

D.C. Cook 1

4Q/2012 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform an Evaluation on Essential Service Water Piping

: The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," for the failure to perform an evaluation required to meet 10 CFR Part 50, Appendix B, Criterion XI, on essential service water piping. Specifically, the inspectors identified the licensee failed to perform a required evaluation on a segment of essential service water piping when the results of the pipe wall thickness measurements demonstrated they were below the established minimum wall thickness acceptance criteria. The licensee entered the issue into their corrective action program and based on an engineering evaluation determined the condition did not represent an operability concern and the structural integrity of the piping system was not compromised.

The performance deficiency was determined to be more than minor because if left uncorrected it had the potential to lead to a more significant safety concern. Specifically, by not performing the required evaluation there was a potential to return a system to service that could exceed the design limits prior to the next inspection. The issue impacted the initiating events cornerstone because the degraded wall thickness could lead to a loss of service water and/or internal flooding initiating event; and the issue adversely affected the attribute of equipment reliability. The finding was screened as very low safety significance (Green) because a subsequent evaluation demonstrated that this issue did not result in the complete or partial loss of operability of the essential service water system. The inspectors determined the finding had a cross cutting aspect in the area of human performance because the licensee did not follow their procedure which required them to generate an action request and perform an evaluation when acceptance criteria were not met.

Inspection Report# : [2012005](#) (*pdf*)

Significance: G Mar 31, 2012

Identified By: NRC

Item Type: FIN Finding

Failure to Install a Grommet Seal on the Main Turbine Thrust Bearing Probe

One self revealed finding of very low safety significance was identified for the failure to install a grommet seal on the main turbine thrust bearing probes as required by a site design standard, VTD SKFI 0001, "Eddy Probe Systems Technical Manual," during the Unit 1 2009 turbine failure restoration project. Consequently, oil migrated into the thrust bearing probe conduit, which contributed to a main turbine trip and resultant automatic reactor trip on September 7, 2011. For corrective actions, the licensee separated the main turbine thrust bearing probe cables into separate conduits; wrapped the cables in additional shielding and insulation to prevent signal coupling; and installed sealing glands on the main turbine thrust housing to eliminate oil intrusion into the conduits. This issue was entered into the licensee's corrective action program as Action Request 2011 10107.

This finding was related to the Initiating Events Cornerstone and was more than minor because it adversely affects the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding is associated with the attribute of human performance. Specifically, the failure to install a grommet seal on the main turbine thrust bearing probes contributed to a main turbine trip and resultant automatic reactor trip. This finding was of very low safety significance because the finding does not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment will not be available. This finding is associated with a cross cutting aspect in the resources component of the human performance

cross cutting area. Specifically, the work order associated with installing the main turbine thrust bearing probes did not include sufficient guidance to ensure that the grommet seal was installed

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

Mitigating Systems

Significance:  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Non-conservative Condensate Storage Tank (CST) Cross-Tie NPSH Calculation

The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to ensure sufficient water volume in the condensate storage tank when both units' auxiliary feedwater (AFW) pumps are aligned to a single condensate storage tank (CST.) Specifically, the licensee failed to perform a calculation to demonstrate sufficient volume and level to prevent net positive suction head and vortex issues when a single CST is providing water to all six AFW pumps as allowed by procedures. The licensee's corrective action included performing a formal calculation and increasing the available water volume in the CST when both units' AFW pumps are cross-tied.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System Cornerstone attribute of equipment performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding screened as of very low safety significance (Green) because it was a design deficiency confirmed not to result in loss of operability. Specifically, the licensee performed an operability determination which concluded the actual useable tank level during the previous 12 months had been sufficient. The inspectors determined the cause of this finding did not represent current licensee performance and, thus, no cross-cutting aspect was assigned.

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

Significance:  Dec 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Maintain High Energy Line Break and Fire Barriers

A self-revealed finding of very low safety significance (Green) and associated NCV occurred based on two violations of 10 CFR 50 Appendix B, Criterion V in the fourth quarter of 2012. The violations occurred due to failure of licensee personnel to secure High Energy Line Break (HELB)/Fire barrier doors following use of the door as required by procedure. These examples resulted in inoperability of Auxiliary Feedwater (AFW) pumps during the two periods when the doors were no longer in use for personnel transit. Upon discovery, the licensee restored the doors to an operable condition. The licensee entered the issues into the corrective action program (CAP).

The performance deficiency was determined to be more than minor because it is associated with the mitigating system cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences; and the issue adversely affected the attribute of equipment reliability. The inspectors determined that the finding was of very low safety significance because inoperability of the safety related auxiliary AFW system was less than allowed outage times in technical specifications. However, due to the multiple mitigative functions performed by the doors, the inspectors requested a review by the regional senior risk analyst (SRA). The doors protect the mitigating AFW systems from fire and high energy line breaks. The SRA concurred with the inspectors that the finding was of very low safety significance (Green) based on a bounding Probabilistic Risk Analysis using the Standardized Plant Analysis Risk (SPAR) model. The inspectors determined the finding had a cross cutting aspect in the area of human performance because the licensee did not use human error prevention techniques.

Inspection Report# : [2012005](#) (*pdf*)

Significance: G Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Preplan and Perform Maintenance on Safety-related Equipment

The inspectors identified a finding of very low safety significance with an associated NCV of Technical Specification (TS) 5.4.1 for the failure to implement procedures to perform preventative maintenance in vaults containing safety related cabling subject to water intrusion. Specifically, licensee personnel failed to ensure the cables were not wetted as required by PMI 5053, "Cable Management Program." Cables were on the ground in the vaults exposing the cables to periodic wetting, which will degrade the cable insulation. On August 27, 2012, the inspectors noted that cables in one vault were on the ground and the vault showed evidence of periodic wetting of the cables. For corrective action, the licensee is performing an apparent cause evaluation; inspecting all cable vaults that have had safety related cabling elevated since February 2010; and raising and re securing cabling in vaults subject to water intrusion. This issue was entered into the licensee's corrective action program as AR 2012 10680.

This finding affected the Mitigating Events Cornerstone and was more than minor because the issue could become a more significant safety concern if left uncorrected. Specifically, failure to properly perform preventative maintenance in vaults containing safety related cables subjected to water intrusion resulted in periodic wetting of cables. Wetting of cables has led to degradation of cable insulation at nuclear facilities. The inspectors used IMC 0609, "Significance Determination Process," Attachment 4, "Initial Characterization of Findings," which directed the inspectors to Exhibit 2, "Mitigating Systems Screening Questions," of Appendix A, to determine significance. This finding was of very low safety significance (Green) because the finding constituted a design or qualification deficiency but did not result in a loss of system safety function. This finding is associated with a cross cutting aspect in the work control component of the human performance cross cutting area. Specifically, engineering did not appropriately plan for maintenance personnel to assist with lifting the floor grating to ensure visual inspections were adequately performed.

Inspection Report# : [2012004](#) (*pdf*)

Significance: G Jul 02, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Vortexing was not evaluated for the volume control, containment spray additive, refueling water storage tanks.

The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to evaluate vortexing in the volume control, containment spray additive, and refueling water storage tanks. Consequently, the minimum allowable submergence for the suction piping of these tanks did not consider the potential for air entrainment due to vortices. This finding was entered into the licensee's corrective action program to evaluate the potential for vortexing at these tanks and revise the affected calculations.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System 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. In addition, the finding was associated with the Containment Barrier cornerstone attribute of structure, system, component, and barrier performance and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The finding screened as of very low safety significance (Green) because: (1) the finding examples associated with the volume control and refueling water storage tanks were deficiencies confirmed not to result in loss of operability in that the licensee performed an evaluation that reasonably concluded the current limit setpoints prevent vortexing in these tanks; and (2) the finding example associated with the containment spray (CTA) additive tank was a design deficiency of the physical integrity of the reactor containment that did not affect the barrier function of the control room against smoke or a toxic atmosphere, represent an actual open pathway in the physical integrity of reactor containment, or involve an actual reduction in function of hydrogen igniters in the reactor containment. This finding did not have an associated cross-cutting aspect because it was not confirmed to reflect current performance due to the age of the

performance deficiency.

Inspection Report# : [2012008](#) (*pdf*)

Significance:  Jul 02, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Incomplete methodology for developing acceptance criteria for suction voids

The inspectors identified 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," for the failure to correctly incorporate the interim methodology for developing acceptance criteria for suction voids in Emergency Core Cooling Systems, Decay Heat Removal, and Containment Spray Systems pumps into procedures. Specifically, the licensee did not translate the limitations of the acceptance criteria with respect to rated performance of pump operation. This finding was entered into the licensee's corrective action program to revise the affected procedure.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System 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. The finding screened as of very low safety significance (Green) because it was a design deficiency confirmed not to result in loss of operability. Specifically, a review of recent monitoring results determined that identified voids did not exceed the applicable acceptance criteria. The inspectors did not find an applicable cross-cutting aspect which represented the underlying cause of this performance deficiency; therefore, no cross-cutting aspect was assigned.

Inspection Report# : [2012008](#) (*pdf*)

Significance:  Jul 02, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Procedures were not developed for performance monitoring of plant parameters.

The inspectors identified 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," for the failure to establish appropriate procedures to implement the requirements of performance monitoring of plant parameters for gas accumulation. Specifically, the licensee had not established instructions in procedures to control important aspects such as frequency of monitoring and acceptance criteria. This finding was entered into the licensee's corrective action program to determine the size of the limiting voids at the affected locations and establish appropriate acceptance criteria.

The performance deficiency was determined to be more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. The finding screened as of very low safety significance (Green) because it was a design deficiency confirmed not to result in loss of operability. Specifically, a review of a sample of recent plant parameter trends determined that unacceptable void formation had not occurred. This finding had a cross-cutting aspect in the area of human performance because the licensee did not make safety significant decisions using a systematic process. Specifically, the licensee decided to use informal trending mechanisms to track the critical plant parameters instead of creating a formal and systematic approach to programmatically control the activity.

Inspection Report# : [2012008](#) (*pdf*)

Significance:  Jul 02, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Minimum flowrates and time requirements for dynamic flushing were not established

The inspectors identified 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," for the failure to establish minimum flowrate and time required in procedures used to perform dynamic flushing activities affecting Emergency Core Cooling Systems, Decay Heat Removal, and Containment Spray Systems pumps. This finding was entered into the licensee's corrective action program to revise the affected procedures.

The performance deficiency was determined to be more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, the failure to establish an appropriate procedure for flushing would have the potential of not removing voids to ensure system operability. The finding screened as of very low safety significance (Green) because it was a design deficiency confirmed not to result in loss of operability. Specifically, a historical review of previous dynamic flushing activities determined that sufficient flowrates and time values were achieved at the appropriate sequences. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.

Inspection Report# : [2012008](#) (*pdf*)

Significance: G Jul 02, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for Responding to a MODE 4 LOCA

The inspectors identified 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," for the failure to include adequate venting instructions in the procedure use to respond to a MODE 4 loss-of-coolant accident. Specifically, the procedure did not include instructions to address all of the affected residual heat removal system high points, including the discharge piping. The finding was entered into the licensee's corrective action program to leave one train of the system idle while the other train cools down the reactor coolant system below 200°F to ensure that the discharge side of one train of residual heat removal system is not vulnerable to steam formation.

The performance deficiency was determined to be more than minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. The finding screened as of very low safety significance (Green) using a Phase II evaluation. The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because the licensee did not thoroughly evaluate relevant external operating experience. Specifically, the licensee's evaluation of Information Notice 2010-11 incorrectly concluded that procedures contained sufficient direction to preclude flashing.

Inspection Report# : [2012008](#) (*pdf*)

Significance: G Jul 02, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

10 CFR 50.59 evaluation for modification of RHR pump casing drain lines was not performed

The inspectors identified a finding of very low safety significance and associated Severity Level IV violation of 10 CFR 50.59, "Changes, Tests, and Experiments," for the failure to perform a written evaluation, which provided the bases for the determination that a change did not require a license amendment. Specifically, the licensee failed to provide a basis for not applying for a license amendment associated with a modification of the residual heat removal pump casing drain lines. The finding was entered into the licensee's corrective action program to: (1) stage a hose and pipe couplings to support venting at the residual heat removal pump casing vent; (2) create a work order request to flush flow through the abandoned drain lines that were cut from the pump casing vent to show the lines could still pass water; (3) develop an alternate means to accomplish this activity; and (4) evaluate the change.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the capability and availability of systems that respond to initiating events to prevent undesirable consequences. Violations of 10 CFR 50.59 are dispositioned using the traditional enforcement process instead of the significance determination process because they are considered to be violations that potentially impede or impact the regulatory process. The finding screened as of very low safety significance (Green) using a Phase II evaluation. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.

Inspection Report# : [2012008](#) (pdf)

Significance:  Jul 02, 2012

Identified By: NRC

Item Type: FIN Finding

10 CFR 50.59 evaluation for modification of RHR pump casing drain lines was not performed

The inspectors identified a finding of very low safety significance and associated Severity Level IV violation of 10 CFR 50.59, "Changes, Tests, and Experiments," for the failure to perform a written evaluation, which provided the bases for the determination that a change did not require a license amendment. Specifically, the licensee failed to provide a basis for not applying for a license amendment associated with a modification of the residual heat removal pump casing drain lines. The finding was entered into the licensee's corrective action program to: (1) stage a hose and pipe couplings to support venting at the residual heat removal pump casing vent; (2) create a work order request to flush flow through the abandoned drain lines that were cut from the pump casing vent to show the lines could still pass water; (3) develop an alternate means to accomplish this activity; and (4) evaluate the change.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating System cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the capability and availability of systems that respond to initiating events to prevent undesirable consequences. Violations of 10 CFR 50.59 are dispositioned using the traditional enforcement process instead of the significance determination process because they are considered to be violations that potentially impede or impact the regulatory process. The finding screened as of very low safety significance (Green) using a Phase II evaluation. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.

Inspection Report# : [2012008](#) (pdf)

Significance:  Jul 02, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for RCS Vacuum Fill During Reduced Inventory Operations

The inspectors identified 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," for failure to establish procedures for reduced inventory operations that were appropriate to preclude air entrainment into Residual Heat Removal (RHR) and Reactor Coolant Systems (RCS). Specifically, a procedure allowed operation of RHR while in reduced inventory operations with a minimum RCS level and maximum pump flowrate combination that was determined to result in air-entrainment vortices. The finding was entered into the licensee's corrective action program to place an administrative hold to the procedure until proper documentation is revised and updated and to revise the procedure to require stricter use of high accuracy level instrumentation.

The performance deficiency was determined to be more than minor because it was associated with the initiating event cornerstone attribute of procedure quality and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. The finding screened as of very low safety significance (Green) using a Phase II evaluation. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.

Inspection Report# : [2012008](#) (pdf)

Significance:  Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Replace Post-Accident Monitor Displays

The inspectors identified a finding of very low safety significance and associated NCV for the failure to establish

preventive maintenance schedules. Technical Specification (TS) 5.4.1 requires that written procedures be established, implemented and maintained for activities specified in Regulatory Guide 1.33. Regulatory Guide 1.33, Appendix A, section 9, Procedures for Performing Maintenance, states, in part, that “Preventive Maintenance schedules should be developed to specify... inspection or replacement of parts that have a specific lifetime...” The licensee did not develop a maintenance schedule for replacing liquid crystal diodes (LCD) within a manufacturer specified five-year life. Consequently, 14 LCDs failed after about eight years of service and three failures resulted in unplanned Limiting Condition for Operation (LCO) entries. The licensee subsequently replaced the LCDs for safety-related displays and has entered the condition into the corrective action program as AR 2012 5744.

The inspectors concluded that the issue was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Design Control. In addition, it adversely affected the cornerstone objective to ensure the availability and reliability of systems that respond to initiating events. Specifically, the failure to establish and implement scheduled replacement of the LCD displays resulted in three unplanned LCO entries for the affected recorders. The inspectors reviewed the finding in accordance with IMC 0609, Attachment 0609.04 Table 4a for the Mitigating Systems Cornerstone and concluded the finding was of very low safety significance because the answer to all four questions for mitigating structures, systems and components and functionality was ‘no’. The inspectors concluded that the finding included a cross-cutting aspect in problem identification and resolution, Corrective Action Program, in that the licensee did not take appropriate corrective actions to address safety issues in a timely manner (P.1(d)). Specifically, the licensee did not replace safety-related LCD displays prior to failure until prompted by the Inspectors.

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

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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.

Miscellaneous

Significance: N/A Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Not Reporting the Use of CPAP Devices by Licensed Operators

An NCV of 10 CFR 50.9, "Completeness and Accuracy of Information," was identified due to the submittal of inaccurate medical information for a licensed operator. The submittal to the NRC was inaccurate because it certified that the operator had been medically examined and had met all medical qualifications, when in fact, a Senior Reactor Operator (SRO) did not disclose that he had been prescribed a therapeutic device to treat sleep apnea. The licensee entered the issues into the corrective action program (CAP). The licensee's corrective actions included amending the SRO licensee to include the restriction related to use of a medical device.

The SRO was unaware that being prescribed a therapeutic device for treatment of sleep apnea in March 2010 was a condition requiring reporting. The licensee submitted medical information associated with relicensing the SRO in March 2012 that was incomplete and incorrect for the SRO. Because violations of 10 CFR 50.9 are considered to be violations that potentially impede or impact the regulatory process, they are dispositioned using the traditional enforcement process. In accordance with the Enforcement Policy, the inspectors concluded that the violation was a Severity Level IV because the SRO met ANSI/ANS 3.4 criteria but failed to report a condition that required an amended license. The licensee's failure to provide complete and accurate information to the NRC impacted the regulatory process because it resulted in an incorrect licensing action and is a performance deficiency. This is a minor ROP issue since the non disclosure of a medical condition for a licensed operator did not result in an adverse impact on plant operation. Since there is no ROP Finding, there is no cross-cutting aspect associated with this violation.

Inspection Report# : [2012005](#) (*pdf*)

Significance: N/A Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedures for Implementation of Annulus Cooling to Remain in a Analyzed Thermal Condition

A Severity Level IV NCV of very low safety significance of Title 10 of the Code of Federal Regulations (CFR) Part 72.150, "Instructions, Procedures, and Drawings," was identified by the inspectors for the failure of the licensee to have procedures in place to ensure that the design basis peak fuel cladding temperature limit would not be exceeded during dry cask canister processing operations. The licensee took appropriate actions prior to conducting evolutions that may have challenged these limits. This has been documented in the licensee's corrective action program as Action Request (AR) 2012 9676.

Consistent with the guidance in Section 2.2 of the NRC Enforcement Manual, Independent Spent Fuel Storage Installation (ISFSIs) are not subject to the Reactor Oversight Process enforcement and, thus, traditional enforcement will be used for these facilities. Therefore the violation was dispositioned using the traditional enforcement process using Section 2.3 of the Enforcement Policy. The violation was determined to be of more than minor significance using IMC 0612, "Power Reactor Inspection Reports," Appendix E, "Examples of Minor Issues," Example 3i, since the bounding conditions for the analyzed thermal condition was not reflected in the procedures to perform the port cap repair. Specifically, the licensee's lack of evaluation did not ensure spent fuel cladding temperatures during canister processing operations would remain less than Spent Fuel Storage and Transportation Interim Staff Guidance 11, "Cladding Considerations for the Transportation and Storage of Spent Fuel," safety limits. The inspectors determined that that the violation could be evaluated using Section 6.5.d.2 of the NRC Enforcement Policy, as a Severity Level IV violation, in that the licensee failed to establish, maintain, or implement adequate controls to ensure that the replacement of the port cap was performed under conditions bounded by a thermal analysis that ensured the integrity of the fuel would be maintained during the repair. Because the finding is associated only with traditional enforcement, there is not an associated cross cutting aspect.

Inspection Report# : [2012004](#) (*pdf*)

Last modified : February 28, 2013