Dresden 3
3Q/2011 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2011
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Change In Unit 2 Reactor Water Level Due To A Failure To Follow Procedure
A finding of very low safety significance and associated non-cited violation of Technical Specification 5.4.1 was self-revealed for a Nuclear Station Operator (NSO) failing to follow step G.14.a of procedure DOP 0600-06, "Feedwater Regulating Valve (FWRV) Operation," Revision 39. This resulted in a reduction in Unit 2 reactor water level. The licensee took the following immediate corrective actions. The NSO placed the 2B FWRV in manual and restored reactor water level. The NSO was relieved from duty.

The finding was determined to be more than minor because the finding could be reasonably viewed as a precursor to a significant event. Specifically, the event could have lead to a reactor scram. The inspectors concluded this finding was associated with the Initiating Events Cornerstone. The inspectors evaluated the finding 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 Initiating Events Cornerstone. Since the finding did not contribute to both the likelihood of a reactor scram and the likelihood that mitigation equipment or functions will not be available, the finding screened as Green. This finding had a cross-cutting aspect in the area of human performance, work practices, because the licensee did not ensure the proper use of human error prevention techniques.
Inspection Report# : 2011003 *(pdf)*

Significance: G Mar 31, 2011
Identified By: Self-Revealing
Item Type: FIN Finding
Dresden 3B Circulating Water Pump Bearing Failure due to Low Oil Level
A self-revealed finding was identified for the bypass of a circulating water pump lower bearing high temperature alarm without first verifying the instrument reading. Prior to bypassing the alarm, the licensee did not verify if the indication was valid. No violation of regulatory requirements occurred. Planned corrective actions included the creation of an action for operations department management to communicate the issue of the bearing temperature not being addressed in a timely manner to operations department personnel, and an action to the system manager to review operator rounds for circulating water for enhancements.
Using the guidance contained in IMC 0612, Appendix B, "Issue Disposition Screening," dated January 1, 2010, the inspectors determined that the finding was more than minor because it affected the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors evaluated the finding using IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," dated January 10, 2008. The inspectors answered 'No' to all questions in the Initiating Events Cornerstone column of Table 4a, "Characterization Worksheet for IE, MS, and BI Cornerstones." Therefore, the finding screened as Green (very low safety significance). The inspectors determined that this issue also affected the cross-cutting area of Human Performance (Work Practices) because the licensee personnel did proceed in the face of uncertainty when bypassing the circulating water pump high bearing temperature alarm without verifying if the indication was valid.
Inspection Report# : 2011002 *(pdf)*

Mitigating Systems

Significance: G Sep 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Improperly Classifying the Unit 2 and 3 Containment Cooling Service Water (CCSW) Pump Vault Drain Check Valves as Non Safety Related
A finding of very low safety significance and associated non cited violation of 10 CFR 50, Appendix B, Criterion II, "Quality Assurance Program," was identified by the inspectors for the reclassification of the Unit 2 and 3 containment cooling service water (CCSW) pump vault drain check valve from a quality status of safety related to non safety related. The licensee had not yet determined corrective actions for this violation by the end of the inspection period.

The finding was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, by removing the quality assurance requirements for this part, the licensee reduced the assurance that replacement parts are of sufficient quality to assure reliable service during and following design basis events. The inspectors concluded this finding was associated with the Mitigating Systems Cornerstone. 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 finding screened as of very low safety significance (Green) because the finding was a qualification deficiency confirmed not to result in loss of operability or functionality. The inspectors did not identify a cross cutting aspect associated with this finding, primarily because the reclassification occurred in 2004.
Inspection Report# : 2011004 *(pdf)*

Significance: G Sep 30, 2011
Identified By: Self-Revealing
Item Type: FIN Finding
Inadequate Relay Preventative Maintenance
A finding of very low safety significance was self revealed for the failure to follow the preventive maintenance program which resulted in the failure of the Unit 3 303241 52A GE HFA relay. This relay gives a start permissive signal for all three reactor feed pumps (RFPs). The licensee's corrective actions included restoring the correct preventive maintenance item (replace the relay) including adding a preventive maintenance item for the associated Unit 2 relay. The licensee also included a review of relays in multiple systems to ensure that the proper preventive maintenance items were identified and scheduled.

The finding was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of a system that responds to an initiating event to prevent undesirable consequences. 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 for the reasons stated in the previous paragraph. The inspectors answered question 4 "YES." The finding represented an actual loss of safety function of one or more trains of equipment designated as risk significant per 10 CFR 50.65 for >24 hours. The inspectors verified that Feedwater Level Control was a high safety significant function per the licensee's Maintenance Rule database and that the inability to restart any of the Unit 3 RFP's lasted longer than 24 hours. The Senior Reactor Analysts (SRAs) performed an SDP phase 2 and 3 analysis of this finding. The exposure period was determined to be approximately 5 months, the time between the last known successful operation of the relay and the failure. For the phase 2 evaluation, the SRAs solved the transient (TRANS), small loss of coolant accident (SLOCA), and of direct current bus (LODC) worksheets in the "Risk Informed Inspection Notebook for Dresden Nuclear Power Station Units 2 and 3 (Revision 2.1a)" assuming that the power conversion system (PCS) was unavailable for greater than 30 days. Using the counting rule for adding sequences described in IMC 0609 Appendix A, "Determining the Significance of Reactor Inspection Findings for At Power Situations," the SDP result was a "6" or a finding of low to moderate safety significance. The SRAs determined that a phase 3 SDP was necessary because the phase 2 result assumed that the main feedwater (MFW) pumps would always be unavailable and because the exposure period was 5 months rather than 1 year assumed by the phase 2 SDP process. For the phase 3 evaluation, the SRA modified the Standardized Plant Analysis Risk Model (SPAR) for Dresden to add basic events modeling the potential for MFW to trip. The SRAs assumed MFW would trip in response to a reactor trip approximately 6 percent of the time and that MFW would not be recoverable. The estimated delta CDF over the exposure period was 9.0E 8/yr, which is a finding of low to moderate safety significance (Green). The dominant

sequence was a manual shutdown followed by the trip of MFW and the inability to restart the pumps. Random failures of the isolation condenser, high pressure coolant injection and low pressure coolant injection were also part of the dominant sequence. There were no cross cutting aspects to this finding.
Inspection Report# : 2011004 *(pdf)*

Significance: G Sep 30, 2011
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Preventive Maintenance Procedure For Valve 2 2301 29
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 self revealed for the failure to have a procedure adequate to ensure quality during the preventive maintenance (PM) performed on the high pressure coolant injection (HPCI) 2 2301 29, “Return to Condenser Valve,” in March 2011. The violation was entered into the licensee’s corrective action program as IR 1250901, “HPCI Return To Condenser Leak From Valve Body.” The licensee’s corrective actions included determining the acceptable internal and external inspection scope and revising procedure DMP 0040 06, “Copes Vulcan Valve and Reverse Acting (Air to Open) Operator Maintenance,” as appropriate.

The finding was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to identify long term degradation during a preventive maintenance activity in March 2011 resulted in the HPCI system becoming inoperable in August 2011. 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 answered Question 2, (Does the finding represent a loss of system safety function?) "Yes" and went to Inspection Manual Chapter 0609, Appendix A. A Region III Senior Reactor Analyst performed an SDP phase 3 evaluation using the Standardized Plant Analysis Risk (SPAR) model for Dresden. The high pressure coolant injection system was modeled as unavailable for an exposure period of 6 days. The delta CDF estimate was 7.9E 8/yr, which represents a finding of very low safety significance (Green). The dominant core damage sequence was a loss of main feedwater followed by the failure or unavailability of high and low pressure injection sources. The inspectors did not identify a cross cutting aspect associated with this finding.
Inspection Report# : 2011004 *(pdf)*

Significance: G Jun 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Instructions for the Inspection of Safety-related Portions of the Intake Structure
A finding of very low safety significance and associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors for licensee’s failure to establish adequate instructions for inspecting bay 13 and portions of the intake structure surrounding the diesel generator cooling water pumps. Specifically, the procedure that provides guidance for inspecting these structures lacked specific instructions on how to detect and record degradation by erosion and corrosion. The licensee entered this issue into their corrective action program and initiated procedure revisions to provide further direction for capturing 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 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 loss of operability or functionality. Specifically, a qualitative assessment of historic surveillance reports found the documented results acceptable. The inspectors determined the cause of this finding did not represent current licensee performance and no cross-cutting aspect was assigned.
Inspection Report# : 2011003 *(pdf)*

Significance: G Jun 30, 2011
Identified By: NRC

Item Type: NCV NonCited Violation
Inadequate Acceptance Criteria for Testing Equipment Relied Upon to Mitigate the Consequences of a Lock and Dam Failure
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 establish adequate acceptance criteria for testing equipment relied upon to mitigate the consequences of a dam failure. Specifically, the acceptance criteria in DOS 0010-01, "Dresden Dam Failure Equipment Test," did not consider additional steps required to demonstrate the ability of the screen refuse pumps to deliver water to the safety-related pumps enclosure to support isolation condensers operability. The licensee entered this issue into their corrective action program and initiated procedure revisions to include these additional steps in the procedure's acceptance criteria.

The performance deficiency was determined to be more than minor because it adversely affected the availability, reliability, and capability of mitigating systems that respond to initiating events to prevent undesirable consequences (i.e., core damage.) The finding screened as of very low safety significance because it was a qualification deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee estimated that the time it would take to perform the additional steps not included in the procedure's acceptance criteria was within the time required. The inspectors determined the cause of this finding did not represent current licensee performance and no cross-cutting aspect was assigned.
Inspection Report# : 2011003 *(pdf)*

Significance: G Jun 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Instructions for Coping with a Dresden Lock and Dam Failure
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 establish adequate instructions for coping with the consequences of a dam failure. Specifically, DOA 0010-01, "Dresden Lock and Dam Failure," lacked controls for the configuration of the associated foreign material exclusion screens and lacked specific instructions on how to shed load off the emergency diesel generators and restore power to the bus associated with equipment relied upon during this event. The licensee entered this issue into their corrective action program and initiated procedure revisions to provide adequate controls on the configuration of the FME screens and to provide further guidance on restoring power to the refuse screen pumps.

The performance deficiency was determined to be more than minor because it adversely affected the availability, reliability, and capability of mitigating systems that respond to initiating events to prevent undesirable consequences. The finding screened as of very low safety significance because it was a qualification deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee estimated that the additional time required to install the inner screens and restore power to the screen refuse pumps was within the required 2-hours. The inspectors determined the cause of this finding did not represent current licensee performance and no cross-cutting aspect was assigned.
Inspection Report# : 2011003 *(pdf)*

Significance: G Jun 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Scoping of a Non-Safety-related Pump Into Maintenance Rule
A finding of very low safety significance and associated NCV of 10 CFR Part 50.65(b)(2)(ii), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified by the inspectors for the licensee's failure to adequately scope a non-safety-related component relied upon to mitigate an accident. Specifically, the licensee failed to include the screen refuse pumps, non-safety-related pumps credited as a support component for the isolation condensers, safety-related systems, during a dam failure, as part of their maintenance effectiveness program. As a corrective action, the licensee initiated IR1221421, to evaluate the need to include the screen refuse pumps into their maintenance rule program.

The performance deficiency was determined to be more than minor because it adversely affected the availability,

reliability, and capability of mitigating systems that respond to initiating events to prevent undesirable consequences (i.e., core damage.) The finding screened as of very low safety significance because it was a qualification deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee performed further review of related maintenance and provided reasonable assurance the screen refuse pumps did not experience a complete loss of function. The inspectors determined the cause of this finding did not represent current licensee performance and no cross-cutting aspect was assigned.
Inspection Report# : 2011003 *(pdf)*

Significance: G Jun 30, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Place One Channel of the Rod Block Monitor Into Trip
The inspectors identified a finding of very low safety significance and NCV of Technical Specification 3.2.1.1, Required Action B.1, for the licensee's failure to place one Rod Block Monitor (RBM) channel on Unit 3 in trip within 1 hour as required upon meeting Condition B, "Two RBM channels inoperable." The licensee performed troubleshooting on the issue and declared the RBM inoperable to repair the failed component.

The finding was determined to be more than minor because if left uncorrected, if could lead to a more significant safety concern. Specifically, if a RBM channel had fewer than three real inputs, but was counting false inputs due to the shorted diode, it would be unable to fulfill its Inop function, and would not insert a rod block to prevent a rod withdrawal error. The inspectors performed a Phase 1 Significance Determination in accordance with IMC 0609, Attachment 4. The inspectors concluded that this finding affected the Mitigating Systems Cornerstone since it was a degradation of reactivity control. The finding screened as Green, or very low safety significance, in Table 4a of Attachment 4, since it is not a design or qualification deficiency and did not represent an actual loss of safety system function. This is because the RBM maintained a sufficient number of real inputs and because the licensee's Rod Withdrawal Error analysis does not assume the RBM function. The inspectors determined that this finding has a cross-cutting aspect in the area of Problem Identification and Resolution in the component of Corrective Action Program, since it involved the licensee's failure to thoroughly evaluate problems.
Inspection Report# : 2011003 *(pdf)*

Significance: G Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Control Room Ventilation Smoke Detector Failure to Perform Post-Maintenance Testing
The inspectors identified a finding of very low safety significance and associated NCV of the Dresden Nuclear Power Station Renewed Facility Operating License for the licensee's failure to perform adequate post-maintenance testing on a smoke detector in the Control Room Ventilation System ductwork. Corrective actions by the licensee included creating an action to determine what happened with the test results and moving the repair of the smoke purge dampers up in the schedule.
Using IMC 0612, Appendix B, "Issue Screening," issued on January 1, 2010, the inspectors determined that this finding was more than minor. The inspectors were unable to resolve the more than minor issue based on the examples in IMC 0612, Appendix E, "Examples of Minor Issues," dated August 11, 2009. The inspectors did, however, determine that the performance deficiency was associated with the Reactor Safety – Mitigating Systems Cornerstone attribute of equipment performance. The failure to perform post-maintenance testing on the smoke detector could impact the cornerstone objective of ensuring the availability, reliability, and capability of sustems that respond to initiating events to prevent undesirable consequences. The inspectors determined that this finding had a cross-cutting aspect in the area of Work Control because the licensee did not appropriately plan work activities by incorporating the need for planned contingencies. Specifically, when the control room ventilation dampers would not reposition to the smoke purge position, the licensee still had the ability to test the alarms associated with the detector but failed to do so (H.3(a)).
Inspection Report# : 2011002 *(pdf)*

Significance: G Mar 31, 2011
Identified By: NRC

Item Type: NCV NonCited Violation
Failure to Perform Surveillance Testing on East Turbine Building Vent HVAC Smoke Detectors
The inspectors identified a non-cited violation (NCV) of the Dresden Nuclear Power Station Renewed Facility Operating License having very low safety significance for the licensee's failure to perform adequate testing on four smoke detectors in the east turbine building ventilation system ductwork. This violation was presented to the licensee late in the inspection period and the licensee had not had time to develop corrective actions before the end of the inspection period.
Using Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," issued on January 1, 2010, the inspectors determined that this finding was more than minor. The inspectors were unable to resolve the more than minor issue based on the examples in IMC 0612, Appendix E, "Examples of Minor Issues," dated August 11, 2009. The inspectors did however, determine that the performance deficiency was associated with Reactor Safety – Mitigating Systems cornerstone attribute of equipment performance. The failure to perform post-maintenance testing on the smoke detectors in the control ventilation ductwork could impact the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors completed a Phase 1 significance determination of this issue using IMC 0609, "Significance Determination Process," Appendix A, Attachment 0609.04, dated January 10, 2008. The inspectors determined that the finding affected fire protection defense-in-depth strategies and therefore, per Table 3b, referred to IMC 0609, Appendix F, dated February 28, 2005. The inspectors determined that the Finding Category was Fixed Fire Protection Systems and the inspectors determined that there was a low degree of degradation since the non-functional detectors only detected smoke from a single source and there were no combustibles of concern located near the detectors. Since the degree of degradation was low the issue screened as green. The inspectors determined that this finding has a cross-cutting aspect in the area of Work Control because the licensee did not appropriately plan work activities by incorporating the need for planned contingencies.
Inspection Report# : 2011002 *(pdf)*

Significance:  Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Undocumented Technical Basis for change to EOP ATWS Mitigation Strategy
The inspectors identified a finding of very low safety significance and associated NCV of Dresden Technical Specification 5.4.1, for failing to maintain adequate procedures for implementing the emergency operating procedures (EOP). Specifically, the licensee developed and implemented procedures that altered an EOP mitigation strategy, without establishing and documenting the technical basis for the deviation from the Boiling Water Reactor Owners Group (BWROG) Emergency Procedure Guidelines (EPG). The licensee entered the issue into their corrective action program. Licensee corrective actions included revising three procedures to bring their mitigation strategy into alignment with the BWROG EPG.
This issue was associated with the Procedure Quality attribute of the Mitigating Systems Cornerstone, and is more than minor, in that the licensee implemented an Emergency Operating Procedure mitigation strategy that deviated from the BWROG EPG, without providing adequate technical justification for the deviation, thereby affecting the cornerstone objective of ensuring that the licensee is capable of mitigating the undesirable consequences associated with an Anticipated Transient Without SCRAM (ATWS). The finding was determined to be of very low safety significance because no actual event requiring the use of deficient procedures occurred while the deficient procedures were in effect. The inspectors determined that the finding was not associated with a cross-cutting aspect because the implementation of the non conservative ATWS mitigating actions occurred more than three years ago, and, therefore, was not reflective of current performance.
Inspection Report# : 2011002 *(pdf)*

Significance:  Dec 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Robust Indication of Adequate Oil Level in High Pressure Coolant Injection Booster Pump Sight Glasses
The inspectors identified a Non-Cited Violation of Technical Specification 5.4.1 for the licensee's failure to implement the section of the high pressure coolant injection (HPCI) booster pump maintenance procedure that prescribes how to robustly mark the HPCI booster pump sight glasses to indicate the acceptable oil levels for the

bearings of the Unit 2 and 3 HPCI booster pumps. Upon being informed of the condition, the licensee verified, using measurements, that the oil level for the bearings was adequate and entered the condition in their corrective action program to provide a more robust indication of the acceptable oil level.
This finding is of greater than minor safety significance because if left uncorrected, it has the potential to lead to a more significant safety concern. Specifically, if a more robust minimum level indication is not used, the wires could slide down the sight glass to the point that they do not prevent operators from allowing the oil level to drop below the minimum acceptable level for the pump to perform its safety function. The finding impacted the Mitigating Systems Cornerstone because it involved degradation of HPCI. It is not greater than Green because it did not result in the loss of operability of the HPCI system. The inspectors determined that this finding has a cross cutting aspect in the area of Problem Identification and Resolution under the component Corrective Action Program because the licensee did not take appropriate corrective actions to address safety issues in a timely manner, commensurate with their safety significance and complexity. P.1(d)
Inspection Report# : 2010005 *(pdf)*

Significance: G Dec 31, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform Magnetic Particle Examination on the 3/2/1501-20/20-10 U3 LPCI Support in Accordance with Procedures
A finding of very low safety significance (Green) and associated Non-Cited Violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors for the failure to accomplish activities affecting quality in accordance with procedures. Specifically, the licensee’s vendor non-destructive examination (NDE) examiner failed to perform a magnetic particle (MT) examination in accordance with procedures on the 3/2/1501-20/20-10 Unit 3 low pressure coolant injection support. The licensee initiated corrective action document IR 01135770 to address the issue.
The finding was determined to be more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern. The failure to perform an adequate MT examination could have allowed undetected flaws to remain in service. This finding is of very low safety significance (Green) because the inspectors answered no to all of the characterizations worksheet questions in Table 4a of MC 0609.04. Specifically, no indications were identified when the examination was re-performed. This finding has a cross-cutting aspect in the area of Human Performance for the Work Practices component because the licensee proceeded in the face of uncertainty and unexpected circumstances by continuing to perform the examination after the equipment became damaged. The licensee’s examiner also elected to continue after identifying there was material present on the pipe in a location that could interfere with the exam. In addition, due to different circumstances surrounding the exam such as: component location, equipment weight, and environmental conditions, the examiner became tired. Nonetheless, the examiner elected to continue to perform the examination in this condition. H.4(a)
Inspection Report# : 2010005 *(pdf)*

Barrier Integrity

Significance: G Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow TS 5.5.2 Implementing Procedures
The inspectors identified a non-cited violation of Technical Specification (TS) Section 5.5.2, “Primary Coolant Sources Outside Containment,” because the licensee was not following procedures which implemented TS 5.5.2. The licensee's corrective actions included: performing Operability Evaluation 11-001; quantifying the leakage from check valve 3-1201-306 three times per week, and repairing the leak on March 10, 2011.
The inspectors determined the finding was more than minor because it was similar to IMC 0612, Appendix E, example 2.h, in that multiple examples were identified where non-licensed operators failed to identify that the leakage was increasing. This resulted in the failure to implement the TS 5.5.2 program. 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 Barrier Integrity

Cornerstone, because portions of the barriers between the primary and secondary containment were degraded. The inspectors were able to answer “No” to all four questions on Table 4a under the Barrier Integrity Cornerstone. Therefore, the finding was determined to be of very low safety significance. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices because the licensee did not ensure supervisory and management oversight of work activities such that nuclear safety was supported. Specifically, non-licensed operators were expected to identify an increase in system leakage without adequate oversight to do so.
Inspection Report# : 2011002 *(pdf)*

Significance: G Nov 19, 2010
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform an Ultrasound Thickness Measurement of the Drywell liner in accordance with procedures (4OA5.1.b(1))
A finding of very low safety-significance (Green) and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors for the failure to accomplish activities affecting quality in accordance with procedures. Specifically, the licensee non-destructive examination (NDE) examiner failed to perform an Ultrasound Thickness Measurement of the drywell liner in accordance with procedures. The licensee initiated corrective action document AR 01141740 to address the issue.

The finding was determined to be more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically by failing to perform an adequate Ultrasound Thickness Measurement of the drywell liner potential degradation could have gone undetected. This finding is of very low safety-significance (Green) because the inspectors answered no to all of the characterizations worksheet questions in Table 4a of MC 0609.04. The inspectors determined this finding had no associated cross-cutting aspect because none of them represented the underlying cause for this violation to occur. (Section 4OA5.1)
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Inspection Report# : 2010010 *(pdf)*

Emergency Preparedness

Significance: SL-IV Jun 23, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
(Traditional Enforcement) 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 24, 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.
Inspection Report# : 2010502 *(pdf)*

Significance: G Jun 23, 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 24, 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.

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.

The related traditional enforcement item is tracked as item 2011-502-01.
Inspection Report# : 2010502 *(pdf)*

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

Last modified : January 04, 2012