

Duane Arnold

1Q/2011 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.

Mitigating Systems

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM ADEQUATE FIRE PATROLS IN AREAS CONTAINING SAFETY RELATED EQUIPMENT.

A finding of very low safety significance and associated NCV of Technical Specification 5.4, "Procedures," was identified by the inspectors for the licensee's failure to conduct fire watch patrols in accordance with Attachment 7 of Administrative Control Procedure 1412.4, "Impairments to Fire Protection Systems." Specifically, fire watch patrols were not performed for two plant areas on February 18 and 19, 2010, to provide detection for potential fires or fire hazards. The licensee entered the issue into their corrective action program as Condition Report (CR) 344333.

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 was associated with the Mitigating Systems cornerstone attribute of Protection against External Factors and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors applied IMC 0609, Appendix F, "Fire Protection Significance Determination Process," to this finding. Using Part 1 of the Fire Protection SDP Phase 1 Worksheet, the finding was determined to be in the fire prevention and administrative controls category. The degradation rating for this finding was low and therefore screened 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 work practices components, and involving aspects associated with the licensee defining and effectively communicating expectations regarding procedural compliance and personnel follow procedures.

Inspection Report# : [2011002](#) (pdf)

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:  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:  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:  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:  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)

Barrier Integrity

Significance:  Mar 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

OPERATING INSTRUCTION DID NOT INCLUDE ADEQUATE CRITERIA PRIOR TO REMOVING PLANT PROCESS COMPUTER FROM SERVICE.

A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed following restoration of the plant process computer (PPC) from a planned maintenance activity. Specifically, Integrated Plant Operating Instruction (IPOI) 3, "Power Operations (35% - 100% Rated Power)", Revision 126, did not include adequate criteria to ensure that reactor core thermal power would not exceed the facility's maximum-licensed steady state power level of 1912 megawatts thermal prior to, and during, the removal of the PPC from service. The licensee entered the issue into the corrective action program as CR 01611062, and significantly revised IPOI 3 and other applicable instructions and procedures to ensure reactor power was sufficiently reduced and would remain steady with the PPC out of service.

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, the inadequate instruction 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. Because the finding was only associated with the fuel barrier under the Reactor Coolant System (RCS) or

Fuel Barrier Column, the finding screened 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 operating experience components, and involving aspects associated with the licensee implementing operating experience through changes to station procedures.

Inspection Report# : [2011002](#) (pdf)

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

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*)

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 : June 07, 2011