Duane Arnold
4Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
AVERAGE POWER RANGE MONITOR CONDITION PROHIBITED BY TECHNICAL SPECIFICATIONS.
A finding of very low safety significance and associated non-citied violation of Technical Specification (TS) 3.3.1.1, "Reactor Protection System (RPS) Instrumentation," Required Action A, was self-revealed on December 1, 2012, for the licensee's failure to place inoperable average power range monitors (APRMs) C and D in trip within 12 hours. Specifically, the licensee failed to identify a failed mode switch contact for local power range monitor (LPRM) 32-25A that rendered Surveillance Requirement (SR) 3.3.1.1.8 not met for periods when APRMs C and/or D were in service between November 27 and December 1, 2012; a condition prohibited by TS. The licensee entered the issue into the corrective action program (CAP) as condition report (CR) 01828842. Immediate corrective actions included bypassing APRMs C and D on December 1, 2012, bypassing LPRM 32-25A, and repairing the failed mode switch. Additional corrective actions included revisions to plant operating instructions to require removal of LPRMs from service if they are found to not be tracking with other LPRMs in service.

The inspectors determined that failing to properly evaluate the APRM operability impact of LPRM 32-25A indications on November 27, 2012, represented a performance deficiency because it was the result of the licensee's failure to meet a TS requirement, and the cause was reasonably within the licensee's ability to foresee and correct and should have been prevented. The performance deficiency was determined to be more than minor and a finding because, if left uncorrected, failing to properly evaluate the operability of APRMs would have the potential to lead to a more significant safety concern. The inspectors applied IMC 0609.04, "Initial Characterization of Findings," to this finding. Because the inspectors answered "No" to questions A through E in Table 3, the inspectors referenced IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Because the inspectors answered "No" to the applicable Section B (Transient Initiators) question under Exhibit 1 (Initiating Events Screening Questions) and "No" to applicable questions 1-3 under Section C (Reactivity Control Systems) of Exhibit 2 (Mitigating Systems Screening Questions), the finding screened as very low safety significance (Green). The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Human Performance, having Decision Making components, and involving the licensee making safety-significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained. Specifically, decisions regarding the operability impact of the degraded LPRM 32-35A indications were not made using the systematic operability evaluation procedure or other formal processes to include interdisciplinary input and reviews of the decision.

Inspection Report# : 2013002 *(pdf)*

Mitigating Systems

Significance: G Oct 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failed to Establish Measures for the Selection and Review for the Suitability of Safety-Related Cables.
he inspectors identified a finding of very low safety significance and an associated NCV of Title 10, Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion III, "Design Control," where the licensee failed to establish measures for the selection and review for the suitability of safety-related cables with Procedure Electrical Cable Program Manual (ECPM) 4.5, "Electrical Cable Operability," Revision 2. Specifically, ECPM 4.5, Attachment 1, "Qualification of Cables in Wetted Environments," allowed for safety-related cabling that was not qualified or specifically designed for total submergence in water to be used in water filled conduits contrary to its unsuitability for this application, without suitable testing or design control measures. The licensee entered the issue into their Corrective Action Program as Action Request (AR) 01902782, "ECPM – Electrical Cable Operability," dated September 10, 2013, which suspended the use of ECPM 4.5 by quarantining the procedure until the identified discrepancies could be resolved.

The performance deficiency was determined to be more than minor because the finding, if left uncorrected, would become a more significant safety concern. Specifically, not identifying and appropriately evaluating degraded or non-conforming conditions to properly assess the operability of cables subjected to protracted and/or extensive exposure to water could warrant not declaring a structure, system, and component (SSC) inoperable by the use of compensatory actions to maintain or enhance a degraded or non-conforming condition. This finding has a cross-cutting aspect in the area of human performance, decision making because the licensee did not use conservative assumptions in implementing ECPM 4.5, "Electrical Cable Operability," Revision 2. Specifically, the licensee failed to perform an effective review of the consequences of their decision to include an attachment to this procedure that provided a method not previously approved for qualifying safety-related cables for submergence.

Inspection Report# : 2013008 *(pdf)*

Significance: G Oct 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failed to Ensure the SBDG Power Cables Were Not Submerged.
The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to correct a condition adverse to quality following discovery of water and mud in safety-related electrical conduit 1K109 associated with the 'A' Standby Diesel Generator (SBDG). Specifically, the licensee identified an obstruction characterized as "mud" located 8-feet from the turbine building (TB) end of conduit 1K109. As a result, the licensee failed to take corrective action to remove the water and mud from the conduit and to evaluate the mud obstruction. The licensee entered the finding into their Corrective Action Program as AR 01909315, "NRC 5059/MOD Inspection Violation of App B Criterion 16," dated October 3, 2013. The licensee has performed insulation resistance checks on the EDG power cable and obtained satisfactory results. Additionally, the licensee performed an evaluation of the mud-like material in the conduit and determined that it is likely cable pulling compound, as opposed to degraded cable jacket material. The licensee also set a date for further inspection of the conduit to April 2014, which coincides with the next EDG outage period. These corrective action items are being tracked in CR 1909315. Additionally the licensee is evaluating the frequency interval for inspecting this and other similar conduits.

The performance deficiency was determined to be more than minor because the finding was associated with the Mitigating Systems' cornerstone's attribute of design control for ensuring the availability, reliability, and capability of systems that respond to Initiating Events to prevent undesirable consequences. Specifically, material characterized by the licensee as mud facilitated continual exposure to a wetted and water submergence environment of the safety-

related ‘A’ SBDG power cables. Continual exposure to a wetted and water submergence environment could lead to cable failure. Cable failure would prevent the system from carrying out its intended safety-related function of automatically starting and connecting to its corresponding essential service bus to supply power to emergency loads in an event (i.e., a loss-of-coolant-accident (LOCA) and/or degraded/under-voltage condition). This finding has a cross-cutting aspect in the area of human performance, decision-making because the licensee did not use conservative assumptions to correct a condition adverse to quality following discovery of water and mud in safety-related electrical conduit 1K109 associated with the ‘A’ SBDG. Specifically, the licensee failed to perform an effective review of the safety-related consequences of their decision not to complete the inspection of conduit 1K109 to ensure that no water and mud remained inside the conduit subjecting the cables to a submergence environment.
Inspection Report# : 2013008 *(pdf)*

Significance: G Sep 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
EXTENT OF CONDITION NOT PROPERLY EVALUATED.
A finding of very low safety significance and associated non-citied violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified by the inspectors for the licensee’s failure to accomplish safety-related procedure EN-AA-203-1001, “Operability Determinations/Functionality Assessments.” Specifically, during the Fall 2012 refueling outage, the licensee failed to evaluate the extent of condition under a prompt operability determination (POD) for the ‘A’ residual heat removal service water (RHRSW) subsystem after identifying several locations of the ‘B’ RHRSW supply piping that was less than the minimum acceptable wall thickness. By not performing a POD, the operations shift manager (OSM) was not able to perform his or her responsibility to review, assess, and approve the operability call regarding the potential for wall thinning of the ‘A’ RHRSW piping. The licensee entered the inspectors’ concerns into the CAP as Condition Report (CR) 01892263. The licensee completed a POD to evaluate the extent of wall thinning condition for the ‘A’ RHRSW subsystem and determined that the ‘A’ RHRSW subsystem was operable but with reduced margin to design specifications. This was reviewed and approved by the OSM. The inspectors determined that the issue of concern represented a performance deficiency because it was the result of the licensee’s failure to meet a procedural requirement, and the cause was reasonably within the licensee’s ability to foresee and correct and should have been prevented. The performance deficiency was determined to be more than minor and a finding because if left uncorrected, failing to properly assess the impact of extent of condition for operability on similar structures, systems, or components (SSCs) would have the potential to lead to a more significant safety concern. The inspectors applied IMC 0609, Attachment 4, “Initial Characterization of Findings,” to this finding. Because the finding pertained to operations while the plant was both shutdown and operating, the inspectors referenced both IMC 0609, Appendix G, “Shutdown Operations Significance Determination Process,” and IMC 0609, Appendix A, “The Significance Determination Process for Findings At-Power.” Per IMC 0609, Appendix G, the inspectors determined that the finding did not require a quantitative assessment and therefore screened as very low safety significance (Green). Additionally, per IMC 0609, Appendix A, the inspectors determined that although the finding was a deficiency affecting the design and qualification of the SSC, the SSC maintained its operability and therefore also screened as very low safety significance (Green).

The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Human Performance, having Decision Making components, and involving the licensee making safety or risk-significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained. Further, this includes formally defining the authority and roles for decisions affecting nuclear safety, and implementing these roles and authorities as designed. Specifically, the evaluation of extent of condition for the identified pipe wall thinning of the ‘B’ RHRSW subsystem was not performed under the systematic operability determination process which resulted in bypassing the OSM’s role in assessing and approving operability following the identification of a degraded or non-conforming condition.
Inspection Report# : 2013004 *(pdf)*

Significance: W Sep 30, 2013
Identified By: NRC
Item Type: VIO Violation
RCIC TURBINE OVERSPEED TRIP.
A finding and apparent violation of Technical Specification (TS) Limiting Condition for Operation (LCO) 3.5.3, Condition B was self-revealed for the licensee's failure to perform an immediate operability determination (IOD) in accordance with licensee procedures on June 21, 2013, when a RCIC system turbine speed indicator in the main control room was found degraded. Specifically, the licensee failed to consider the degraded speed indication indicative of a problem within the RCIC EG-M circuitry (failed voltage-dropping resistor) that resulted in the inoperability of RCIC on August 22, 2013, when the RCIC turbine tripped on overspeed during post-maintenance surveillance testing. The licensee documented the issue in CR 01898931. Corrective actions included the replacement of the voltage-dropping resistor for the RCIC EG-M power supply, a review of extent of condition, and performing appropriate post-maintenance testing.

The inspectors determined that the licensee's failure to perform an immediate operability determination in accordance with licensee procedures on June 21, 2013, when a RCIC system turbine speed indicator in the main control room was found degraded was a performance deficiency, because it was the result of the failure to meet a procedure requirement, and the cause was reasonably within the licensee's ability to foresee and correct and should have been prevented. The performance deficiency was determined to be more than minor and a finding because it impacted the Mitigating Systems 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. Specifically, the performance deficiency resulted in the inoperability of the RCIC system from June 21 through August 24, 2013.

Inspection Report# : 2013004 *(pdf)*
Inspection Report# : 2014007 *(pdf)*

Significance: W Sep 05, 2013
Identified By: NRC
Item Type: VIO Violation
'A' STANDBY DIESEL GENERATOR LUBE OIL HEAT EXCHANGER GASKET FAILURE.
A finding and violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed for the licensee's failure to prescribe a work instruction of a type appropriate to the circumstances for the re-assembly of the 'A' standby diesel generator (SBDG) lube oil (LO) heat exchanger (HX), an activity affecting quality. Specifically, on October 18, 2012, work order 40132858 was performed to replace the 'A' SBDG LO HX tube bundle assembly. On March 8, 2013, the LO HX tube bundle sheet-to-shell gasket catastrophically failed, rendering the 'A' SBDG unavailable. The gasket failure was attributed, in part, to the work order not containing sufficient detail and acceptance criteria, appropriate torque values, and operating experience information to ensure the gasket was properly compressed. The licensee documented the issue in condition report (CR) 01855032 and immediate corrective actions included a replacement of the 'A' SBDG LO HX gasket.

The inspectors determined that the licensee's failure to prescribe a work order appropriate to the circumstances was a performance deficiency, because it was the result of the failure to meet regulatory requirements, and the cause was reasonably within the licensee's ability to foresee and correct and should have been prevented. The performance deficiency was determined to be more than minor and a finding because it impacted the Mitigating Systems 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. Specifically, the performance deficiency resulted in the failure of the 'A' SBDG LO HX gasket during a maintenance run of the engine on March 8, 2013. This finding was assessed based on the best available information

using the applicable Significance Determination Process (SDP) and based on the risk evaluation, the significance determination was White or low to moderate safety significance.
Inspection Report# : 2013010 *(pdf)*
Inspection Report# : 2013011 *(pdf)*

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ENSURE OPERABILITY OF LOW PRESSURE COOLANT INJECTION FOLLOWING A POSTULATED LOCA IN MODE 3.
A finding of very low safety significance (Green) and associated non-citied violation 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the failure to ensure the low pressure coolant injection (LPCI) mode of operation of residual heat removal (RHR) would be capable of performing its mitigating function while in Mode 3 following a postulated loss of coolant accident (LOCA).
The licensee documented the issue in the CAP as CRs 01625023, 01626334, and 01776321. Corrective actions included the development of mitigating actions to manually realign RHR to LPCI mode should a LOCA occur while in Mode 3 to ensure system operability.

The performance deficiency was determined to be more than minor because the finding was associated with Mitigating System Cornerstone attribute of Equipment Performance and affected the cornerstone objective of ensuring the capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, under the postulated conditions, steam voiding could occur within the RHR system and impact the ability of LPCI to respond during a postulated Mode 3 LOCA. The finding required a Phase II SDP evaluation because the operability of the LPCI system was determined to be impacted. Based on the Phase II SDP risk-analyses and SAPHIRE analysis developed by the regional senior risk analyst (SRA), the inspectors determined the finding was of very low safety significance. The inspectors determined this finding had a cross-cutting aspect in the area of Problem Identification and Resolution, having Operating Experience (OE) components, and involving the licensee systematically collecting and evaluating relevant internal and external OE. Specifically, the licensee's evaluation of Information Notice 2010-11 did not result in a detailed evaluation for potential issues related to the OE.

Inspection Report# : 2013002 *(pdf)*

Significance: G Mar 31, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
CORRECTIVE ACTIONS ASSOCIATED WITH POTENTIAL CABLE SUBMERGENCE IMPROPERLY CLOSED.
A finding of very low safety significance (Green) and associated non-citied violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed on October 12, 2012, for the licensee's failure to meet corrective action program procedural requirements associated with the correction of a contributing cause and the evaluation of the extent of condition of potentially submerged, degraded, and non-conforming safety-related electrical cables. The licensee entered the issue into the CAP as CR 01824467. Planned corrective actions included creating a cable monitoring program, establishing periodic inspections and dewatering of embedded conduits, and establishing periodic insulation resistance testing of safety-related electrical cables located within embedded conduits.

The inspectors determined that failing to meet corrective action program procedural requirements represented a performance deficiency because it was the result of the licensee's failure to meet a regulatory requirement, and the cause was reasonably within the licensee's ability to foresee and correct and should have been prevented. The

performance deficiency was determined to be more than minor and a finding because, if left uncorrected, failing to correct the contributing causes and evaluate the extent of condition of conditions adverse to quality would have the potential to lead to a more significant safety concern. The inspectors applied IMC 0609.04, "Initial Characterization of Findings," to this finding. Because the finding pertained to an event while the plant was shut down, Table 3 instructed reference of IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." Because the finding did not require a quantitative assessment, the finding screened as very low safety significance (Green). The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Problem Identification and Resolution, having Corrective Action Program components, and involving the licensee thoroughly evaluating problems such that the resolutions address causes and extents of conditions, as necessary, including, for significant actions, conducting effectiveness reviews of corrective actions to ensure that the problems are resolved. Specifically, the licensee inappropriately postponed, cancelled, or closed significant corrective actions that likely would have identified and promptly resolved additional instances of submerged degraded and non-conforming safety-related electrical cables.

Inspection Report# : 2013002 *(pdf)*

Barrier Integrity

Significance:  Sep 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO REPORT CHANNEL CHECKS.
A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to prescribe a procedure with appropriate qualitative acceptance criteria to ensure that CHANNEL CHECKs were satisfactorily accomplished in accordance with TS Surveillance Requirement (SR) 3.3.6.2 prior to September 12, 2013. Specifically, Surveillance Test Procedure (STP) 3.0.0-01 did not perform a qualitative assessment of channel behavior, nor did it require comparisons to other channel indications measuring the same parameter. Had STP 3.0.0-01 contained appropriate acceptance criteria, the main steam line area temperature indicating switch (TIS)-4480 would have been considered inoperable based on trending prior to switch anomalies resulting in declaring TIS-4480 inoperable on June 22, 2013. The licensee documented the issue in CR 01903528, briefed operators on the requirement to perform qualitative checks of the applicable instruments, and initiated a procedure change to restore compliance of the STP to meet the requirements of SR 3.3.6.2.

The inspectors determined the licensee's failure to prescribe an STP with appropriate acceptance criteria was a performance deficiency because it was the result of the failure to meet a regulatory requirement, and the cause was reasonably within the licensee's ability to foresee and correct and should have been prevented. The performance deficiency was determined to be more than minor and a finding because it impacted the Barrier Integrity Cornerstone attribute of procedure quality and adversely affected the Cornerstone objective of providing reasonable assurance that physical design barriers (i.e., containment) protect the public from radionuclide releases caused by accidents and events. The inspectors applied IMC 0609, Appendix A, Exhibit 3 for the Barrier Integrity Cornerstone. Because the finding did not represent an actual open pathway in the physical integrity of the reactor containment or containment isolation system, the finding screened as very low safety significance (Green).

Inspection Report# : 2013004 *(pdf)*

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FUEL POOL RADIATION MONITOR CORRECTIVE ACTIONS.
The inspectors identified a finding of very low safety significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for two examples of the failure to follow procedures associated to the troubleshooting and repair of RIS4131A Refuel Floor Exhaust Radiation Monitor. The licensee initiated WO 40190702-01, "RIS4131A Refuel Floor Exhaust Rad Mon Upscale and Group 3," to troubleshoot and repair the power supplies. The licensee was still evaluating planned corrective actions for the failure to follow the work order instructions.

The performance deficiency was determined to be more than minor because it was associated with the Barrier Integrity Cornerstone attribute of providing reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, RIS4131A failing to operate in conjunction with a single additional failure (RIS4131B) could allow the release of radioactive contamination due to preventing an automatic secondary containment isolation (Group 3). The finding screened as having very low safety significance (Green) because the inspectors answered "Yes" to question C.1 of IMC 0609, Appendix A, Exhibit 3. The inspectors determined that the contributing cause that provided the most insight into the performance deficiency was associated with the cross-cutting aspect of Human Performance, having Work Control components that support long-term equipment reliability by performing maintenance that is more preventive than reactive

Inspection Report# : 2013007 *(pdf)*

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CONDUCT ADEQUATE POST-MAINTENANCE TESTING.
The inspectors identified a finding of very low safety significance (Green) and associated non-cited violation of 10 CFR 50, Appendix B, Criterion XI, "Test Control," for the licensee's failure to conduct post maintenance testing in accordance with procedure Maintenance Directive (MD)-024, "Post-Maintenance Testing," following maintenance on secondary containment damper 1VAD017B1. Specifically, the testing that the licensee performed was not adequate to verify that the damper could perform its intended function and resulted in the damper subsequently failing in service. The licensee entered the issue into their CAP as CR 01862900. Immediate corrective actions included declaring secondary containment inoperable, determining if any other dampers were not fully closed (none were identified), and rebuilding and retesting damper 1VAD017B1.

The performance deficiency was determined to be more than minor because it was associated with the Barrier Integrity Cornerstone attribute of Procedure Quality and adversely affected the cornerstone objective of ensuring that physical design barriers (secondary containment) protect the public from radionuclide releases caused by accidents. The finding screened as having very low safety significance (Green) because it represented a degradation of the radiological barrier provided for the secondary containment building and the inspectors answered "No" to Questions B.1 and B.2 in IMC 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions." The inspectors determined that the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Problem Identification and Resolution, having Corrective Action Program Components, and involving the licensee thoroughly evaluating problems such that the resolutions address causes and extent of conditions, as necessary. Specifically, for the damper of concern, the licensee did not implement corrective actions from root cause evaluation (RCE) 01739467, which stated "Create a maintenance procedure for rebuilding and adjusting secondary containment dampers and operators that directs the following: provide guidance on adjusting over travel of damper blades [aka

stop rod adjustment],” and “limit switch verification.”

Inspection Report# : 2013002 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IMPLEMENT AND MAINTAIN PROCEDURES REGARDING BREATHING AIR QUALITY.
A finding of very low safety significance and associated non-cited violation of 10 CFR 20.1703 was identified by the inspectors on January 18, 2013, for the licensee’s failure to implement and maintain written procedures regarding breathing air quality and self-contained breathing apparatus (SCBA) inspections. These issues were entered into the licensee’s CAP as CRs 01840046, 01839697, and 01839666. Corrective actions included air quality tests that were subsequently performed resulting in Grade “D” or better, and completing breathing air and monthly SCBA inspections. Additionally, the licensee was in the process of establishing a tracking mechanism to ensure these tests and inspections were appropriately scheduled for completion.

The inspectors determined that not consistently performing the Grade “D” air quality tests or SCBA monthly inspections was a performance deficiency, the cause of which was reasonably within the licensee’s ability to foresee and correct, and should have been prevented. The performance deficiency was determined to be of more than minor safety significance because if left uncorrected, not performing testing of breathing air quality and SCBAs would have the potential to lead to a more significant safety concern. In accordance with IMC 0609, Appendix C, “Occupational Radiation Safety Significance Determination Process,” the inspectors determined that the finding had very low safety significance (Green) because the finding did not involve: (1) as-low-as-is-reasonably-achievable (ALARA) planning and controls, (2) a radiological overexposure, (3) a substantial potential for an overexposure, or (4) a compromised ability to assess dose. The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross cutting aspect of Human Performance, having Work Practices components, and involving the licensee ensuring supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported. Specifically, ownership and accountability to perform air quality testing was not well established or controlled within the work schedule process to ensure the tests would be performed as required.
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

Last modified : February 24, 2014