

Significance:  Sep 17, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Corrective Action to Prevent Recurrence Failed to Address Root Causes

The inspectors identified a finding of very low safety significance with an associated Non-Cited Violation of Palisades Technical Specification 5.4.1, "Procedures." Specifically, the licensee's procedure for the performance of root cause analysis required the issuance of a Corrective Action to Prevent Recurrence (CAPR) to address each identified root cause and the licensee's only CAPR failed to address the root causes identified by the licensee. This issue was entered into the licensee's corrective action program as CR-PLP-2010-03976.

The inspectors concluded the finding was more than minor because, if left uncorrected, it would become a more significant safety concern; specifically, the finding impacted the adequate corrective action to prevent recurrence of an event that impacted the Initiating Event Cornerstone objective of limiting events that challenge safety functions; for example, preventing criticality in an area not designed for criticality. Because probabilistic risk assessment tools were not suited for the original White finding, the inspectors had evaluated the White finding using IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." Based on the degradation that resulted in a significant loss of margin to criticality, NRC management concluded the original finding was of low to moderate safety significance (White). This violation is of very low safety-significance because other corrective actions taken by the licensee in response to additional NRC findings have been adequate to prevent recurrence. Because this violation was of very low safety-significance, neither was it repetitive nor willful, and was entered into the licensee's corrective action program the violation is being treated as an NCV, consistent with the NRC Enforcement Policy. The inspectors determined that the finding had an associated cross-cutting aspect in the area of Problem Identification and Resolution under the Corrective Action Program Component because the corrective actions issued for the identified root causes failed to address the identified root causes. Specifically, the licensee did not have a CAPR that addressed each of the identified root causes. (P.1(c))

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

Mitigating Systems

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Pipe Welds Not Incorporated into the ISI Program

A finding of very low safety significance and associated NCV of 10 CFR 50.55a(g)4 was identified by the inspectors for the licensee's failure to establish a weld reference system for 11 welds in the cross-tie line between the chemical and volume control system and the containment spray system. Consequently, these welds had not been entered into the inservice inspection weld database used to schedule followup surface or volumetric examinations. To correct this

issue, the licensee implemented changes to the applicable Inservice Inspection isometric drawings and entered these welds into the Inservice Inspection database. The violation was entered into the licensee's corrective action program as CR PLP-2010-05229.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Absent NRC identification, the licensee would not have examined a sample of these welds, which could have allowed service induced cracks to go undetected. Undetected cracks would place the cross-tie pipe segment at increased risk for through-wall leakage and/or failure, which affected the Mitigating System Cornerstone attribute of Equipment Performance (reliability). The licensee promptly corrected this issue and scheduled weld examinations to ensure cracks would be detected. The inspectors answered "Yes" to the Significance Determination Process Phase I screening question; "Is the finding a design or qualification deficiency confirmed not to result in loss of operability or functionality"? Therefore, the finding screened as having very low safety significance. This finding had a cross-cutting aspect in the area of Human Performance, Resources because the licensee did not provide complete, accurate, and up-to-date procedures, or work packages for the correct labeling of components. Specifically, the licensee staff failed to establish a weld reference system because up-to-date procedures were not developed to ensure identification and labeling of new welds installed in safety-related systems.

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

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Required Quality Control Inspections

Inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion X, "Inspection," for the failure to ensure that Quality Control (QC) verification inspections were consistently included and correctly specified in quality-affecting procedures and work instructions for construction-like work activities as required by the Quality Assurance Program. The licensee performed extensive reviews, and inspectors performed independent reviews of the licensee's conclusions as well as independent sampling, to confirm that improper or missed inspections did not actually affect the operability of plant equipment. Entergy initiated prompt fleet-wide corrective actions to ensure proper work order evaluation and proper inclusion of QC verification inspections. This issue was entered into the corrective action program under CRs CR-HQN 2009-01184 and CR-HQN-2010-0013.

The failure to ensure that adequate Quality Control verification inspections were included in quality-affecting procedures and work instructions as required by the Quality Assurance Program was a performance deficiency. This programmatic deficiency was more than minor because, if left uncorrected, it could lead to a more significant safety concern in that the failure to check quality attributes could involve an actual impact to plant equipment. This issue affected the Design Control attribute of the Mitigating Systems Cornerstone because missed or improper quality control inspections during plant modifications could impact the availability, reliability, and capability of systems needed to respond to initiating events. This performance deficiency was determined to have very low safety significance in Phase 1 of the SDP, since it was confirmed to involve a qualification deficiency that did not result in a loss of operability or functionality. The inspectors determined that this performance deficiency involved a cross-cutting aspect related to the human performance in decision-making because the licensee did not have an effective systematic process for obtaining interdisciplinary reviews of proposed work instructions to determine whether QC verification inspections were appropriate.

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

Significance: SL-IV Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to provide Complete and Accurate Information

The inspectors identified a Severity Level IV NCV of 10 CFR 50.9 for the licensee's failure to provide information to the NRC that was complete and accurate in all material respects. Specifically, in a letter on dated October 5, 2009, the licensee inaccurately stated new couplings for a service water pump were independently tested prior to installation. The licensee provided this information as part of a request for a Notice of Enforcement Discretion (NOED). The licensee requested the NOED due to a failure of a service water pump coupling that had not been properly heat

treated. The licensee subsequently informed the NRC that the tests had not been performed and entered the condition into the corrective action program.

The inspectors concluded that the licensee had reasonable opportunity to foresee and correct the inaccurate/incomplete information prior to the information being submitted to the NRC. As a result, this issue was considered a performance deficiency. Using the information provided in IMC 0612, Appendix B, "Issue Screening," the inspectors determined that traditional enforcement was warranted, because violations of 10 CFR 50.9 are considered to potentially impede or impact the regulatory process. Specifically, in order to determine the acceptability of granting discretion, the NRC needed assurance that the replacement couplings met hardness requirements. Using the information provided in the Enforcement Policy, Section 6.9, this issue was determined to be a Severity Level (SL) IV NCV, as it did not meet the definition for a Severity Level I, II, or III Violation. Specifically the violation was not greater than SL IV, because the inspectors concluded that the lack of hardness testing did not impact the NRC's conclusion since the licensee did not enter the period of enforcement discretion. The inspectors also evaluated the underlying performance deficiency under the ROP. Since the licensee did not enter the period of enforcement discretion and all the questions for more than minor in Appendix B were answered no, the inspectors concluded that there was no ROP finding and therefore no cross-cutting aspect.

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

Significance:  Oct 22, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Ultrasonic Examination on Primary System Makeup Storage Tank in Accordance with Procedures.

A finding of very low safety-significance (Green) 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 failure to accomplish activities affecting quality in accordance with procedures. Specifically, the licensee's vendor examiner for Non-Destructive Examination (NDE) failed to perform an ultrasonic (UT) wall thickness (one-time inspection) examination in accordance with procedures on the T-81, Primary System Makeup Storage Tank. The licensee initiated corrective action document CR-PLP-2010-04653 to address the issue.

The finding was determined to be more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern. The failure to perform an adequate UT examination did not assure that the intended function of the tank would be maintained consistent with the current licensing basis through the extended period of operation. This finding is of very low safety-significance (Green) because the inspectors answered no to all of the characterizations worksheet questions in Table 4a of IMC 0609.04. This finding has a cross-cutting aspect in the area of Human Performance for the Work Practices component because the licensee did not effectively communicate expectations regarding procedural compliance and the examiner failed to follow procedures [H.4 (b)]. (Section 40A5.1.b (1))

Inspection Report# : [2010010](#) (*pdf*)

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform an Adequate Risk Assessment for Maintenance Activities

The inspectors identified a finding of very low safety significance (Green) and associated NCV of 10 CFR 50.65 a(4) for failing to properly assess and manage the risk associated with the removal of the auxiliary feedwater (AFW) pump room floor plug during emergent maintenance activities. Specifically, the impact of the floor plug was not considered in the risk assessment and licensee personnel were unaware of resources needed to restore configuration. The performance deficiency was identified after the floor plug had been reinstalled. Prior to the next maintenance activity involving floor plugs, the licensee ensured appropriate actions were taken in accordance with their procedures. The issue was entered into the licensee's CAP as CR PLP 2010 03434.

The issue was more than minor because it adversely affected the Protection from External Factors attribute of the Mitigating Systems cornerstone, whose objective is to ensure the availability, reliability, and capability of systems that

respond to initiating events. Additionally, the inspectors compared the issue to examples in IMC 0612 Appendix E, and concluded it was similar to example 7.e. for more than minor in that the risk assessment was not adequate for a situation where licensee procedures required risk management actions to be taken to address plant configuration. Specifically, the licensee did not perform a risk assessment for removal of the AFW pump room floor plug and did not establish adequate risk management actions to reinstall it in the event of flooding. The finding screened as Green based on an evaluation performed by a Senior Risk Analyst (SRA) using IMC 0609 Appendix M, "Significance Determination Process Using Qualitative Criteria," with a bounding risk evaluation which estimated a relatively low increase in risk for the given configuration. The finding had an associated cross cutting aspect in the area of Human Performance (Resources) in that the licensee failed to provide complete, accurate, and up to date procedures that are adequate to ensure nuclear safety.

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

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Complete Actions Required by LCO 3.0.3 and 3.3.1

The inspectors identified a finding of very low safety significance (Green) and associated NCV of TS 3.3.1 and 3.0.3 for failure to comply with required TS actions. Specifically, on August 23, the licensee lost the automatic Loss of Load Trip but neither placed a trip unit in trip nor placed the plant in Mode 3 as required by TS 3.3.1 and TS 3.0.3 respectively. The licensee has restored the Loss of Load trip to operable status and entered the issue into the CAP as CR PLP 2010 03579.

The inspectors concluded that this issue was more than minor because it adversely affected the Mitigating System Cornerstone objective of ensuring the availability of systems that respond to initiating events. In addition, the inspectors reviewed IMC 0612 Appendix E and determined the issue was not similar to those items listed. The inspectors used IMC 0609 Attachment 4, Phase 1 screening, and discussed the issue with the regional SRA. The inspectors determined that the finding was of very low safety significance, Green, since the Reactor Protection System Safety Function was not lost. The finding had an associated cross cutting aspect in the area of Human Performance (Decision Making) in that the licensee failed to verify the validity of underlying assumptions.

This is related to traditional enforcement item 2010-004-03.

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

Significance: SL-IV Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Make an 8 Hour Report Pursuant to 10 CFR 50.72

The inspectors identified an NCV for failure to make an 8 hour report as required by 10 CFR 50.72. On August 23, the licensee lost the trip function associated with the Loss of Turbine Load but did not recognize that this condition was a loss of a safety function and reportable within 8 hours as required by 10 CFR 50.72. After discussions with the residents, the licensee reported the condition pursuant to 10 CFR 50.72. The licensee entered this condition into the CAP as CR PLP 2010 3752.

The inspectors concluded that the issue was more than minor because the failure to make the required report impacted the regulatory process. The finding affected the Mitigating System Cornerstone because the intent of the reporting is to capture events where there would have been failure of a safety system to properly operate. The Finding was processed through the traditional enforcement process. The inspectors concluded that the finding was of SL IV because failure to make a required 10 CFR 50.72 report is an example of a SL IV violation in the Enforcement Policy. The underlying cause of this issue is the same as the Green NCV listed in 1R15 so no additional cross-cutting aspect was assigned.

This is related to performance deficiency 2010-004-02.

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

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Ground on Preferred AC Bus Due to Improperly Installed electrical Bushing

The inspectors identified a finding of very low safety significance (Green) and associated NCV of 10 CFR 50 Appendix B, Criterion V for failure to accomplish activities affecting quality as prescribed by the documented instructions, procedures, or drawings. Specifically, the licensee replaced a solenoid valve on a safety related chiller in a manner that permitted a ground to develop on a preferred electrical bus after two years of operations. The licensee repaired the solenoid valve and entered the issue into the CAP as CR PLP 2010 03234.

The issue was more than minor because it adversely affected the Equipment Performance attribute of the Mitigating Systems Cornerstone, whose objective is to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the ground reduced the reliability of the associated safety related electrical bus. Further, correction of the ground rendered the control room Heating, Ventilation and Air Conditioning (HVAC) chiller inoperable. The finding screened as Green because there was no loss of system safety function. The licensee determined the cause to be an improperly tightened electrical bushing, and that the proper tightening of bushings was part of electrical maintenance training. Therefore, human error prevention techniques used by the craft during assembly were not sufficient to preclude the bushing from being improperly tightened.

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

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Fire Barrier

The inspectors identified a finding of very low safety significance (Green) and an associated NCV of License Section 2.C(3), Fire Protection Program for failing to maintain in effect all provisions of the Fire Protection Program. Specifically, the fire protection plan requires 3-hour fire barriers, unless there is adequate justification that a fire barrier, which is less than 3 hours is acceptable. The licensee credited a 2-hour fire barrier in lieu of a 3-hour barrier based on less than two hours of combustible material in the cable spreading room. In 2006, the licensee determined the cable spreading room contained in excess of two hours worth of combustible material. As an immediate action, the licensee implemented compensatory actions and performed fire tours in the area.

The issue is more than minor because it affects the Protection Against External Events attribute of the Mitigating Systems Cornerstone in that it affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. Specifically, the licensee had an invalid basis for the adequacy of a firewall protecting safety related equipment. The finding screened as Green because the fire barrier retained at least a two hour rating and the seismic issues did not impact both trains. The finding does not include an associated cross cutting aspect due to the issue dating back greater than three years and not reflective of current performance. (1R05)

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

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Improper Construction of Scaffolding

A finding of very low safety significance (Green) and associated NCV of Palisades Technical Specification (TS) 5.4.1, Procedures, was identified by the inspectors for failing to adequately implement a procedure to construct a scaffold near the 1 2 emergency diesel generator (EDG). Specifically, a fire sprinkler was impaired without the proper fire protection evaluation; and required seismic evaluations were not performed despite being in close proximity to safety related equipment. The issue was entered into the licensee's corrective action program and the scaffold was modified.

The issue is more than minor because it affects the Protection Against External Events attribute of the Mitigating Systems Cornerstone in that it affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. Specifically a fire protection feature (sprinkler) in a safety related area was affected without compensatory measures. Additionally, the scaffold was in close proximity to safety related

equipment, and the equipment could have been impacted by a seismic event. The finding screened as Green based on remaining sprinkler capability and the fact that only one EDG could be affected by the scaffold during a seismic event. The finding had an associated cross cutting aspect in the area of Human Performance (Planning) in that the licensee failed to appropriately plan work activities by incorporating the need for compensatory actions (H.3(a)). (1R05)

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

Barrier Integrity

Emergency Preparedness

Significance:  Mar 05, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Evaluation of Interface with State and Local Governments

The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR 50.54(t), “Conditions of licenses,” for the failure to complete an independent review of all program elements of the emergency preparedness program. The independent assessment did not evaluate and document the adequacy of the interfaces with State and local governments at an interval not to exceed 12 months for all groups. Specifically, Quality Assurance’s assessment failed to evaluate the adequacy of interface with one of the counties in 2008, and the interface with the State and two counties was not evaluated in 2009. The licensee entered the issue in their corrective action program as CR-PLP-2009-04915.

The deficiency did not meet the criteria for traditional enforcement, therefore, was screened using the Emergency Preparedness (EP) SDP. The finding was determined to be more than minor because the finding adversely affected the EP 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. The failure to conduct the audit to evaluate the effectiveness of the EP program had the attribute associated with Offsite EP, specifically, the evaluation of the working relationship between the offsite and onsite emergency response organizations and programs. The inspector evaluated the finding using with IMC 0609, Appendix B, Sheet I, Failure to Comply flowchart. The audit program was noncompliant with a regulatory requirement not involving an EP planning standard or a risk significant planning standard; therefore, the finding was determined to be of very low safety significance (Green).

The finding has a cross-cutting component in the Problem Identification and Resolution area with the component of Self and Independent Assessments. The licensee did not conduct the self-assessments in sufficient depth to evaluate the interfaces for all offsite governments. (P.3(a)) (Section 1EP5)

Inspection Report# : [2010502](#) (pdf)

Occupational Radiation Safety

Public Radiation Safety

Significance:  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately manage Changes to the ODCM

The inspectors identified a finding of very low-safety-significance and an associated NCV for the failure to implement TS requirement 5.5.1, Offsite Dose Calculation Manual (ODCM). Specifically, the inspectors determined that the evaluation written to support the 2004 change to eliminate drinking water well sampling from the ODCM was not correct. This evaluation failed to address community wells that provide drinking water to homes immediately adjacent to plant property to the south. These community wells are between the plant site and the Covert Township Park. These locations were drinking water wells that were historically sampled until the 2004 ODCM change. Corrective actions were being developed in the corrective action program (condition report (CR) PLP 2010 01013) and senior plant management expressed the understanding that sampling was important and the condition would be corrected.

The finding was more than minor because it affected the Public Radiation Safety Cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain, in that these conditions could result in reduced capability to detect potential impacts associated with this pathway. The finding was assessed using IMC 0609, Attachment D for the Public Radiation Safety SDP and determined to be of very low safety significance because it involved the environmental monitoring program. The finding was not associated with a cross cutting aspect because the flawed evaluation occurred in 2004 and appeared to be a legacy issue which did not represent current licensee performance. (Section 4OA5)

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

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 : March 03, 2011