

North Anna 1

2Q/2011 Plant Inspection Findings

Initiating Events

Significance: TBD Jun 30, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Take Adequate Corrective Action to Preclude a Fire in the Units 1 and 2 Control Room Complex

A self-revealing finding was identified for the failure to take adequate corrective action for degradation of annunciator card resistors in accordance with the standards as established by the licensee's corrective action program procedure which resulted in a fire in the respective annunciator cabinet located in the Units 1 and 2 control room complex. The licensee entered the problem into their corrective action program as condition report 412487.

The finding was more than minor because it could be reasonably viewed as a precursor to a significant event based on fire development leading to an evacuation of the control room. In accordance with NRC IMC 0609, "Significant Determination Process," and the associated Appendix F, the inspectors performed a phase 1 analysis and determined the finding would require a Phase 2 analysis by a regional senior reactor analyst because the fire impacts the control room. Consequently, the significance of this finding is TBD pending completion of the significance evaluation. The cause of this finding involved the cross-cutting area of problem identification and resolution, the component of the corrective action program, and the aspect of appropriate and timely corrective action, P.1(d), because the licensee's corrective action plan, in spite of additional failures involving fire precursors, was not timely to preclude a fire event. (Section 40A3.2)

Inspection Report# : [2011003](#) (pdf)

Significance:  Dec 31, 2010

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Maintain PM Procedures for Circuit Breakers Current with Industry Information and OE

A Green, self-revealing finding was identified for the failure to maintain a preventative maintenance (PM) procedure for circuit breakers current with industry information and operating experience (OE), as required by procedure, DNAP-2001, "Equipment Reliability Process," Revision 0. The licensee entered this problem into their corrective action program as condition report 331819.

The failure to maintain an adequate preventive maintenance (PM) procedure led to an age related failure of a motor starter (main contactor) causing a fire in safetyrelated breaker cubicle J1 of motor control center (MCC) 1J1-2S which supplied power to the D control rod drive mechanism cooling fan, 01-HV-F-37D. The failure to establish an adequate PM task for testing the main contactor of a circuit breaker to ensure that it is in good operating condition and will operate reliably until the next scheduled maintenance was determined to be a performance deficiency. Significance Determination Process (SDP) phase 1 screening of the finding was performed and the finding was determined to increase the likelihood of a fire external event and required a phase 3 SDP evaluation. A phase 3 SDP analysis was performed by a regional SRA in accordance with Inspection Manual Chapter 0609 Appendix F, NUREG /CR -6850 as amended by NUREG/CR -6850 supplement 1, with the NRC North Anna SPAR risk model used to determine the conditional core damage probability (CCDP) for the fire scenarios. The dominant sequence was a fire in MCC1J1-2S damaging MSIV cables resulting in a reactor trip transient with failure of high pressure recirculation and residual heat removal due to fire effects leading to core damage. The evaluation concluded that the core damage frequency (CDF) increase of the potential fire scenarios was characterized as of very low safety significance (Green). This finding involved the cross-cutting area of problem identification and resolution, the component of OE, and the aspect of implementation and institutionalization of OE through changes to station processes and procedures (P.2(b)), because the licensee failed to incorporate existing industry OE to ensure procedural guidance was adequate for testing of the main contactor.

Significance:  Sep 30, 2010

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate set point for balbance-of-plant bus undervoltage relay

A self-revealing finding was identified for the failure to establish an adequate set point for a balance-of-plant 4160 V bus undervoltage protection relay. The inadequate set point caused a reactor trip upon automatic start of a steam generator feedwater pump. The event was reported to the NRC in Licensee Event Report (LER) 0500339/2010-002-00. Corrective action has been taken to reduce the probability of recurrence of the problem. The licensee has placed this issue in their corrective action program as Root Cause Evaluation (RCE) 001012.

The fact that the motor starting voltage dip of the twin 4500 horsepower motor feedwater pump was below the set point of the bus undervoltage protection relays was a performance deficiency. The typical industry standard practice for bus undervoltage is that the set point be below the motor starting voltage dip to preclude spurious actuation of the undervoltage relays for expected voltage transients such as motor starting. This industry standard practice is documented in Institute of Electrical and Electronics Engineers Standard 666-1991, "IEEE Design Guide for Electric Power Service Systems for Generating Stations." Table 7.2, "Motor Protection Devices," states that the suggested setting for undervoltage relay is that it be set to override voltage drop due to motor starting. The potential for spurious tripping of the undervoltage relays has nuclear safety ramifications, in that it can contribute to a reactor trip, as it did on May 28, 2010. The performance deficiency is more than minor because it was associated with the attribute of design control and adversely affected the objective of the initiating event cornerstone. The inappropriate undervoltage relay set point contributed to a reactor trip which is an event that upset plant stability and challenged critical safety functions. The finding was evaluated for significance using Inspection Manual Chapter 0609, Appendix E. The finding was determined to be very low safety significance, Green, because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation functions will not be available. The cause of the finding was evaluated in the licensee's corrective action program as RCE001012. According to the LER and RCE001012, the cause of the finding was determined to be lack of a design basis for the undervoltage protection relay. Since the set point was established well outside the two-year window of current performance and there was no prior event that provided an opportunity to identify this problem, this issue did not represent current licensee performance. Therefore, no associated cross-cutting aspect was identified. (Section 40A3.3)

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

Mitigating Systems

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Control Transient Fire Loads in a Safety-Related Area

The inspectors identified a non-cited violation of the North Anna Power Station, Unit 1 Renewed Facility Operating License, NPF-4, Condition 2.D, Fire Protection, which involved a failure to comply with transient fire load procedure requirements that resulted in transient fire loads improperly located in a safety-related area, the Unit 1 motor driven auxiliary feedwater (MDAFW) room, contrary to transient fire load report requirements. The licensee entered the problem into their corrective action program as condition report 423054.

The finding was more than minor because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and the related attribute of protection against external factors such as fire. This finding had a credible impact on safety because the transient fire load exceeded the limit of Class B liquid transient loads. In accordance with NRC IMC 0609, "Significant Determination Process," Appendix F, the inspectors performed a Phase 1 analysis and determined that the finding was of very low safety significance or Green because although the combustible controls program element was of high degradation due to oily rags in an unapproved container, the Unit 1 MDAFW room had a low fire frequency of 1E-6 and the duration of the violation was less than 3 days, which resulted in a

screening check frequency of 1E-8 which was less than the screening criteria of 1E-6. The cause of this finding involved the cross-cutting area of human performance, the component of work practices, and the aspect of procedural compliance, H.4(b), because the licensee failed to follow procedural requirements for the control of transient fire loads in a safety-related area. (Section 1R05.1)

Inspection Report# : [2011003](#) (pdf)

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Fire Doors in Accordance with the Fire Protection Program

The inspectors identified a non-cited violation of the North Anna Power Station, Units 1 & 2 Renewed Facility Operating Licenses, NPF-4 & 7, Condition 2.D, Fire Protection, which involved a failure to comply with the requirements for maintaining the operability of fire door, 02-BLD-STR-S71-18, "2H Emergency Diesel Gen Room Door SB Elev 271." The inspectors also identified an additional example of this violation which involved fire door, 01-BLD-STR-S07-3, "Unit 1/Unit 2 Switchgear Door Service Building EL 307." The licensee entered the problems into their corrective action program as condition reports 417750 and 418705 for 02-BLD-STR-S71-18, and 430445, 01-BLD-STR-S07-3.

The inspectors identified a performance deficiency (PD) for the failure to maintain the fire doors operable per the requirements of the Fire Protection Program and consequently failing to declare the fire doors inoperable with appropriate compensatory measures. The PD was more than minor because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and the related attribute of protection against external factors such as fire. This finding had a credible impact on safety because the inoperability of the fire doors would have an adverse impact on the functionality of the gaseous suppression systems. In accordance with NRC IMC 0609, "Significant Determination Process," Appendix F, the inspectors performed a Phase 1 analysis and determined the finding resulted in very low significance, Green, because although the fire confinement program element was of high degradation, the fire frequencies related to the rooms were 1E-6 and the duration of the component inoperability was less than three days, which resulted in screening check frequency of 1E-8 which was less than the screening criteria of 1E-6. The cause of this finding involved the cross-cutting area of human performance, the component of resources, and the aspect of adequate equipment, H.2(d), because the licensee failed to ensure that fire door closures were adequate for the protection of equipment important to safety. (Section 1R05.2)

Inspection Report# : [2011003](#) (pdf)

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Comply with Technical Specifications for Alignment of the Refueling Water Storage Tank to the Non-Seismic Refueling Purification System

The inspectors identified a non-cited violation of Technical Specification (TS) 3.5.4, "Refueling Water Storage Tank (RWST)," for the failure to comply with the Limiting Conditions for Operation (LCO), while the Units 1 and 2 RWSTs were aligned to the non-seismic Refueling Purification (RP) system for purification during Mode 1, causing the RWSTs to be inoperable. Specifically, when the RP system was aligned to the RWST, the licensee did not declare the RWST inoperable. The licensee entered the problem into their corrective action program as condition report 397144 and suspended the use of procedures, 1-OP-16.4, "Purification Operations of Unit 1 Storage Tank," and 2-OP-16.4, "Purification Operations of Unit 2 Storage Tank," for purification of the RWST in Modes 1-4 until further review has been completed. The licensee had originally modified their procedures to allow this activity in 1996.

The failure to comply with the actions of TS LCO 3.5.4 while the Units 1 and 2 RWSTs were aligned to the non-seismic RP system for purification on September 4, 2010, and January 7, 2010, respectively, resulting in the inoperability of the RWSTs was a performance deficiency (PD). The PD was more than minor because it affected the design control attribute of the mitigating system cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with NRC

IMC 0609, "Significant Determination Process," the inspectors performed a Phase 1 analysis and determined that this finding was within the mitigating systems cornerstone and was potentially risk significant due to a seismic external event and therefore required a Phase 3 SDP analysis. A phase 3 risk assessment was performed by a regional SRA using the NRC SPAR model. A bounding one year exposure period was utilized. The non-seismic RP piping was assumed to fail at the same seismic input as that assumed for a loss of offsite power. The dominant sequence was a seismically induced non-recoverable loss of offsite power with a failure of the AFW system due to loss of the emergency condensate storage tank and failure of feed and bleed due to loss of the RWST leading to core damage. The risk was mitigated by the low probability of a seismic event and the use of a dedicated operator for isolation of the non-seismic piping. The analysis determined that the risk increase of the performance deficiency was an increase in core damage frequency less than 1E-6/year yielding a GREEN finding of very low safety significance. The finding had no cross-cutting aspects due to its legacy nature. (Section 1R18,2)

Inspection Report# : [2011003](#) (pdf)

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Cause Evaluation of Scaffolding Affecting Unit 1 'A' Charging Pump

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the failure to identify a condition adverse to quality involving noncompliance with a licensee procedure during an apparent cause evaluation (ACE) for scaffolding adversely affecting the Unit 1 'A' charging pump. The licensee entered this problem into their corrective action program as condition report 416488.

The inspectors determined that the failure to identify a condition adverse to quality involving noncompliance with a licensee procedure during an ACE was a performance deficiency (PD). The PD was more than minor because (1) if left uncorrected it would have the potential to result in a more significant safety event, and (2) it impacted the mitigating systems cornerstone objective to ensure the reliability and capability of systems which respond to initiating events and the related attribute of equipment performance because the reliability of the affected safety related components would be adversely impacted during a seismic event. In accordance with NRC Inspection Manual Chapter 0609, "Significant Determination Process," the inspectors performed a Phase 1 analysis and determined the finding was of very low safety significance or Green because the affected equipment would not result in a total loss of a safety function during a seismic event. This finding involved the cross-cutting area of human performance, the component of the resources, and the aspect of procedure use and adherence, H.4(b), because the licensee failed to adequately follow procedures for the identification of seismic deficiencies involving scaffolding. (Section 40A2.3)

Inspection Report# : [2011003](#) (pdf)

Significance:  Jun 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Qualification Testing of Fire Barrier Penetration Seals

The inspectors identified a non-cited violation of North Anna Power Station, Units 1 & 2 Renewed Facility Operating Licenses, NPF-4 & 7, Condition 2.D, Fire Protection, for failure to maintain in effect all provisions of their NRC-approved fire protection program. Specifically, the licensee failed to have adequate qualification testing results for installed aluminum conduits that penetrate fire barriers separating fire areas containing equipment required for safe shutdown. The requirement to have adequate qualification testing for such fire barrier penetrations is contained in Appendix A to Branch Technical Position APCS 9.5-1, which is part of the licensee's NRC-approved fire protection program. As part of the corrective actions, the licensee performed testing to determine the qualification of aluminum conduit penetrations, and performed modifications, as appropriate, to restore compliance.

The finding is more than minor because it is associated with the reactor safety Mitigating Systems cornerstone attribute of protection against external factors (i.e., fire) and it affects the cornerstone objective of ensuring the reliability and capability of systems that respond to initiating events. Specifically, not having qualification testing results for aluminum conduits that penetrate fire rated barriers adversely affected the fire confinement capability

defense-in-depth element, because subsequent testing revealed that some conduits did not meet the penetration seal criteria established in BTP APCSB 9.5-1. In accordance with NRC IMC 0609, "Significant Determination Process," Appendix F, the inspectors determined that the performance deficiency represented a finding of very low safety significance (Green). Specifically, the fire barriers in question either provided a 2-hour or greater fire endurance rating, or the barriers separated rooms that did not contain equipment credited for fire safe shutdown of the plant. Inspectors determined that no cross cutting aspect was applicable to this performance deficiency because this finding was not indicative of current licensee performance. (Section 4OA5.4)

Inspection Report# : [2011003](#) (pdf)

Significance:  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Post Maintenance Test Program Instructions for Safety-Related Instrument and Control Preventative Maintenance

A Green, non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the NRC for failure to adequately prescribe the correct program instructions to ensure safety-related instrument and control (I&C) preventative maintenance (PMs) received the appropriate post maintenance testing (PMT). The licensee entered this problem into their corrective action program as condition report 417730.

A performance deficiency was identified by the NRC for the failure to adequately prescribe programmatic PMT instructions to ensure safety-related I&C PMs had proper PMT. The inspectors reviewed Inspection Manual Chapter (IMC) 0612, Appendix B, and determined the finding was more than minor because if left uncorrected it would have the potential to result in a more significant safety event. In accordance with IMC 0609, "Significant Determination Process," the inspectors performed a Phase 1 analysis and determined that the finding was of very low significance because the finding was not a design deficiency, did not represent a loss of safety function and did not screen as potentially risk significant due to a seismic, flooding or severe weather initiating event. This finding involved the cross-cutting area of human performance, the component of the resources, and the aspect of complete documentation, H.2(c), because the licensee failed to adequately prescribe programmatic PMT instructions to ensure safety-related I&C PMs had proper PMT.

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

Significance:  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Action for Fatigued Fuse Clips in Safety-Related Breakers

A Green, non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the NRC for failure to promptly identify and correct a condition adverse to quality regarding fatigued fuse clips associated with safety-related breakers. The licensee entered this problem into their corrective action program as condition report 400128.

The inspectors determined that the failure to promptly initiate corrective actions for fatigued fuse clips was a performance deficiency (PD) which resulted in two safetyrelated breaker failures. The inspectors reviewed IMC 0612, Appendix B, and determined the PD was more than minor because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and the related attribute of design control for the initial structure, system, component design. In accordance with NRC Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," the inspectors performed a Phase 1 analysis and determined that the finding was of very low significance because the finding was not a design deficiency, did not represent a loss of safety function and did not screen as potentially risk significant due to a seismic, flooding or severe weather initiating event. This finding involved the cross-cutting area of problem identification and resolution, the component of the corrective action program, and the aspect of thorough evaluation of problems such that resolutions address extent of condition, P.1(c), because the licensee failed to initiate adequate corrective actions to address extent of condition for fatigued fuse clips.

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

Significance: G Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control Measures for Field Changes Affecting Station Battery Cables

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," for the failure to ensure that design control measures for field changes impacting the support of station battery cables were commensurate with those applied to the original design requirements. The licensee entered this problem into their corrective action program as condition report 358461.

The inspectors determined that the failure to adhere to the requirements of Criterion III for field changes involving the support of station battery cables was a performance deficiency (PD). This PD had a credible impact on safety due to an increase in battery post loading not analyzed by the vendor for a seismic event impacting the unsupported cables. The PD was more than minor, because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences and the related attribute of design controls due to changes made to battery cable supports which created a condition adverse to quality. In accordance with NRC Inspection Manual Chapter (IMC) 0609, "Significant Determination Process," the inspectors performed a Phase 1 analysis and determined that the finding was of very low significance (Green) because the design deficiency did not result in the loss of functionality. The finding had no cross-cutting aspects because it is not indicative of current licensee performance.

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

Significance: G Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate procedurally controlled temporary modification for the emergency diesel generator starting air system

A non-cited violation of 10 CFR 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the failure to ensure that design control measures for a field change performed on the Unit 1, '1J' emergency diesel generator (EDG) starting air receivers were commensurate with those of the original design. The field change consisted of a procedurally controlled temporary modification (TM) that installed a non-safety related hose between the safety related EDG starting air receivers. The licensee entered this problem into their corrective action program as condition report 389521.

The inspectors determined that the failure to adhere to the requirements of Criterion III for a field change involving a procedurally controlled TM was a performance deficiency (PD). This PD had a credible impact on safety due to the implementation of a TM which introduced a common mode failure mechanism for both EDG starting air receivers which would render the respective EDG unavailable and inoperable. The PD was more than minor, because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences and the related attribute of design controls due to the removal of independence between the EDG starting air receivers and consequent impact on the redundancy of the EDGs. In accordance with NRC Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," the inspectors performed a Phase 1 analysis and determined that the finding was of very low significance (Green) because the design deficiency did not result in the loss of functionality. The finding had no cross-cutting aspects because it is not indicative of current licensee performance. (Section 1R18.1)

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

Significance: G Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Correct Conditions Adverse to Quality for Valve Actuator Diaphragms

A non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for two examples of the failure to promptly identify and correct a condition adverse to quality present in the actuator diaphragms of 1-CH-HCV-1200C, letdown orifice isolation, and 1-RC-PCV-1456, reactor coolant system (RCS) pressurizer power operated relief valve (PORV). The licensee entered these problems into their corrective action program as condition reports 355000 and 387916.

The inspectors determined that the failure to promptly correct conditions adverse to quality for 1-CH-HCV-1200C and 1-RC-PCV-1456 was a performance deficiency (PD). The NRC Enforcement Manual allows for the grouping of multiple examples of the same violation during an inspection period and the assignment of an issue to that example which is most significant. The inspectors determined that the second example, involving 1-RC-PCV-1456, was the more significant issue. The inspectors reviewed IMC 0612, Appendix B and determined the finding was more than minor because it affected the Barrier Integrity cornerstone objective of providing reasonable assurance that physical design barriers (e.g. RCS) protect the public from radionuclide releases caused by accidents or events. Specifically, the pressurizer PORVs provide protection to the RCS by preventing brittle fracture at low temperature conditions and protect RCS integrity at high temperature conditions. The inspectors reviewed IMC 0609, Attachment 4 and determined that since the finding involved a degradation of the Barriers Cornerstone, specifically the RCS barrier, a phase 3 analysis was required. The NRC's SPAR model was utilized to assess the risk significance of the finding modeling the impact of an increased likelihood of failing-to-open. The analyst calculated new failure probabilities for the Unit 1 PORVs (1-RC-PCV-1455C/1456) based on actual/observed failures of the valves. The analyst confirmed that the other valves affected by the performance deficiency (e.g., loop drain valves) were of negligible risk significance and were not included in the North Anna SPAR model. The dominant sequences were transients where a loss of the Condensate Storage Tank occurs and one/both of the PORVs fail to open when called upon, in order to initiate feed and bleed, subsequently leading to core damage. The analyst determined that the risk increase in core damage frequency was $<1E-6$ per year, a finding of very low safety significance, Green. The cause of this finding involved the cross-cutting area of problem identification and resolution, the component of corrective action program, and the aspect of implementation of corrective action (P.1(d)), because the licensee failed to correct the safety issue that existed with 1-RC-PCV-1456 in a timely manner, commensurate with its safety significance and complexity.

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

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Apr 29, 2011

Identified By: NRC

Item Type: FIN Finding

PI&R inspection results

The inspectors concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution, as evidenced by the relatively few number of deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner. However, the inspectors did identify minor performance deficiencies associated with the CAP in the areas of problem identification, prioritization and evaluation of identified problems, and effectiveness of corrective actions.

The inspectors determined that overall; audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. However, the inspectors identified a minor performance deficiency associated with the self-assessment program. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations. However, the inspectors identified minor performance deficiencies associated with the licensee's use of operating experience.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.

Inspection Report# : [2011008](#) (*pdf*)

Last modified : October 14, 2011