

# Callaway

## 2Q/2012 Plant Inspection Findings

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### Initiating Events

**Significance:**  Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Ensure Separation of Stainless Steel and Carbon Steel Hand Files and Wire Brushes**

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, for the failure to have procedures that ensured that hand files and wire brushes designated for stainless steel weld preparation were stored separately from hand files and wire brushes used on carbon steel. The licensee took corrective actions to remove the stainless steel designations from stainless steel tools that were mixed with tools used on carbon steel, established segregated locations in tool rooms for the separation of abrasive tools, and trained tool room attendants to properly store and mark abrasive tools designated for use on stainless steel. This issue was entered into the licensee's corrective action program as Callaway Action Request 201108921.

Inspectors determined that the failure to assure that hand files and wire brushes designated for exclusive use on stainless steel were stored separately from tools used on other materials was a performance deficiency. This finding was more than minor because it was associated with the equipment performance attribute of the Initiating Events Cornerstone and adversely affected the cornerstone objective to limit the likelihood of those events that upset plant stability and, if left uncorrected, could become a more significant safety concern. Inspectors performed a Phase 1 screening in accordance with Inspection Manual Chapter 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings," and determined that the finding was of very low safety significance because the issue would not result in exceeding the technical specification limit for identified reactor coolant system leakage or affect other mitigating systems resulting in a total loss of their safety function. This finding has a cross-cutting aspect in the area of problem identification and resolution, associated with the corrective action program, because the licensee did not thoroughly evaluate problems such that the resolutions addressed causes and extent of conditions, as necessary. Specifically, the licensee's response to Callaway Action Request 201107806 identified contaminated tools as the cause of rusting on the motor-driven auxiliary feed pump room cooler stainless steel piping, but the licensee took no further action to identify the cause of the contamination.

Inspection Report# : [2011005](#) (*pdf*)

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### Mitigating Systems

**Significance:**  Jun 26, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Incorporate Operating Experience for a 10 CFR 50.65(a)(3) Assessment**

The inspectors identified a finding for failure to ensure that a system credited in the Final Safety Analysis Report for mitigating internal flooding was available and reliable. On May 1, 2012, the licensee discovered the floor drains in the engineered safety feature switchgear rooms for both trains were almost completely plugged from debris and were not capable of passing water at the credited flow rate. This was a result of failure to perform inspections or preventive maintenance on the system since original construction. In May 2005, the NRC issued Information Notice 2005-11 regarding, in part, internal flooding and blocked floor drains. Title 10 of the Code of Federal Regulations 50.65(a)(3) states, in part, that "evaluations shall take into account, where practical, industry-wide operating experience. Adjustments shall be made. . ." Contrary to the above, in 2005, the licensee evaluated, but did not take action on

applicable industry-wide operating experience. In response, the licensee cleaned the drains, created preventive maintenance tasks to verify proper floor drain operation, and was evaluating the planned corrective actions to address the violation. These were documented in Callaway Action Requests 201203302 and 201204582.

The inspectors determined that failure to ensure a system credited in the Final Safety Analysis Report was available and reliable to mitigate internal flooding was a performance deficiency. Specifically, the licensee failed to perform preventive maintenance or testing to ensure the engineered safety feature switchgear room floor drains would drain water from the switchgear rooms for both trains at the rate credited for flood mitigation. The inspectors evaluated the performance deficiency in accordance with Inspection Manual Chapter 0612, Appendix B, "Issue Screening." This performance deficiency was more than minor because it affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. During a Phase 1 screening for significance the inspectors determined the finding was potentially risk significant due to its contribution to a flooding initiating event. It was referred to a senior reactor analyst who determined that because the delta core damage frequency was less than 1E-6 and the finding was not a significant contributor to the large early release frequency, the finding was of very low safety significance. This finding does not have a cross-cutting aspect because the performance deficiency is not representative of current licensee performance.

Inspection Report# : [2012003](#) (*pdf*)

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**Significance:** Jun 26, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure to Declare Component Cooling Water Train A Inoperable Due to Voids**

The inspectors reviewed a self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion V, involving the licensee's failure to properly assess the operability of component cooling water train A when voids were recognized during a post-maintenance run. On March 19, 2012, when component cooling water pump A was started following maintenance, a large void was discovered in the system. Operators diagnosed that voids had been introduced into the system during the restoration of the spent fuel pool train A heat exchanger. Operators declared the system operable based on seeing pump flows and current readings return to normal values; however, several hours later, the licensee discovered that voids were still present in the system and declared the system inoperable. After extensive venting, the licensee declared the system operable based on an acceptable, measurable quantity of voiding in the system. This issue was entered into the licensee's corrective action program as Callaway Action Request 201203506.

Failure to fully assess a degraded condition before declaring component cooling water system train A operable was a performance deficiency. This finding is more than minor because it is associated with the human performance attribute of the Mitigating Systems Cornerstone and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems to respond to initiating events. Using Manual Chapter 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," this finding was determined to be of very low safety significance because it did not create a loss of system safety function of a single train for greater than the technical specification allowed outage time and did not affect seismic, flooding, or severe weather initiating events. This finding has a cross-cutting aspect in the area of problem identification and resolution associated with the operating experience component because the licensee failed to institutionalize operational experience through changes to station processes, procedures and training programs to support plant safety.

Inspection Report# : [2012003](#) (*pdf*)

**G**

**Significance:** May 04, 2012

Identified By: NRC

Item Type: FIN Finding

**Failure to establish preventive maintenance for equipment used to achieve post-fire safe shutdown.**

The team identified a finding for the failure to establish preventive maintenance of local transfer/isolation switch JEHS0021A, "B D/G Fuel Oil Transfer Pump Iso/Run" for the train B emergency diesel generator fuel oil transfer pump in procedures covering fire protection program implementation. As a result, the licensee failed to ensure that the local control circuit for the fuel oil transfer pump would be isolated from the effects of fire damage caused by a control room fire. The train B emergency diesel generator was the credited alternative ac power supply for the control room fire scenario. The licensee entered this deficiency into their corrective action program as Callaway Action

Request System 201202931 to establish preventive maintenance for this component.

The failure to establish preventive maintenance on local transfer/isolation switch JEHS0021A, “B D/G Fuel Oil Transfer Pump Iso/Run” in procedures covering fire protection program implementation was a performance deficiency. Specifically, the licensee failed to ensure that component specific isolation/run switch testing procedures existed and ensured circuit isolation and transfer of control from the control room in the event of a fire. The performance deficiency was more than minor because it was associated with the procedure quality attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding using Inspection Manual Chapter 0609, Appendix F, “Fire Protection Significance Determination Process,” because it affected fire protection defense in depth strategies involving post fire safe shutdown. Using Appendix F, Attachment 2, “Degradation Rating Guidance Specific to Various Fire Protection Program Elements,” the team assigned a low degradation rating to the finding because the capability to achieve safe shutdown in the event of a control room fire would be minimally impacted by the failure to establish a preventive maintenance procedure for the train B emergency diesel generator fuel oil transfer pump local transfer/isolation switch. Because this finding had a low degradation rating, it screened as having very low safety significance (Green). The finding did not have a cross-cutting aspect because it was not indicative of current performance since the performance deficiency existed for more than three years.

Inspection Report# : [2012007](#) (pdf)

**G**

**Significance:** Mar 27, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Properly Evaluate the Design of Steam Generator Drain Plugs**

The inspectors reviewed a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” after the licensee failed to ensure that testing used to verify the adequacy of a steam generator drain plug was conducted under expected design conditions. On November 1, 2011, containment workers noticed reactor coolant system leakage out of the steam generator B manway onto the floor. Reactor coolant system water from the reactor cavity was draining past a dislodged tube plug out the steam generator manway onto the floor below. Plant operators verified the spent fuel pool isolation to the reactor cavity was intact and pumped the approximately 400,000 gallons of reactor cavity water to the refueling water storage tank. This stopped the leak and left the reactor coolant system at a midloop condition. The licensee’s root cause analysis determined that criteria for the drain plug design and installation specifications were inadequate. Specifically, the plug had not been tested under expected conditions such as a slick environment due to boron in the water. Testing with a simulated boric acid solution revealed that slippage occurred at much lower loads than the 70 psi assumed in the original design review. The possibility of side loads being applied to the plug during eddy current maintenance had also not been properly considered. Callaway Action Request 201109257 was generated with actions to address the causes of the plug becoming dislodged.

This finding is more than minor because it is associated with the reactor coolant system equipment and barrier performance attribute of the Barrier Integrity Cornerstone and affects the associated cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. A senior reactor analyst performed a bounding significance determination using NRC Inspection Manual 0609, Appendix G, "Shutdown Operations Significance Determination Process." The senior reactoranalyst determined that there was very little potential for core damage because Callaway Plant was defueled with the reactor head removed at the time. This finding has no cross-cutting aspect because the design plug was tested in 2007, and therefore, is not indicative of current plant performance.

Inspection Report# : [2012002](#) (pdf)

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**Significance:** Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Maintain Simulator Fidelity**

The inspectors identified a non-cited violation of 10 CFR Part 55.46(c), “Plant-Referenced Simulators,” for failure of the licensee to ensure that the plant-referenced simulator demonstrated expected plant response to transient and

accident conditions to which the simulator has been designed to respond. Specifically, the licensee failed to ensure simulator modeling of power-operated relief valve and pressurizer safety valve operation was consistent with the actual plant, introducing the potential for negative operator training. Due to errors made in modeling updates after steam generator replacement in 2005, each pressurizer safety valve was sized in the simulator to allow approximately 3.3 times higher than the design flow rate in the actual plant, and each power operated relief valve was sized to allow approximately 3.5 times higher than the design flow rate capacity provided in the actual plant. The licensee documented their corrective actions for this issue in Callaway Action Request 201101255.

The failure of the licensee's simulator staff to ensure that the plant-referenced simulator demonstrated expected plant response to transient and accident conditions for which the simulator has been designed to respond was a performance deficiency. The performance deficiency is more than minor because it adversely impacted the human performance attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, if left uncorrected, the performance deficiency could have become more significant in that training on related accident scenarios could have a negative impact on how licensed operators would respond to an actual event in the control room. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheets, and the corresponding Appendix I, "Licensed Operator Requalification Significance Determination Process," the finding was determined to have very low safety significance (Green) because there was no actual event at the plant similar to the simulator scenario where inappropriate actions were taken in the control room based on training with incorrectly sized components in the simulator. This finding has no cross-cutting aspect assigned because the cause was not representative of current licensee performance.

Inspection Report# : [2011005](#) (pdf)

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**Significance:** Dec 31, 2011

Identified By: NRC

Item Type: FIN Finding

#### **Failure to Conduct Simulator Testing in Accordance with ANSI/ANS 3.5-1998**

The inspectors identified a finding associated with the conduct of simulator performance testing because the licensee was not testing in accordance with the standards of ANSI/ANS 3.5-1998. Specifically, the licensee did not include relief valve flow in their 2010 test of transient (10) of ANSI/ANS 3.5-1998, Appendix B, Section B3.2.1, "Slow Primary System Depressurization to Saturated Condition with Pressurizer Relief or Safety Valve Stuck Open." The licensee initiated corrective action documented in Callaway Action Request 201107912.

Conducting simulator performance testing that was not in accordance with the ANSI/ANS 3.5-1998 standard was a performance deficiency. The performance deficiency is more than minor because it adversely impacted the human performance attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, if left uncorrected, the performance deficiency could have become more significant in that not completing the required simulator testing annually can lead to not detecting and correcting errors in the simulator so that it models the actual plant correctly. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheets, and the corresponding Appendix I, "Licensed Operator Requalification Significance Determination Process," the finding was determined to have very low safety significance (green) because there was no actual event caused by not modeling the actual plant correctly. This finding has no cross-cutting aspect assigned because the cause was not representative of current licensee performance.

Inspection Report# : [2011005](#) (pdf)

**G**

**Significance:** Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Adequately Assess and Manage Outage Risk Associated with Significant Switchyard Work**

The inspectors identified a non-cited violation of 10 CFR 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," involving the licensee's failure to assess and manage outage risk related to significant switchyard work. Specifically, the licensee allowed risk significant relay test work to result in loss of one of two offsite safety related 4 kV power feeds to the plant during Refueling Outage 18. With Callaway Plant in Mode 6, "Refueling," the risk assessment for October 21, 2011, and the Outage Shutdown Management Plan prohibited significant switchyard work. However, at 1:21 p.m., emergency diesel generator A bus NB01 became

deenergized due to improper switchyard testing. Callaway Action Request 201108888 was initiated to develop corrective actions.

Failure to properly assess and manage the risk of significant switchyard work during a high decay heat condition was a performance deficiency. This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The offsite power system was affected by this event. Using Manual Chapter 0609, Appendix G, Attachment 1, Checklist 4 – “PWR Refueling Operation: RCS level > 23’ OR PWR Shutdown Operation with Time to Boil > 2 hours And Inventory in the Pressurizer,” this finding was determined to be of very low safety significance because it did not increase the likelihood of a loss of reactor coolant system inventory, did not degrade the ability to terminate a leak path or add reactor coolant system inventory when needed, and did not degrade

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the ability to recover decay heat removal, if lost. This finding has a cross-cutting aspect in the area of human performance associated with the resources component because Procedure EDP-ZZ-01129, “Callaway Plant Risk Assessment,” Attachment 6, Step 6.c, was not sufficiently complete and accurate to define significant switchyard work.

Inspection Report# : [2011005](#) (pdf)

**Significance:**  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Improper Ground and Test Device Damages Residual Heat Removal Pump Switchgear**

The inspectors reviewed a Green self-revealing non-cited violation of 10 CFR Part 50 Appendix B, Criterion V, “Procedures,” involving the licensee’s failure to correctly install a ground test device for the train A safety-related 4160 volt switchgear, NB01. During maintenance on the train A safety related bus, workers improperly placed a ground test device with 2000 ampere stab adapters into the 1200 ampere breaker cubicle (for the residual heat removal pump). This damaged the switchgear connection point and caused the breaker to fail, rendering the pump inoperable. The reactor was defueled so the residual heat removal system was not required by technical specifications at the time, but the bus was required to be removed from service for repairs. The licensee repaired the bus connection point, and the pump was retested satisfactorily. This finding was entered into the licensee's corrective action program as Callaway Action Request 201109122.

Failure to install the correctly configured ground and test device into the NB0101 cubicle of the NB01 switchgear was a performance deficiency. This is more than minor because it is associated with the human performance attribute of the Mitigating Systems Cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

Specifically, improper maintenance caused the residual heat removal pump to become unavailable. Because no fuel was in the vessel at the time of the event, the inspectors referred the issue to a Region IV senior reactor analyst for the significance determination. The analyst used NRC Inspection Manual 0609, Appendix G, “Shutdown Operations Significance Determination Process,” to evaluate the significance of the finding. Since all of the fuel had been removed from the vessel there was no potential for core damage (the delta core damage frequency was zero).

Therefore, the finding is of very low safety significance (Green). The finding has a cross-cutting aspect in the area of human performance associated with the resources component in that the licensee failed to ensure training of maintenance personnel was adequate to assure nuclear safety.

Inspection Report# : [2011005](#) (pdf)

**Significance:**  Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Isolate Control Room Air Comditining Unite SGK04A for Maintenance**

The inspectors reviewed a Green self-revealing non-cited violation of Technical Specification 5.4.1.a, “Procedures,” involving the failure to isolate an electrical power supply during maintenance on control room air conditioning system train A. Specifically, while removing an electrical cabinet for maintenance, workers discovered an energized lead that was supposed to have been isolated for the work. Workers failed to stop work and make appropriate notifications. As

a result, when the lead was reterminated, it grounded the bus and caused inverter NN11 to shift to an alternate power supply. This caused operators to make an unplanned entry into a 24-hour shutdown technical specification action statement. The licensee restored normal power to inverter NN11 within 4 hours. This issue was entered into the corrective action program as Callaway Action Request 201107612.

Failure to stop work when a lockout tagout isolation was discovered to be inadequate was a performance deficiency. This finding is more than minor because it is associated with the configuration control attribute of the Mitigating Systems Cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, inverter NN11 was rendered less reliable by the improper maintenance. Using Manual Chapter 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," this finding was determined to be of very low safety significance because it did not create a loss of system safety function of a single train for greater than the technical specification allowed outage times, and did not affect seismic, flooding, or severe weather initiating events. This finding has a cross-cutting aspect in the area of human performance associated with the work practices component because licensee personnel failed to stop in the face of uncertainty or unexpected circumstances.

Inspection Report# : [2011005](#) (pdf)

**G**

**Significance:** Dec 31, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Correctly Implement Plant Maintenance Procedures**

The inspectors reviewed a self-revealing non-cited violation of Technical Specification 5.4.1.a, "Procedures," involving the failure to ensure compliance with relay test maintenance procedures associated with electrical switchyard work that affected the performance of safety related equipment. On October 21, 2011, Callaway Plant was in Mode 6 with switchyard activities in progress to test transfer trip and lockout relay devices. At 1:21 p.m. the control room operators received several annunciators indicating that diesel generator bus A and its safety related loads had become deenergized. An improperly operated lockout relay had cascaded a test signal onto other components in the plant electrical system. This issue was entered into the corrective action program as Callaway Action Request 201108691.

Failure to establish the safe working conditions per the transfer trip procedure and failure to operate the lockout relay in the manner specified by the lockout relay procedure were performance deficiencies. This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, one of the two offsite power feeds to the plant was lost. Using Manual Chapter 0609 Appendix G Attachment 1, Checklist 4 – "PWR Refueling Operation: RCS level > 23' OR PWR Shutdown Operation with Time to Boil > 2 hours And Inventory in the Pressurizer," this finding was determined to be of very low safety significance because it did not increase the likelihood of a loss of reactor coolant system inventory, did not degrade the ability to terminate a leak path or add reactor coolant system inventory when needed, and did not degrade the ability to recover decay heat removal. This finding has a cross-cutting aspect in the area of human performance associated with the work controls component because the electrical relay test technicians, onsite engineering, and work control staff failed to adequately maintain interfaces to communicate and safely coordinate significant switchyard activities to ensure proper human performance.

Inspection Report# : [2011005](#) (pdf)

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**Significance:** Sep 23, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **Failure to Correctly Implement Plant Maintenance Procedures**

The inspectors reviewed a self-revealing noncited violation of Technical Specification 5.4.1.a, "Procedures," for the licensee's failure to correctly follow maintenance procedures which resulted in a failure of motor-operated valve EFHV0065 associated with the ultimate heat sink train A cooling tower. To perform its safety function the valve must be capable of being closed. On September 15, 2010, the mechanical maintenance department removed and rebuilt the actuator for the motor-operated valve. The valve actuator stop nuts were not set correctly and remained set outside the

range of the electrical limits due to electrical maintenance workers failing to complete the procedure and work instructions initiated by the mechanical department. On June 22, 2011, an attempt to manually align essential service water return over the train A safety-related cooling tower failed when the motor-operated valve was manually positioned past the zero percent open position due to the improperly set stop nuts. This disengaged the valve operator worm from its worm gear, opened the valve, and rendered the valve being incapable of being closed. The immediate corrective action to replace the valve actuator was completed on June 23, 2011. The licensee initiated Callaway Action Request 201105074 to evaluate cause and extent-of-condition and specify corrective actions.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affects the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," this finding was of very low safety significance because it did not create a loss of system safety function of a single train for greater than the technical specification allowed outage times, and did not affect seismic, flooding, or severe weather initiating events. This finding has a cross-cutting aspect in the area of human performance associated with the work controls component because the mechanical and electrical maintenance technicians failed to adequately maintain interfaces to communicate, coordinate, and cooperate with each other during activities in which interdepartmental coordination is necessary to assure plant and human performance.

Inspection Report# : [2011004](#) (*pdf*)

**Significance:**  Sep 23, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

#### **Failure to Evaluate Breaker Relay Settings Results in Partial Loss of Station Blackout Response Capability**

The inspectors reviewed a self-revealing finding for the failure of AmerenUE engineering personnel to correctly establish the relay settings for the alternate emergency power supply diesel output breakers. On August 21, 2011, Callaway Plant experienced a loss of power to the alternate emergency power supply diesel bus PA05. This resulted in all four alternate emergency power supply diesels starting; however, the number three diesel output breaker immediately tripped open. The licensee determined that the breaker's protective relaying was improperly set. Further investigation by AmerenUE discovered that all four of the diesel output breakers had incorrect settings. The incorrect settings occurred due to the limited range of the relay chosen for the application and the engineering recommendations that prioritized protecting the diesel over limiting the margin to unintended breaker trips. Callaway engineering reviews had not identified the low margin to unintended trips. The licensee initiated corrective actions associated with Callaway Action Request 201106701 to change the differential current relay settings.

This finding is more than minor because it is associated with the design control attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding is of very low safety significance because it was a design deficiency that did not result in a loss of system safety function, did not represent an actual loss of safety function of one or more non-technical specification trains of equipment designated as risk-significant per 10 CFR 50.65, for greater than 24 hours, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of problem identification and resolution because the licensee failed to implement a corrective action program with a low threshold for identifying issues commensurate with their safety significance.

Inspection Report# : [2011004](#) (*pdf*)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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# Occupational Radiation Safety

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## Public Radiation Safety

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### Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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### Miscellaneous

Last modified : September 12, 2012