

Cooper 4Q/2013 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify and Correct a Condition Adverse to Quality

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," associated with the licensee's failure to promptly identify and correct a condition adverse to quality. Specifically, from July 2010 to present, the licensee failed to properly evaluate the diesel generator fuel oil storage tank vents to demonstrate their ability to perform their specified safety function in the event of a tornado missile. The licensee is in the process of developing corrective actions to restore compliance for this issue. This issue has been entered into the corrective action program as Condition Report CR-CNS-2014-00146.

The licensee's failure to promptly identify and correct a condition adverse to quality was a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the design control attribute of the Mitigating Systems Cornerstone, and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated July 1, 2012, inspectors determined this finding to have very low safety significance (Green) because it: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with decisionmaking component because the licensee did not ensure that the proposed action was safe in order to proceed, rather than unsafe to disapprove the action.

Inspection Report# : [2013005](#) (*pdf*)

Significance: G Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Risk Management Actions for Proposed Maintenance Activities

The inspectors identified a non-cited violation of 10 CFR 50.65(a)(4), "Requirements for Monitoring the Effectiveness for Maintenance at Nuclear Power Plants," for the licensee's failure to implement required risk management actions during maintenance activities affecting the seismic qualification of the safety-related 4160 Vac Bus F and G when the cabinet doors are opened during under voltage relay testing. The licensee corrected this issue by providing procedural guidance for implementation of the required risk management actions. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2013-06870.

The licensee's failure to implement required risk management actions during maintenance activities was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the associated objective. Specifically, by failing to implement required risk management actions to restore 4160 Vac Bus F and G to their seismically qualified condition, i.e. cabinet doors closed, this thereby affected the associated objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," dated May 5, 2005, Flowchart 2, "Assessment of Risk Management Actions," the inspectors determined the need to calculate a risk deficit to determine the significance of this issue. A senior reactor analyst performed a bounding detailed risk evaluation, which determined that the incremental core damage probability associated with this finding was less than 1×10^{-6} , so the finding has very low safety significance (Green). The finding has a cross-cutting aspect in the area of human performance associated with the work practices component because the licensee failed to define and effectively communicate expectations regarding procedural compliance and to ensure that personnel follow procedures.

Inspection Report# : [2013005 \(pdf\)](#)

Significance: G Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Operability Procedure

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, Drawings," associated with the licensee's failure to perform an adequate operability determination in accordance with Station Procedure 0.5OPS, "Operations Review of Condition Reports/Operability Determination." Specifically, the licensee failed to evaluate the effect on operability of taking electrical relays for the service water pumps out of their seismically qualified configuration. To correct this issue the licensee directed that the affected service water pump be declared inoperable during Division II under voltage testing. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2014-00122.

The failure to properly assess and document the basis for operability when a degraded or nonconforming condition was identified was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee's failure

to properly document and assess the basis for operability resulted in a condition of unknown operability for a degraded nonconforming condition. Using Inspection Manual Chapter 0609, Appendix A, "Initial Screening and Characterization of Findings," dated July 1, 2012, inspectors determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with decision-making component because the licensee did not ensure that the proposed action was safe in order to proceed, rather than unsafe to disapprove the action.

Inspection Report# : [2013005](#) (*pdf*)

Significance:  Sep 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Design Control of the Control Room Emergency Filter System Safety-related Air Operated Valve

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," associated with the licensee's failure to ensure the correct materials were installed in the control room emergency filtration system air operated valve HV-AO-272. Specifically, incompatible grease was introduced into the valve causing increased friction and degrading stroke times. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2013-04327.

The failure to ensure the correct materials were installed in the control room emergency filtration system air operated valve HV-AO-272 was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone. Specifically, the licensee introduced an incompatible grease into HV-AO-272 causing increased friction and degrading stroke times, thereby affecting the associated objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) For Findings At-Power," and determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with work practices component because the licensee personnel failed to define and effectively communicate expectations regarding procedural compliance and to ensure that personnel followed procedures [H.4(b)].

Inspection Report# : [2013004](#) (*pdf*)

Significance:  Sep 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish Goals and Monitor for the Roof Drain System

The inspectors identified a non-cited violation of 10 CFR 50.65, "Requirements for monitoring the effectiveness of maintenance at nuclear power plants," associated with the licensee's failure to establish goals per paragraph (a)(1), and monitor the performance of the drains for the reactor building, control building, and diesel generator building against these goals following the determination that the licensee had failed to adequately monitor the performance of the drains. Specifically, following the identification of NCV 05000298/2012005-02, "Failure to Adequately Monitor the Performance of Roof Drains" in Inspection Report 05000298/2012005, the license moved the systems to 50.65(a)(1) status but failed to establish goals as required. The licensee entered this issue into their corrective action program for resolution as Condition Report CR-CNS-2013-06590.

The failure to establish goals for systems in 50.65(a)(1) status was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because it was associated with the protection against the external factors attribute of the Mitigating Systems Cornerstone. Specifically, the failure to establish goals and monitor the drains for the reactor building, control building, and diesel generator buildings against these goals could result the failure to detect deteriorating performance, thereby affecting the associated cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) For Findings At-Power," and determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with the work practices component because the licensee failed to define and effectively communicate expectations regarding procedural compliance and personnel follow procedures. Specifically, licensee personnel failed to follow procedural guidance that required goals and monitoring when the systems were placed in 50.65(a)(1) monitoring [H.4(b)].

Inspection Report# : [2013004](#) (*pdf*)

Significance:  Sep 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Operability Procedure

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, Drawings," associated with the licensee's failure to follow Station Procedure 0.5OPS, "Operations Review of Condition Reports/Operability Determination," and properly document the basis for operability when degrading or nonconforming condition was identified. Specifically, the licensee failed to consider that failure of a relay prevented residual heat removal Division II minimum flow valve RHR-MOV-16B from opening automatically when residual heat removal pump B flow was lowered, and concluded a failure of the replacement relay would not have an adverse effect on nuclear safety. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2013-06455.

The failure to properly assess and document the basis for operability when a degraded or nonconforming condition was identified was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective. Specifically, the licensee's failure to properly document and assess the basis for operability resulted in a condition of unknown operability for a degraded nonconforming system, thereby affecting

the associated objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) For Findings At-Power,” and determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee’s maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with the decision-making component because the licensee did not adopt a requirement to demonstrate that the proposed action was safe in order to proceed, rather than a requirement to demonstrate that it was unsafe in order to disapprove the action [H.1(b)].

Inspection Report# : [2013004](#) (*pdf*)

Significance:  Aug 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Adequate Corrective Action for a Condition Adverse to Fire Protection

The team identified a Green non-cited violation of License Condition 2.C.(4), “Fire Protection,” for the failure to implement and maintain in effect all provisions of the approved fire protection program. Specifically, the team identified that the licensee failed to implement adequate corrective actions for a condition adverse to fire protection related to circuits that could disable the automatic starting of the electric driven fire pump due to fire damage. The licensee entered this finding into its corrective action program under Condition Report 2013-05866.

The failure to promptly identify and correct a condition adverse to fire protection was a performance deficiency. This finding is more than minor because it is associated with the Mitigating Systems cornerstone attribute of Protection Against External Events (fire) and affects the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

The team performed a walkdown of both, electric and diesel, fire pump circuits from the control room to the fire pump house. The control room has fire pump switches and status lights in the sprinkler control and fire alarm panel. The control room is continuously manned and fire extinguishers are available for manual fire suppression. The fire pump circuits in the cable spreading room are routed in separate conduits in parallel with no fixed ignition sources near the conduits. Transient combustibles in the cable spreading room are limited and strictly controlled. Transient combustibles are only a potential threat where the conduits vertically go through the floor. The fire pump circuits in the seal water pump area and hallway (control building elevation 903) are not routed near any fixed ignition sources. Combustible materials are stored near the conduits in the multipurpose facility, but there are no significant ignition sources or work areas nearby. Using Inspection Manual Chapter 0609, Appendix F, “Fire Protection Significance Determination Process,” the finding was assigned a low degradation rating, because the wiring was routed in conduits through areas with limited combustibles and no ignition sources; consequently this finding is of very low safety significance (Green) per Attachment 1, Task 1.3.1, Question 1. The finding did not have a cross-cutting aspect since it was not indicative of present performance in that the performance deficiency occurred more than three years ago.

Inspection Report# : [2013007](#) (*pdf*)

Significance:  Jun 22, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Assess Risk and Implement Risk Management Actions for Proposed Maintenance

The inspectors identified two examples of a non-cited violation of 10 CFR 50.65(a)(4), "Requirements for Monitoring the Effectiveness for Maintenance at Nuclear Power Plants," for the licensee's failure to adequately assess risk and implement risk management actions associated with maintenance activities affecting outflow paths that had been credited in the internal flooding analysis for a moderate-energy line break in the service water pump room. The licensee's corrective actions included immediately reevaluating the risk associated with the subject activities, implementing additional risk-management actions, and reconfiguring a drain hose associated with the activity. The licensee entered these deficiencies into their corrective action program for resolution as Condition Reports CR-CNS-2013-03813 and CR-CNS-2013-04347.

The licensee's failure to adequately assess the risk and implement required risk-management actions for proposed maintenance activities was a performance deficiency. This performance deficiency was more than minor and was therefore a finding because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the associated objective. Specifically, by failing to evaluate the risk associated with the maintenance activities, the licensee failed implement risk management actions to restrain staged tools, materials, and equipment to prevent blockage of outflow paths that had been credited in the internal-flooding analysis for a moderate-energy line break in the service water pump room. Because these outflow paths help ensure the availability of systems that respond to initiating events to prevent undesirable consequences, blockage of those paths affected that availability, and thereby affected the cornerstone objective. In accordance with Inspection Manual Chapter 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," Flowchart 1, "Assessment of Risk Deficit," the inspectors determined the need to calculate the risk deficit to determine the significance of this issue. A senior reactor analyst performed a bounding detailed risk evaluation which determined that the incremental core damage probability associated with this finding was less than 1×10^{-6} , so the finding has very low safety significance (Green). The finding has a cross-cutting aspect in the area of human performance associated with the work practices component because the licensee personnel failed to define and effectively communicate expectations regarding procedural compliance and to ensure that personnel followed procedures.
Inspection Report# : [2013003](#) (*pdf*)

Significance: G Jun 22, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Operability Procedure

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," associated with the licensee's failure to follow Station Procedure 0.5OPS, "Operations Review of Condition Reports/Operability Determination," and properly document the basis for operability when a degraded or nonconforming condition was identified. Specifically, the inspectors identified that the licensee failed to

consider all relevant information when assessing operability of service water pumps A, B, and D for the design-basis barge impact on the intake structure. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2013-03850.

The failure to properly assess and document the basis for operability when a degraded or nonconforming condition was identified was a performance deficiency. This performance deficiency was more than minor and is therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective. Specifically, the licensee's failure to properly document and assess the basis for operability resulted in a condition of unknown operability for a degraded nonconforming system, thereby affecting the associated objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using Inspection Manual Chapter 0609, Appendix A, "Initial Screening and Characterization of Findings," and determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with the decision-making component because the licensee did not ensure that the proposed action was safe in order to proceed, rather than unsafe in order to disapprove the action.

Inspection Report# : [2013003](#) (*pdf*)

Significance:  Mar 29, 2013

Identified By: NRC

Item Type: VIO Violation

Failure to Maintain Seismic Qualification of Standby Liquid Control System

The team identified a Green violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to assure that design basis requirements associated with the standby liquid control (SLC) system test tank were correctly translated into procedures. As a result, the licensee failed to maintain the tank empty as required to meet seismic design requirements. The violation is cited because the licensee failed to restore compliance in a reasonable time following documentation of the issue as a non-cited violation in NRC Inspection Report 05000298/2012002, issued May 10, 2012 (ML12131A674). The licensee entered these issues into its corrective action program for resolution as Condition Report CR-CNS-2013-01962, CR-CNS-2013-02027, and CR-CNS-2013-02328.

The failure to maintain design control of the standby liquid control system was a performance deficiency. This performance deficiency was of more than minor safety significance because it was associated with the design control attribute of the mitigating systems cornerstone and it adversely affected cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee's failure to implement procedures to ensure the SLC test tank remained in a seismically qualified condition resulted in an inability to provide reasonable assurance of operability following a

seismic event. Using Inspection Manual Chapter 0609, Appendix A, Exhibit 2, the team determined that the finding was of very low safety significance (Green) because it was a design deficiency that did not result in the loss of functionality.

This finding had a cross-cutting aspect in the area of human performance associated with the decision-making component because the licensee failed to adopt a requirement to demonstrate that a proposed action was safe in order to proceed rather than a requirement to demonstrate it was unsafe in order to disapprove the action (H.1(b)).

Inspection Report# : [2013005](#) (*pdf*)

Inspection Report# : [2013009](#) (*pdf*)

Significance:  Mar 23, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Maintain Design Control of the High Pressure Coolant Injection System

The inspectors reviewed a self-revealing Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” associated with the licensee’s failure to maintain design control of high pressure coolant injection relief valve HPCI-RV-12RV. The licensee entered this issue into their corrective action program as Condition Reports CR-CNS-2013-00474 and CR-CNS-2013-00507.

The failure to maintain design control of high pressure coolant injection system relief valve HPCI-RV-12RV was a performance deficiency. This performance deficiency was more than minor and therefore, a finding, because it was associated with the design control attribute of the Mitigating Systems Cornerstone. Specifically, the licensee failed to adequately analyze the effects of the change in flow rate of the replacement relief valve, thereby affecting the associated cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” the inspectors determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design or qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee’s maintenance rule program. This finding did not have a cross-cutting aspect because the most significant contributor did not reflect current licensee performance.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 23, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Design Control of the Internal Flooding Analysis

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” associated with the licensee’s failure to assure that the applicable design basis requirements, associated with the station’s internal flooding analysis in response to a medium energy line break, were correctly translated into the plant design. Specifically, the licensee used incorrect assumptions for a time critical operator action, and this resulted in a nonconservative analysis for a moderate energy line break in the 903 feet control building corridor. The licensee entered this deficiency into their corrective action program for resolution as Condition Reports CR-CNS-2013-00579, CR-CNS-2013-00619, and CR-CNS-2013-01553.

The failure to maintain design control with respect to the internal flooding analysis was a performance deficiency.

This performance deficiency was more than minor, and therefore a finding, because it was associated with the design control attribute of the Mitigating Systems Cornerstone. Specifically, the licensee's failure to use correct assumptions for time-critical operator actions resulted in a nonconservative analysis for a moderate energy line break in the 903-foot control building corridor, thereby affecting the associated cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design or qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component because the licensee failed to thoroughly evaluate problems such that the resolutions address the causes.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 23, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Operability Procedure

The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," associated with the licensee's failure to follow Station Procedure 0.5OPS, "Operations Review of Condition Reports/Operability Determination," and properly document the basis for operability when a degraded or nonconforming condition was identified. Specifically, operators removed caution tags for the cross-connect valves of the diesel generator 1 air start receivers when the tags were required to support compensatory actions for a degraded condition. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2013-00386.

The failure to properly assess and document the basis for operability when a degraded or nonconforming condition had been identified was a performance deficiency. This performance deficiency was more than minor, and therefore, a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone. Specifically, the licensee's failure to properly document and assess the basis for operability resulted in a condition of unknown operability for a degraded nonconforming system, thereby affecting the associated objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the finding using Inspection Manual Chapter 0609, Appendix A, "Initial Screening and Characterization of Findings," and determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design or qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with the decision-making component because the licensee did not ensure that the proposed action was safe in order to proceed, rather than unsafe in order to disapprove the action.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 23, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Work Instructions

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for work instructions associated with the emergency diesel generator 1 voltage regulator cabinet that did not include a step to record the final thickness of shims used to level the voltage regulator cabinet and, as a result, the total shim thickness of the as-built configuration exceeded the allowable value. This finding was entered into the licensee's corrective action program as Condition Report CR-CNS-2013-01769.

The failure to provide work order instructions appropriate to the circumstance for installing the voltage regulator cabinet is a performance deficiency. This finding was more than minor because it was associated with the procedure quality attribute of the Mitigating Systems Cornerstone and adversely affected the Mitigating System Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that the finding was of very low safety significance (Green) because it did not result in the loss of the safety function of any system or train and did not screen as potentially risk significant due to seismic, flooding, or severe weather initiating events. The inspectors determined that the finding included a cross-cutting aspect in the area of human performance associated with the work practices component because the licensee did not appropriately plan the work activities to install the anchorage for the voltage regulator cabinet. Specifically, the licensee did not include instructions in the work package to measure and record the total thickness of shimming plates used.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Initial Licensing Examination and Licensed Operator Examination Integrity

The examiners identified a non-cited violation of 10 CFR Part 55.49, "Integrity of Examinations and Tests," for the failure of the licensee to ensure the integrity of initial licensing exams and licensed operator annual operating tests from 1997 to 2012. During validation activities being conducted supporting the 2012 initial licensing examination, the NRC identified a failure to implement the site's simulator Security Procedure OTP 810, "Operations Department Examination Security (Revision 11)." Additional follow up revealed that there was a portion of the licensee's computer network tied to their simulator that had not been isolated from the simulator during exam activities (initial and requalification examinations) for a period of approximately 15 years. Both provided plant staff the ability to view exam material in an uncontrolled manner. Providing this ability to view exam material in this manner is considered an exam integrity compromise. However, an evaluation involving site access logs, personal interviews with staff, and review of trends in exam results showed that the compromise did not have an actual effect on the equitable and consistent administration of the affected exams. The licensee entered the finding into the corrective action program as Condition Reports CR CNS-2012-06335 and -06336.

The failure of the licensee's training staff to maintain the integrity of examinations administered to initial license applicants and licensed operations personnel was a performance deficiency. The finding was more than minor because it adversely affected 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 allowing licensed operators to return to the control room without valid demonstration of appropriate knowledge on their annual operating tests, or allowing operators to obtain licenses based on a compromised examination, could be a precursor to a more significant event. Using NRC Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 4, Tables 1 and 2 worksheets; and the corresponding Appendix I, "Licensed Operator Requalification Significance Determination Process," the finding was determined to have very low safety significance

(Green). Although the 2012 finding resulted in a compromise of the integrity of initial licensing examinations and annual operating tests for approximately 15 years, with no compensatory actions immediately taken when the compromise should have been discovered, the equitable and consistent administration of the examinations in question were not actually affected by this compromise. In addition, the failure to meet 10 CFR 55.49 was evaluated through the traditional enforcement process, which resulted in its association with a Severity Level IV violation consistent with Sections 2.2.4 and 6.4.d of the NRC Enforcement Policy. This finding has a cross-cutting aspect in the human performance area associated with the resources component because the licensee failed to ensure that procedures were adequate to assure nuclear safety. Development and maintenance of Procedure OTP 810 had not involved review by the simulator support staff since the procedure's inception. The simulator support staff is responsible for the configuration of computer networks that are connected to the simulator facility.

Inspection Report# : [2012301](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Significance: G Sep 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide a Staging Area for Augmented Emergency Response Personnel When the Site Is Not Accessible

The inspector identified a non-cited violation of 10 CFR Part 50, Appendix E, IV.E(8)(d), for failure to implement by June 20, 2012, a facility that would be accessible even if the site is under threat of or experiencing hostile action to function as a staging area for augmentation. Specifically, the licensee's implementation of a staging area at the Auburn, Nebraska, Offsite Response Facility would have created impediments to effective Joint Information Center operations.

The failure to provide a facility accessible when the site is experiencing or under threat of hostile action is a performance deficiency within the licensee's ability to foresee and correct. This finding is more than minor because it affected the facilities and equipment attribute of the Emergency Preparedness Cornerstone. The finding is of very low safety significance because it was a failure to comply with NRC requirements and was not a loss of planning standard function. The planning standard function was not lost because the finding affected an alternate facility and the impediments would not have precluded the Joint Information Center from fulfilling its emergency functions. The licensee has entered this issue into their corrective action system as Condition Report CR-CNS-2013-04765. This finding was assigned a cross-cutting aspect in the area of human performance associated with the resource component because the licensee did not provide and maintain adequate emergency facilities, and the finding is reflective of current performance [H.2(d)].

Inspection Report# : [2013004](#) (*pdf*)

Occupational Radiation Safety

Significance: G Dec 31, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Implement a Radiation Protection Procedure

Inspectors reviewed a self-revealing non-cited violation of Technical Specification 5.4.1.a, associated with a radiation protection technician who failed to follow the requirements of Radiation Work Permit 2013-001, "Radiation Protection Activities," Revision 1. This radiation work permit did not authorize entry into areas with dose rates exceeding 80 mrem/hr. The licensee determined that this issue was due to a human performance error and corrected the issue as such. The licensee entered this issue into their corrective action program as Condition Report CR-CNS-2013-07506.

The failure to follow radiation work permit requirements was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the program and process attribute of the Occupational Radiation Safety Cornerstone and affected the associated cornerstone objective to ensure the adequate protection of the worker's health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Specifically, this finding resulted in a radiation protection technician receiving an unintended and unexpected radiation dose. Using Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated August 19, 2008, the inspectors determined that the finding was of very low safety significance (Green) because: (1) it was not associated with as low as is reasonably achievable (ALARA) planning; (2) it did not involve an overexposure; (3) there was no substantial potential for an overexposure; and (4) the licensee's ability to assess dose was not compromised. The finding has a cross-cutting aspect in the area of human performance associated with the work practices component because licensee personnel failed to use human error prevention techniques, such as pre-job briefs, self-andpeer checking, and proper documentation of activities commensurate with the risk of the assigned task, such that, work activities were performed safely.

Inspection Report# : [2013005](#) (*pdf*)

Significance: G Mar 23, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Implement a Radiation Protection Procedure

The inspectors reviewed a self-revealing, non-cited violation of Technical Specification 5.4.1, associated with an operator who entered a high radiation/high-noise area contrary to an ALARA pre-job briefing and without high-noise dosimetry as required by Special Work Permit 2012-051. The licensee entered this issue into their corrective action program as Condition Report CR-CNS-2012-10636.

The failure to follow special radiation work permit requirements when entering a high radiation/high noise area was a performance deficiency. This performance deficiency was more than minor and therefore, a finding, because it was associated with the program and process attribute of the Occupational Radiation Safety cornerstone and affected the associated cornerstone objective to ensure the adequate protection of the worker's health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Specifically, this finding resulted in an operator received an unintended and unexpected radiation dose. Using Inspection Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," the inspectors determined that finding was of very low safety significance (Green) because: (1) it was not associated with as low as is reasonably achievable (ALARA) planning; (2) it did not involve an overexposure; (3) there was no substantial potential for an

overexposure; and (4) the licensee's ability to assess dose was not compromised. The operator incorrectly assumed entry into the overheads in high radiation areas was allowed. Therefore, finding has a cross-cutting aspect in the area of human performance associated with the decision-making component because the licensee failed to use conservative assumptions in decision-making and ensure that the proposed action is safe in order to proceed, rather than unsafe in order to disapprove the action.

Inspection Report# : [2013002](#) (*pdf*)

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 Mar 29, 2013

Identified By: NRC

Item Type: VIO Violation

Failure to Notify the NRC within Eight Hours of a Nonemergency Event

The team identified a Severity Level IV non-cited violation of 10 CFR 50.72, "Immediate Notification Requirements for Operating Nuclear Power Reactors," for the licensee's failure to make a required report to the NRC. After the licensee determined that the standby liquid control test tank could not meet Seismic Class I requirements unless empty, the team discovered that the tank was full. The licensee immediately drained the tank and implemented a compensatory action to maintain it empty. However, the licensee failed to recognize that because the compensatory measure was required to provide a reasonable assurance of operability, the as-found condition of the SLC system—with the test tank full—rendered both trains of the system inoperable. Because this could have prevented the fulfillment of the SLC system's safety function, the licensee was required to report the condition to the NRC within eight hours of discovery. After identification, the licensee entered this issue into its corrective action program and made a late report to the NRC, restoring compliance with the regulation.

The failure to make a required report to the NRC within the required time was a performance deficiency. The team determined that traditional enforcement applied to this violation because the violation impeded the regulatory process. Specifically, the NRC relies on the licensee to identify and report conditions or events meeting the criteria specified in regulations in order to perform its regulatory oversight function. Assessing the violation in accordance with Enforcement Policy, the team determined it to be of Severity Level IV because it involved the licensee's failure to make a report required by 10 CFR 50.72 (Enforcement Policy example 6.9.d.9). Because this was a traditional enforcement violation with no associated finding, no cross-cutting aspect is assigned to this violation.

Inspection Report# : [2013009](#) (*pdf*)

Last modified : February 24, 2014