Byron 1
2Q/2011 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ENSURE THAT THE DESIGN OF THE AF SUCTION PIPING WAS ADEQUATE TO PREVENT AIR ENTRAINMENT FOLLOWING A SEISMIC OR TORNADO EVENT
The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," when licensee personnel failed to analyze whether the design of the auxiliary feedwater system ensured that air entrained into the system following a postulated seismic or tornado event did not prevent the system from performing its safety function. Specifically, licensee personnel failed to evaluate the failure of non-seismically qualified condensate storage tank suction piping during an earthquake or tornado that would cause the operating auxiliary feedwater pumps to draw air from the break location, potentially air-binding the pumps. The licensee entered this issue into their corrective action program to determine the required changes to the design of the system and performed an operability evaluation.

The finding was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Protection Against External Events and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding screened as having very low safety significance because it was a design deficiency confirmed not to result in a loss of operability or functionality. The inspectors determined that there was no cross-cutting aspect associated with this finding because it was not confirmed to reflect current performance due to the age of the performance deficiency.
Inspection Report# : 2011003 *(pdf)*

Significance: G Jun 16, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Specify and Perform Required Independent Quality Verification Hold Point Inspections.
The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion X, "Inspection," for the failure to ensure that independent quality verification (QV) inspection hold points (HPs) were specified in work orders (WOs) used during Raychem splicing activities on a safety-related instrumentation cable, in the containment. Specifically, during replacement of the failed RCS Loop 1B Wide-Range, Hot-Leg (resistance temperature detector) RTD 1TE-RC023A in 2006 and in 2008, the licensee used electrical Raychem splices to connect the RTD leads to its cable without including the required QV inspection HPs in the associated WO instructions. Consequently, the QV independent inspections were not performed as required by Exelon corporate Nuclear Oversight (NO) and Maintenance procedures and by the Quality Assurance Topical Report (QATR). Subsequently, the licensee initiated corrective actions to rework the Raychem splice at the next window of opportunity and to communicate and reinforce the importance of inclusion of QV HP inspections, when required. This issue was entered into the licensee's corrective action program (CAP) under Issue Reports (IRs) 01226961, 01214766, 01217502 and 01218406.

The failure to ensure that independent QV HP inspections were included in WO instructions as required by Exelon Corporate procedures and the QATR was a performance deficiency. This performance deficiency was more than minor because, if left uncorrected, it would lead to a more significant safety concern in that the failure to

independently verify quality attributes in safety-related equipment could involve an adverse impact to plant equipment. The inspectors concluded that this finding was associated with the Mitigating Systems Cornerstone. This performance deficiency was determined to have very low safety significance in Phase I of the SDP, since it was confirmed to involve a lack of required QV HPs for this Raychem splicing activity that did not result in a loss of operability or functionality. The inspectors determined that the underlying finding had a cross-cutting aspect in the area of Human Performance, Decision Making, because the licensee did not have an effective systematic process for obtaining interdisciplinary reviews of proposed maintenance work instructions to determine whether independent QV HP inspections were appropriately specified and implemented to assure plant safety. [H.1(a)] (Section 1R17.2.b)
Inspection Report# : 2011009 *(pdf)*

Significance: G Jun 16, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Procedure Requirements for Temporary Scaffolds that Remain in Place for Over 90 Days.
The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," related to inadequate control of installed temporary scaffolds. Specifically, licensee's procedure for the installation, modification, and removal of scaffolds was not followed, on a routine basis, for temporary scaffolds that remained in the plant for greater than 90 days. This could impact the operability or availability of plant system. The licensee entered this issue into the CAP as IR 01212656. Corrective actions for this issue included an investigation as to why procedure adherence issues with regard to scaffolds continue to occur and an extent of condition review of similar plant programs.

The inspectors determined that this issue was more than minor in accordance with IMC 0612, Appendix E, "Examples of Minor Issues." Specifically, the inspectors concluded that this issue was similar to the more than minor criteria established in Example 4.a, "Insignificant Procedural Errors," since the licensee failed to perform the required engineering evaluation for the temporary installed scaffolding that remained in the plant for more than 90 days. Therefore, this performance deficiency also impacted the Mitigating Systems Cornerstone objective of protection against external events (seismic events). The finding was of very low safety significance because there was not a confirmed loss of operability of any mitigating system component. The inspectors determined that the underlying finding had a cross-cutting aspect in the area of Human Performance, Decision-Making, because the licensee did not make the appropriate safety or risk significant decisions by failing to utilize the systematic scaffolding construction process to ensure adequate quality and, therefore, adequate safety was maintained when scaffolds remained installed for greater than 90 days. [H.1(a)]. (Section 4OA2.b.(1))
Inspection Report# : 2011009 *(pdf)*

Significance: G Jun 16, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
EDG Usable Fuel Calculations Failed to Consider Appropriate EDG Frequency Variations.
The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to correctly translate applicable design basis (calculations) into specifications. Specifically, the licensee failed to take into account fuel oil consumption at an increased frequency of 61.2 Hz in their EDG loading calculations which resulted in non-conservative Technical Specifications. The licensee entered this finding into their corrective action program as IR 01226844 and implemented actions to evaluate incorporation of the EDG frequency administrative limits into applicable site operating procedures to ensure an adequate supply of fuel was available.

The inspectors determined that this finding was more than minor because the finding was associated with the Mitigating Systems cornerstone attribute of design control and affected the cornerstone objective of ensuring the capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the licensee failed to account for the increased fuel oil consumption resulting from operation at a higher EDG frequency variation of 61.2 Hz as allowed by TS 3.8.1 and room temperature of up to 120°F in their EDG loading calculations. Therefore, the licensee did not ensure that the minimum fuel oil level in the storage tanks, as required per TS 3.8.3, was adequate to support the EDGs' 7-day mission time. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution Corrective Action Program because the licensee did not

thoroughly evaluate the EDG fuel oil consumption when considering EDG frequency variation. Specifically, the licensee failed to translate applicable design bases into specifications, which resulted in non-conservative TS. [P.1(c)] (Section 4OA2.b.(2))
Inspection Report# : 2011009 *(pdf)*

Significance: G May 04, 2011
Identified By: NRC
Item Type: FIN Finding
Failure to Adequately Document and Justify Continued Operability of the Auxiliary Feedwater System.
A finding of very low safety significance was identified at the Braidwood and Byron Stations by the inspectors when licensee personnel failed to adequately document and justify continued operability of the auxiliary feedwater (AF) system. Specifically, licensee evaluations of known voids in the AF alternate source suction piping did not provide an adequate technical basis to support operability of the AF pumps during a suction swap-over scenario. Subsequently, the licensee filled the voids and a Root Cause Evaluation (RCE) was initiated under Issue Report (IR) 1194196 (Braidwood) and IR 1194324 (Byron). The RCE was initiated to determine why prior opportunities for discovery of the inadequate void acceptance basis were missed and to develop associated corrective actions.

The inspectors determined the finding was more than minor because, if left uncorrected, the failure to recognize conditions that could render equipment inoperable had the potential to lead to a more significant safety concern. Because the finding was not a design deficiency, did not result in a loss of safety function, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event, the inspectors concluded that the finding was of very low safety significance (Green). This finding was associated with a cross-cutting aspect in the Decision-Making component of the Human Performance cross-cutting area because the licensee did not use conservative assumptions and did not verify the validity of underlying assumptions in their evaluations of the AF suction piping voids. (H.1(b)) (Section 4OA5.1.7.b)
Inspection Report# : 2011015 *(pdf)*

Significance: G Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
AUXILIARY FEEDWATER PUMP LUBE OIL HEAT EXCHANGER CONFIGURED INCORRECTLY
An NRC-identified finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors when licensee personnel failed to install the Unit 1 Train B auxiliary feedwater pump lube oil heat exchanger end bell in accordance with design drawings. The finding was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of Configuration Control and affected the cornerstone objective of ensuring the capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the as-found orientation of the heat exchanger end bell was not consistent with design drawings and adversely affected the performance of the auxiliary feedwater pump lube oil heat exchanger.
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 Mitigating Systems Cornerstone. The inspectors determined that the finding was a design or qualification deficiency confirmed not to result in a loss of operability or functionality. This conclusion was reached after reviewing an analysis performed by the licensee that concluded the auxiliary feedwater system would perform its safety-related function with the lube oil heat exchanger end bell in the as-found and as-installed configuration. The licensee subsequently restored the configuration, consistent with design drawings. Due to the age of this issue, it was not determined to be reflective of current licensee performance and therefore a cross-cutting aspect was not assigned to this finding. (Section 1R07)

Inspection Report# : 2011002 *(pdf)*

Significance: G Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation

INADEQUATE INSTRUCTIONS FOR MEASURING ECCS VOIDS
An NRC-identified finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors when licensee personnel failed to establish instructions for measuring pipe voids detected during surveillances of the emergency core cooling systems for gas accumulation. Specifically, instructions to measure the size of gas voids detected during venting at each safety injection and residual heat removal system vent location were not provided so that the effect of the void on system operability could be evaluated. The licensee entered this issue into their corrective action program and initiated procedure revisions to provide additional guidance for recording data to size voids identified during venting operations.
The performance deficiency 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 finding screened as having very low safety significance because it did not result in a loss of operability or functionality. Specifically, a qualitative assessment of the voids detected by venting since the implementation of the licensee’s resolution of Generic Letter 2008 01 established reasonable assurance that these voids did not result in a loss of operability. The inspectors did not identify a cross-cutting aspect that represented the underlying cause of this performance deficiency. Therefore, no cross-cutting aspect was assigned to this finding.

Inspection Report# : 2011002 *(pdf)*

Significance:  Dec 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Instructions for the Inspection of the River Screen House and Essential Service Water Cooling Tower
A finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors when licensee personnel failed to establish specific instructions for inspecting the River Screen House and Essential Service Water Cooling Tower. Specifically, the procedure that provided guidance for inspecting these structures lacked specific instructions on how to detect concrete degradation, erosion, corrosion and biological fouling. The licensee entered this issue into their corrective action program and initiated procedure revisions to provide further direction for identifying and documenting the degradation of these structures and related components.

The performance deficiency 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 finding screened as of very low safety significance because it was a qualification deficiency confirmed not to result in a loss of operability or functionality. Specifically, a qualitative assessment of historic surveillance reports found the documented results acceptable. The inspectors determined that this finding did not represent current licensee performance and therefore no cross-cutting aspect was assigned. (Section 1R07.1)
Inspection Report# : 2010005 *(pdf)*

Significance:  Dec 03, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Adequate Guidance in Safe-Shutdown Procedures
A finding of very low safety-significance and associated NCV of Technical Specification 5.4.1.c for Units 1 and 2 was identified by the inspectors for the licensee's failure to provide adequate guidance in safe shutdown procedures. Specifically, the licensee failed to provide adequate guidance to reenergize the 4 kiloVolt (kV) buses, which were required to power safe shutdown components to achieve hot shutdown in the event of a fire in Fire Zone 11.3-0. The licensee subsequently entered the issue into their corrective action program and initiated actions, which included recommendations to revise safe shutdown procedures to provide guidance for recovery actions to reenergize the required affected busses.

The inspectors determined that this finding was more than minor because the failure to provide adequate procedural guidance to reenergize the 4 kV buses could have potentially compromised the ability to safely shutdown the plant in the event of a fire in Fire Zone 11.3-0. This finding was of very low safety significance (Green) based on a Phase III

significance determination analysis. The finding did not have a cross-cutting aspect because it was not reflective of current performance. (Section 1R05.1R05.6.b(1))
Inspection Report# : 2010006 *(pdf)*

Significance: G Dec 03, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Periodically Test 125 Vdc Molded Case Circuit Breakers
. A finding of very low safety significance and associated NCV of the Byron Station facility operating licensee conditions for fire protection was identified by the inspectors for the licensee's failure to periodically test samples of molded case circuit breakers (MCCBs) at the 125 Volt direct current (Vdc) level. The licensee subsequently entered the issue into their corrective action program and verified that sufficient design margin existed such that breaker coordination would not be adversely affected.

The inspectors determined that this finding was more than minor because the failure to test the MCCBs would result in a failure to detect excessive set-point drift which impacted breaker coordination. This finding was of very low safety significance (Green) because the licensee verified that sufficient design margin existed such that breaker coordination would not be adversely affected. In addition, no failures of 125 Vdc MCCBs to trip due to set-point drift had been identified. The finding did not have a cross-cutting aspect because it was not reflective of current performance. (Section 1R05.1R05.6.b(2))
Inspection Report# : 2010006 *(pdf)*

Barrier Integrity

Significance: G Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO EVALUATE THE EFFECTS OF DYNAMIC LOADS AT THE CS DISCHARGE PIPING
An NRC-identified finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors when licensee personnel failed to evaluate the effects of dynamic loads at the containment spray discharge piping. The inspectors were concerned because portions of the containment spray discharge piping were normally voided by design and neither the structural design nor operation of the system addressed the dynamic loads that would result when the voided piping was rapidly filled following system initiation. The licensee entered this issue into the corrective action program and, at the time of the inspection, planned to include an evaluation of dynamic loads into the design basis of containment spray.
The performance deficiency was determined to be more than minor because it was associated with the Structures, Systems, Components, and Barrier Performance attribute of the Barrier Integrity Cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The finding screened as having very low safety significance because it did not affect either core damage frequency or large early release frequency. The inspectors determined that this finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Operating Experience, because the licensee did not thoroughly evaluate external operating experience.

Inspection Report# : 2011002 *(pdf)*

Significance: G Sep 30, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM ADEQUATE EVALUATION FOR CRANE UPGRADE
A finding of very low safety significance and an associated Non-Cited Violation (NCV) of Title 10 Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion III, "Design Control" was identified by the inspectors for the licensee's failure to perform adequate evaluations to upgrade the single failure proof crane. Specifically, the inspectors

identified six examples where the licensee failed to perform adequate evaluations in accordance with American Society of Mechanical Engineers (ASME) NOG-1-2004, requirements. The licensee documented the conditions in Issue Report (IR) 1099897, and IR 1100062 and initiated actions for calculation revisions and field modifications.

The Fuel Handling Building (FHB) crane is designed to Seismic Category I requirements and the licensee used compliance with ASME NOG-1-2004, as the design basis for their crane upgrade to a single failure proof crane. The inspectors determined that the failure to perform adequate evaluations was contrary to ASME NOG-1-2004 requirements and was a performance deficiency. The finding was more than minor as it was associated with the Barrier Integrity cornerstone, because a fuel handling building crane heavy load drop can damage the Spent Fuel Pool (SFP) Cooling System or spent fuel cladding. The inspectors evaluated the finding using Inspection Manual Chapter (IMC) 0609.04, “Phase 1 - Initial Screening and Characterization of Findings,” and based on a “No” answer to all of the questions in the Barrier Integrity column of Table 4a, determined the finding to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Human Performance, Resources because the licensee did not provide adequate oversight of work activities, including contractors, such that design documentation was accurate to support nuclear safety. H.2(c) (Section 4OA5)

Inspection Report# : 2010004 *(pdf)*

Emergency Preparedness

Significance: SL-IV Jun 22, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Changes to EAL Basis Decreased the Effectiveness of the Plan without Prior NRC Approval
The inspector identified a violation of very low safety significance involving a Severity Level IV NCV of 10 CFR 50.54(q) for failing to obtain prior approval for an emergency plan change which decreased the effectiveness of the plan. Specifically, the licensee modified the Emergency Action Level (EAL) Basis in EAL HU6, Revision 22, which indefinitely extended the start of the 15 minute emergency classification clock beyond a credible notification that a fire is occurring or indication of a valid fire detection system alarm. This change decreased the effectiveness of the emergency plan by reducing the capability to perform a risk significant planning function in a timely manner. The violation affected the NRC’s ability to perform its regulatory function because it involved implementing a change that decreased the effectiveness of the emergency plan without NRC approval. Therefore, this issue was evaluated using Traditional Enforcement. The NRC determined that a Severity Level IV violation was appropriate due to the reduction of the capability to perform a risk significant planning standard function in a timely manner. The licensee entered this issue into its corrective action program and revised the EAL basis to restore compliance. (Section 1EP4)

The related performance deficiency is tracked as item 200-502-02.
Inspection Report# : 2010502 *(pdf)*

Significance: G Jun 22, 2011
Identified By: NRC
Item Type: FIN Finding
Changes to EAL Basis Decreased the Effectiveness of the Plan without Prior NRC Approval
The inspector identified a finding of very low safety significance involving a Severity Level IV NCV of 10 CFR 50.54 (q) for failing to obtain prior approval for an emergency plan change which decreased the effectiveness of the plan. Specifically, the licensee modified the Emergency Action Level (EAL) Basis in EAL HU6, Revision 22, which indefinitely extended the start of the 15 minute emergency classification clock beyond a credible notification that a fire is occurring or indication of a valid fire detection system alarm. This change decreased the effectiveness of the emergency plan by reducing the capability to perform a risk significant planning function in a timely manner.

The finding was more than minor using IMC 0612, because it is associated with the emergency preparedness cornerstone attribute of procedure quality for EAL and emergency plan changes, and it adversely affected the cornerstone objective of ensuring that the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Therefore, the performance deficiency was a finding.

Using IMC 0609, Appendix B, the inspector determined that the finding had a very low safety significance because the finding is a failure to comply with 10 CFR 50.54(q) involving the risk significant planning standard 50.47(b)(4), which, in this case, met the example of a Green finding because it involved one Unusual Event classification (EAL HU6).

Due to the age of this issue, it was not determined to be reflective of current licensee performance and therefore a cross-cutting aspect was not assigned to this finding. (Section 1EP4)

The associated traditional enforcement item is tracked as item 2011-50X-01.

Inspection Report# : 2010502 *(pdf)*

Occupational Radiation Safety

Significance: G Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
OUT-OF-DATE/EXPIRED RESPIRATOR CARTRIDGES
An NRC-identified finding of very low safety significance and an associated NCV of TS 5.4.1 was identified by the inspectors when out of date respirator cartridges were found available for use. Radiation protection procedures that cover respiratory protection program did not require cartridges to be replaced after the manufacturer specified shelf-life had expired. The manufacturer of the respirator canister recognized that it was possible that chemical cartridges, which were more than a year old, might lose some of their efficiency in their ability to absorb contaminants. The manufacturer prescribed an expiration date of 3 years from the date of the canister manufacture and this date was stamped on to the canister label.
The regulatory authority for respiratory protection is the Occupational Safety and Health Administration (OSHA). The regulations are defined in 29 CFR 1910.134 titled “Respiratory Protection.” Title 29 CFR 1910.134(d)(3)(iii) provides requirements for the protection against gases and vapors. These requirements include that air purifying respirators be equipped with an End-of-Service Life Indicator (ESLI) or the employer implements a change schedule for canisters and cartridges that is based on objective information or data that will ensure that canisters and cartridges are changed before the end of their service life. The employer shall describe in the respirator program the information and data relied upon and the basis for the canister and cartridge change schedule and the basis for reliance on the data.
The inspectors reviewed the guidance in IMC 0612, Appendix E, Examples of Minor Issues, but did not identify any examples similar to the performance deficiency. However, in accordance with IMC 0612, the inspectors determined that the finding was more than minor because if left uncorrected the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, cartridges that were beyond the recommended shelf-life could lose some of their efficiency in their ability to absorb contaminants and result in additional radiation doses to the users. The finding was assessed using the Occupational Radiation SDP and was determined to be of very low safety significance because these problems were not as-low-as-is-reasonably-achievable (ALARA) planning issues, there were no overexposures, nor substantial potential for overexposures and the licensee’s ability to assess dose was not compromised. Corrective actions planned by the licensee included replacing the expired cartridges and adding guidance to procedures for checking expiration dates during routine inventories. The inspectors determined that the cause of this incident involved a cross-cutting component in the human performance area for inadequate resources. Specifically, the licensee did not have complete, accurate and up-to-date procedures.

Inspection Report# : 2011002 *(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 Dec 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedures for Implementing FSAR Required Annulus Cooling (Section 4OA5.2.b.1)
The inspectors identified a Severity Level IV NCV of very low safety significance of 10 CFR 72.150, "Instruction, Procedures, and Drawings." Specifically, the licensee failed to have procedures in place to ensure that the design basis peak fuel cladding limit would not be exceeded during canister loading operations. The licensee entered this issue into their corrective action program and revised the procedure to provide monitoring criteria.

The violation was determined to be of more than minor significance using IMC 0612, “Power Reactor Inspection Reports,” Appendix E, “Examples of Minor Issues,” Example 2c, in that the procedures failed to incorporate thermal acceptance criteria established by the Holtec Final Safety Analysis Report and that the failure to incorporate thermal acceptance criteria was repetitive. Although the violation contributed to the likelihood of peak fuel cladding temperatures exceeding the safety limit, subsequent analysis by the licensee determined that fuel cladding temperature limits were not exceeded. The violation screened as having very low safety significance. (Section 4OA5.2)
Inspection Report# : 2010005 *(pdf)*

Significance: SL-IV Dec 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedural Guidance for Heavy Loads Operations (Section 4OA5.2.b.2)
The inspectors identified a Severity Level IV NCV of very low safety significance of 10 CFR 72.150, "Instructions, Procedures, and Drawings." Specifically, the licensee failed to have procedures in place to ensure that heavy loads were operated safely in the Fuel Handling Building. The licensee entered this issue into their corrective action program and revised the procedure to provide monitoring criteria.

The violation was determined to be of more than minor significance because if left uncorrected, it could lead to a more significant safety concern. Consistent with the guidance in Section 2.6.D of the NRC Enforcement Manual, if a violation does not fit an example in the Enforcement Policy Violation Examples, it should be assigned a severity level: (1) commensurate with its safety significance; and (2) informed by similar violations addressed in the Violation Examples. The violation screened as having very low safety significance. (Section 4OA5.2)
Inspection Report# : 2010005 *(pdf)*

Significance: SL-IV Sep 17, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate procedures for Implementing FSAR Required Annulus Cooling.
The inspectors identified a Severity Level IV NCV of 10 CFR 72.150, "Instructions, Procedures, and Drawings." Specifically, the licensee failed to have procedures in place to ensure that the design basis peak fuel cladding temperature limit would not be exceeded during vacuum drying operations. The licensee entered this issue into its corrective action program and revised the procedure to provide monitoring criteria.

The violation was determined to be of more than minor significance because, if left uncorrected, it could lead to a more safety significant event. Although the violation contributed to the likelihood of peak fuel cladding temperatures exceeding the safety limit, subsequent analysis by the licensee and the NRC determined that fuel cladding temperature limits were not exceeded during this event; therefore, the violation screened as having very low safety significance.

(Section 4OA5.2)
Inspection Report# : 2010007 *(pdf)*

Last modified : October 14, 2011