

## Point Beach 1 4Q/2013 Plant Inspection Findings

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### Initiating Events

**Significance:** G Jun 30, 2013

Identified By: NRC

Item Type: FIN Finding

#### **Failure to Control Materials Classified as High Winds/Tornado Hazards**

The inspectors identified a finding of very low safety significance for the licensee's failure to maintain control over the proper storage and placement of materials that were classified as high winds/tornado hazards, in accordance with procedure NP 1.9.6, "Plant Cleanliness and Storage." Specifically, the inspectors identified that the licensee failed to perform weekly high wind missile hazards inspections since April 17, 2013. As a result, unsecured wooden pallets, wooden planks, metal rods and a metallic desk were discovered by the inspectors near Units 1 and 2 transformer areas. The issue was entered into the licensee's corrective action program (CAP) for resolution as action request AR01882921. The licensee took immediate corrective action to remove and/or properly store the material after the tornado warning on June 17, 2013.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected, the unsecured items would have the potential to lead to a more significant safety concern during high wind and tornado events. The inspectors determined the finding to be of very low safety significance because the inspectors answered "No" to each question listed in IMC 0609, Appendix A, Exhibit 1, "Initiating Event Screening Questions." The inspectors determined that the finding has a cross cutting aspect in the area of human performance, work practices, because the licensee did not provide supervisory or management oversight of work activities such that nuclear safety was supported. Specifically, the licensee failed to provide appropriate oversight of work activities such that, when the program owner of the weekly high wind inspection changed, the requirement to perform weekly high winds tornado hazard walkdowns was not understood (H.4(c)).

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

**Significance:** G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Operability Evaluation Process Following Water Leakage into the Control Room**

The inspectors identified a finding of very low safety significance and an associated non-cited violation of 10 CFR 50, Appendix B, Criterion V for the licensee's failure to follow procedure EN AA 203 1001, "Operability Determinations/Functionality Assessments." Specifically, following water leakage into the control room, the licensee's immediate operability determination failed to evaluate the effect the leakage had on the control room envelope operability. Additionally, the licensee did not address the functionality of the degraded flood barrier and its impact on operability. This issue was entered into the corrective action program (CAP) as AR01877185. Corrective actions for this issue included performing a test of the control room envelope to demonstrate that appropriate positive pressure could be maintained with the known degraded barrier, and repair of the degraded flood barrier following performance of a functionality assessment.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Protection Against External Factors attribute of the Initiating Event Cornerstone, and

adversely affected the Cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance in accordance with IMC 0609, Appendix A, Exhibit 1, because they answered “No” to the questions under Transient Initiators and External Event Initiators. The inspectors concluded that this finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program, because the licensee failed to thoroughly evaluate this problem such that the resolution addressed the cause and evaluated the condition for operability (P.1(c)).

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

**Significance:**  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Incorrect Equipment Selected for Ultrasonic Examination**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for failure to select an appropriately contoured ultrasonic examination search unit wedge in accordance with procedure NDE 173, “PDI Generic Procedure for the Ultrasonic Examination of Austenitic Piping Welds.” Consequently, three elbow to pipe socket welds on the chemical and volume control system (CVCS) line were examined with the incorrectly contoured search unit and this examination would not provide a demonstrated level of accuracy necessary to reliably detect and size thermal fatigue cracks. The licensee entered this condition into the corrective action program (CAP) as AR01860155. To restore compliance with NRC regulations, the licensee considered the option of repeating these weld examinations using a qualified ultrasonic examination technique or the option to seek NRC approval to deviate from the American Society of Mechanical Engineers (ASME) Code Section XI requirements for ultrasonic examination.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, “Issue Screening,” issued September 7, 2012, because the inspectors answered “Yes” to the more than minor screening question, “If left uncorrected, would the performance deficiency have the potential to lead to a more significant safety concern?” Specifically, the examination of three chemical and volume control system welds was presumed adequate and absent NRC intervention, would have been returned to service for an indefinite period of service, which would have placed the piping at increased risk for undetected thermal fatigue cracking, leakage, or component failure. In accordance with Table 2, “Cornerstones Affected by Degraded Condition or Programmatic Weakness,” of IMC 0609, Attachment 4, “Initial Characterization of Findings,” issued June 19, 2012, the inspectors checked the box under the Initiating Events Cornerstone because leakage at this chemical and volume control system letdown line could result in a primary system loss of coolant accident. The inspectors determined this finding was of very low safety significance based on answering “No” to the questions in Part A of Exhibit 1, “Initiating Events Screening Questions,” in IMC 0609, Attachment A, “The Significance Determination Process (SDP) for Findings At Power,” issued on June 19, 2012. The inspectors answered these questions “No” because of the small diameter (2 inch) of the line and because the affected pipe welds were subjected to a VT 2 visual and penetrant testing (PT) examination that did not identify rejectable defects. The primary cause of the failure to select ultrasonic equipment (search unit contour) in accordance with procedure NDE 173 was related to the cross-cutting component of human performance, work practices, because the licensee’s management staff did not adequately set up clear expectations for procedure control and adherence for this activity. Specifically, insufficient direction was provided to vendor staff for simultaneous use of two procedures, NDE 178 and NDE 173, with different equipment requirements and restrictions (H.4(b)).

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

**Significance:**  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Properly Implement a Compensatory Fire Watch As Required by the Fire Protection Program**

A finding of very low safety significance and an associated non-cited violation (NCV) of Technical Specification (TS)

5.4.1.h, “Fire Protection Implementation,” for Units 1 and 2, was identified by the inspectors for the licensee’s failure to implement compensatory fire watches for multiple fire zones in the plant auxiliary building, in accordance with the fire protection program requirements. Specifically, the licensee failed to implement the guidelines for compensatory fire watches as described in Operations Manual (OM) 3.27, “Control of Fire Protection and Appendix R Safe Shutdown Equipment” for the affected fire zones. The issue was entered into the licensee’s corrective action program (CAP) as AR01855430.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Initiating Events Cornerstone attribute of Protection Against External Factors (Fire) and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during plant operations. The inspectors evaluated the finding using IMC 0609, Appendix F, because the finding degraded the ability to adequately implement fire prevention and administrative controls affecting the ability to reach and maintain safe shutdown capabilities. A Region III (RIII) Senior Reactor Analyst (SRA) performed a modified Phase 2 evaluation and determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of human performance, work practices, because the licensee failed to define and effectively communicate expectations regarding procedural compliance and personnel did not follow procedures (H.4(b)). Specifically, the expectation for procedural compliance, for when the fire zones become high radiation areas requires that fire rounds are to be performed by Operations instead of security.

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

## Mitigating Systems

**Significance:**  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Follow Maintenance and Test Equipment Procedure**

The inspectors identified a finding of very low safety significance and an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the licensee’s failure to follow procedure NP 8.7.1, “Measurement and Test Equipment [M&TE].” Specifically, the inspectors identified multiple examples where the licensee did not document the withdrawal and use of M&TE in either the M&TE usage log or its electronic equivalent. This issue was entered into the licensee’s corrective action program (CAP) as action request (AR) 01925171.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, “Issue Screening,” dated September 7, 2012, because, if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. Specifically, without accurate M&TE usage logs the licensee may not evaluate all past surveillances affected by failed M&TE, potentially resulting in a failed TS surveillance going undetected. The inspectors determined that the finding was associated with the Mitigating Systems Cornerstone, because not evaluating the prior use of inaccurate M&TE could permit equipment required to mitigate the consequences of the accident to not perform its design and licensing basis functions when called upon. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, “Significance Determination Process,” Attachment 0609.04, “Initial Characterization of Findings,” dated June 19, 2012, and Appendix A, “The Significance Determination Process for Findings At Power,” Exhibit 2, “Mitigating Systems Screening Questions,” dated June 19, 2012. The inspectors concluded that the finding was of very low safety significance (Green), because the inspectors answered “No” to the Mitigating Systems screening questions. The inspectors concluded that this finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee failed to effectively communicate the station expectations related to changes in responsibilities for implementing NP 8.7.1.

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

**Significance:**  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Account for Plant-Specific Maintenance History in the Development of Preventive Maintenance Frequency**

The inspectors identified a finding of very low safety significance and an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V for the licensee's failure to follow procedure FP PE 90 01, "Preventive Maintenance Program." Specifically, in 2009, when setting the preventive maintenance frequency for containment isolation valve 1MS 02083, the licensee determined that a 15-year frequency was appropriate instead of the recommended 10 years. The licensee's justification was based on internal maintenance history showing good performance. However, the inspectors' review revealed that the maintenance history for this category of valves did not support this determination. The valve subsequently failed during surveillance on March 21, 2013, after 13 years of service. The licensee entered this issue into the corrective action program (CAP) as AR01858451; corrective actions included replacing the valve and an action to review the preventive maintenance frequencies of critical solenoid operated valves.

The inspectors determined that the finding was more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Barrier Performance attribute of the Barrier Integrity Cornerstone, and adversely affected the Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors evaluated this finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," Checklist 3, and determined that the finding was of very low safety significance because the inspectors determined that a quantitative assessment was not required. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding did not reflect current performance due to the age of the performance deficiency.

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

**Significance:**  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Establish Adequate Procedures to Respond to Probable Maximum Precipitation Event**

A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to establish an abnormal operating procedure (AOP) to respond to a flooding event and for failure to establish procedures for control and maintenance of external flooding design features for the probable maximum precipitation event as described in the FSAR. The issue was entered into the licensee's CAP as AR01856322 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Mitigating Systems Cornerstone attributes of Protection Against External Factors (Flood Hazard) and Procedure Quality, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 2, for the Mitigating Systems Cornerstone, and determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of human performance, resources, because the licensee failed to maintain long term plant safety by maintenance of the external flooding design features (H.2(a)). Specifically, in the recent past, the licensee inappropriately cancelled the preventive maintenance associated with the ditches and storm drains following the completion of the drainage system study in June 2010.

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

**Significance:** N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Submit LER 05000266/2012-003-00, "2B-04 Safeguards 480V Bus De-Energized," Within 60 Days**

A Severity Level IV (SL-IV) non-cited violation (NCV) of 10 CFR 50.73(a)(1), "Licensee Event Report (LER) System," with an underlying Green issue was identified for the licensee's failure to submit an LER in accordance with 10 CFR 50.73(a)(2)(i)(B) and 10 CFR 50.73(a)(2)(v)(D) within 60 days for a valid loss of safety related electrical bus 2B-04, "Unit 2 480V Safeguards Bus." This issue was entered into the licensee's CAP as AR01851639 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because, if left uncorrected, it would have the potential to lead to a more significant safety concern, since untimely reporting of issues hinders the inspectors' ability to perform timely and adequate regulatory reviews of the cause and underlying issues. Specifically, the inspectors determined that the issue was considered as traditional enforcement because it had the potential for impacting the NRC's ability to perform regulatory functions and constituted an SL-IV NCV, consistent with the examples contained in Section 6.9 of the Enforcement Policy. The inspectors reviewed the underlying issue associated with the mitigating systems cornerstone and determined that the finding has a cross-cutting aspect in the area of problem identification and resolution, evaluation, because the licensee failed to thoroughly evaluate the problem such that the resolutions properly addressed operability and reportability. (P.1(c))  
Inspection Report# : [2013002](#) (*pdf*)

**Significance:** **W** Mar 31, 2013

Identified By: NRC

Item Type: VIO Violation

**Failure to Establish an Adequate Procedure to Implement Wave Run-Up Design Features**

A WHITE finding and a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors in that from January 19, 1996 until March 13, 2013, the licensee failed to have a procedure appropriate to the circumstances to address external flooding as described in the Final Safety Analysis Report (FSAR.) Specifically, Procedure PC 80 Part 7, as implemented, would not protect safety-related equipment in the turbine building or pumphouse because the procedure (1) did not appropriately prescribe the installation of barriers such that gaps in or between the barriers were eliminated to prevent water intrusion, (2) did not protect equipment by requiring barriers to be placed in front of the doors, from 1996 to 2008, as described in the FSAR, and (3) did not require the barriers to protect the plant to an elevation of at least 9 feet (589 foot elevation) as described in the FSAR.

The performance deficiency was screened against the Reactor Oversight Process per the guidance of IMC 0612, Appendix B, and determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attributes of Protection Against External Factors (Flood Hazard) and Procedure Quality, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the licensee's failure to procedurally control and maintain external flooding design features and to provide procedural controls for external events could negatively impact mitigating systems' ability to respond to an external flooding event. The inspectors evaluated the finding using IMC 0609, Attachment 0609.04, Tables 2 and 3, and Appendix A, and determined a detailed risk evaluation was needed. This finding does not present an immediate safety concern, in that, the licensee has taken corrective action and revised procedures implementing wave run-up protection features. Specifically, the licensee's procedure has been revised to direct the installation of jersey barriers in conjunction with the use of sandbags, existing jersey barriers have been modified, and sandbags and additional jersey barriers have been purchased and pre-staged. These issues are being characterized as an apparent violation in accordance with the NRC's Enforcement Policy, with its final significance to be dispositioned in separate future correspondence. This finding has a cross cutting aspect in the area of problem identification and resolution, corrective action program, because the

licensee failed to thoroughly evaluate problems such that the resolutions address causes and extent of conditions [P.1 (c)].

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

Inspection Report# : [2013011](#) (*pdf*)

Inspection Report# : [2013012](#) (*pdf*)

## Barrier Integrity

**Significance:**  Dec 31, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### Failure to Provide Adequate Work Instructions

A self-revealed finding of very low safety significance and an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, occurred when a surveillance procedure was performed with several steps marked not applicable which resulted in Unit 1 power rising over the license limit. Specifically, when the Unit 1 turbine driven auxiliary feedwater pump was operated as part of a post maintenance test, the discharge isolation valves remained open which resulted in a small unplanned positive reactivity change. This issue was entered into the licensee's CAP as AR 01920721.

The inspectors determined that this finding was more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because, if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, the failure of the control room operators to respond promptly could have led to the final reactor power being higher than during this issue. The inspectors determined that the finding was associated with the Initiating Events Cornerstone, specifically the configuration control attribute of operating equipment lineup. The inspectors determined that the finding could be evaluated using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process for Findings At Power," Exhibit 1, "Initiating Events Screening Questions." The finding was determined to be of very low safety significance (Green) because the inadequate work instructions did not result in a reactor trip. The inspectors determined that the finding had a cross-cutting aspect in the area of human performance, work control, planning, because a human performance error was made during the planning process in an effort to reduce the work load during the test, and due to a cognitive error, the post maintenance test was made inadequate. Specifically, steps were marked non-applicable that would have placed the pump discharge valves in their required position for the next portion of the surveillance test.

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

**Significance:**  Sep 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

### Failure to Follow Operability/Functionality Evaluation Process Following Radiation Monitor Failure

The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, for the licensee's failure to follow procedure EN AA 203 1001, "Operability Determinations/Functionality Assessments." Specifically, when the Unit 1 main steam line A release monitor, 1RE 232, went into high alarm due to high ambient temperatures, the licensee's immediate functionality determination failed to evaluate the potential impact of the degraded state of the radiation monitor in the emergency plan. Additionally, a functionality assessment was not requested as specified by the procedure. This issue was entered into

the licensee's corrective action program (CAP) as action request (AR) 01902921.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected, the failure to perform operability and functionality evaluations, and to recognize conditions that could render equipment inoperable, had the potential to lead to a more significant concern. The inspectors determined that the finding was associated with the Barrier Integrity Cornerstone, because the main steam line radiation monitor provides reasonable assurance that physical design barriers protect the public from radionuclide releases. The inspectors determined the finding to be of very low safety significance in accordance with IMC 0609, Appendix A, Exhibit 1, because they answered "No" to the questions under the Barrier Integrity screening questions. The inspectors concluded that this finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee failed to use conservative assumptions in decision making after the receipt of the unexpected high alarm on 1RE 232 and did not request a functionality assessment to ensure that the condition and proposed actions were fully understood. Specifically, operations personnel did not request a documented evaluation to support understanding why the alarming monitor did not affect the functionality of the instrument as it related to the instrument's emergency plan functions. (H.1 (b))

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

**Significance:**  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Lack of Acceptance Criteria for Containment Visual Examinations**

The inspectors identified a non-cited violation of 10 CFR 50.55a(g)(4), for failure to define acceptance criteria for containment visual examinations. Consequently, active containment liner degradation (pitting) was identified and the liner returned to service without defined criteria for accepting this condition. The licensee entered this issue into the corrective action program (CAP) as action requests AR01858862 and AR01861158, and developed visual examination acceptance criteria to restore compliance with this NRC regulation.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, "Issue Screening" dated September 7, 2012, because it adversely affected the Barrier Integrity Cornerstone attribute of maintaining the functional integrity of containment. The inspectors also answered "Yes" to the more than minor screening question, "If left uncorrected, would the performance deficiency have the potential to lead to a more significant safety concern?" Specifically, the lack of acceptance criteria in site procedures for containment visual examinations would become a more significant safety concern in that active liner degradation may not be properly evaluated and/or promptly corrected, resulting in a containment liner breach. In accordance with Table 2, "Cornerstones Affected by Degraded Condition or Programmatic Weakness," of IMC 0609, Attachment 4, "Initial Characterization of Findings," issued June 19, 2012, the inspectors checked the box under the Barrier Integrity Cornerstone because the corrosion induced pitting degraded the containment barrier. The inspectors determined this finding was of very low safety significance based on answering "No" to the Exhibit 3, "Barrier Integrity Screening Questions," in IMC 0609, Attachment A, "The Significance Determination Process (SDP) for Findings At Power," issued on June 19, 2012. Specifically, the inspectors answered "No" to the screening question associated with an actual open pathway (e.g., breach) in the containment and "No" to the question associated with reduction in function of hydrogen igniters in containment. The inspectors determined that the primary cause of the failure to define containment visual examination acceptance criteria was related to the cross-cutting component of human performance, decision-making, because licensee staff did not apply a systematic process, when faced with unexpected plant conditions, to ensure safety was maintained. Specifically, a systematic process for developing acceptance criteria was not applied for the containment visual examinations (H.1(a)).

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

**Significance:**  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Response for Loss of Spent Fuel Pool Cooling Did Not Consider the Most Limited Time to Boil**

A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the licensee's failure to account for the most limiting spent fuel pool (SFP) time to boil in calculations and procedures. Specifically, the service water design-basis analysis and abnormal operating procedure (AOP) for loss of SFP cooling used a time to boil value based on non-limiting conditions. The issue was entered into the licensee's CAP as AR01852528 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Barrier Integrity Cornerstone, in that, if left uncorrected, it would have lead to a more significant safety concern. The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 3, for the Barrier Integrity Cornerstone, and determined the significance of this finding could be evaluated using qualitative criteria in accordance with IMC 0609, Appendix M. With consultation of an RIII SRA, the inspectors determined the finding screened as of very low safety significance because it involved a design-basis event (e.g., loss of cooling accident (LOCA)) on one unit occurring during a short window of time when the SFP is subjected to the maximum allowed heat load shortly after the other unit is defueled. 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# : [2013002](#) (*pdf*)

**Significance:** G Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Follow Operability Evaluation Process for a Degraded Containment Liner**

A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors when the licensee failed to perform a prompt operability evaluation as required by station procedures. Specifically, procedure PI AA 205, "Condition Evaluation and Corrective Action," required that a prompt operability evaluation be performed when equipment was determined to be operable but degraded. Had this evaluation been performed, the licensee would have recognized that information did not exist to support operability of the containment liner. The issue was entered into the licensee's CAP as AR01851688 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Barrier Integrity Cornerstone attribute of reactor coolant system (RCS) equipment and barrier performance, and adversely affected the Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 3, which indicated that a Phase 2 analysis was required per Appendix H. The inspectors and the Region III SRA performed a Phase 2 evaluation using IMC 0609, Appendix H, Table 6.2, and concluded, based on the small size of the hole in the SW piping, that leakage from the containment to the environment would not be greater than 100 percent containment volume per day; therefore, the issue screened as being of very low safety significance. The finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program, low threshold, because the licensee failed to thoroughly evaluate the breach in the SW system (P.1(a)). Specifically, the lack of a CR that completely and accurately evaluated the hole in the SW system resulted in an unrecognized and unevaluated breach in a system that was considered an extension of the containment.

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

## Emergency Preparedness

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## Occupational Radiation Safety

**Significance:**  Sep 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Update FSAR for Radioactive Waste Storage Changes (2RS8)**

The inspectors identified a finding of very low safety significance and an associated Severity Level IV (SL-IV) NCV of 10 CFR 50.71(e), "Maintenance of Records, Making of Reports," for the licensee's failure to comply with the requirements to periodically update the Final Safety Analysis Report (FSAR) to include an accurate description of the site's solid waste management system and radiation monitoring system as a result of modifications made to the site. This issue was entered into the licensee's CAP as AR01898640 and AR01898643.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected, this could lead to a more significant safety concern because future changes to the facility, procedures, and programs would not be able to consider the licensing basis information that was removed or never inserted. The finding was determined to be of very low safety significance (Green) in accordance with IMC 0609, Appendix D, "Public Radiation Safety Cornerstone Significance Determination Process," because it involved radioactive material control but did not result in public exposure greater than 5 mrem [millirem]. Additionally, using IMC 0612, Appendix B, "Issue Screening," the inspectors determined that the violation of 10 CFR 50.71(e) could be dispositioned using traditional enforcement because it had the potential to impact the NRC's ability to perform its regulatory function. The violation was determined to be a SL-IV violation using the NRC's Enforcement Policy, Section 6.1, because the inaccurate information was not used to make an unacceptable change to the facility procedures. The inspectors concluded that this finding did not have an associated cross-cutting aspect.

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

**Significance:**  Mar 31, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Failure to Survey for Neutron Dose from Source Storage**

A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR 20.1501 was self-revealed when the licensee failed to evaluate dose to personnel from neutron radiation. Specifically, on September 5, 2012, it was self revealed to the licensee that unevaluated neutron dose was present in an office area located outside the Radiologically Controlled Area (RCA) due to a source storage room housing a neutron source. This issue was entered into the licensee's CAP as AR01809560. Corrective actions included moving the neutron source into the RCA, performing a condition evaluation, and performing dose estimates to various plant personnel.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because the finding was associated with the Occupational and Public Radiation Safety Cornerstones and adversely affected the cornerstones objective. The inspectors evaluated the finding using IMC 0609, Appendix D, for the Public Radiation Safety Cornerstone, and determined the finding to be of very low safety significance. The finding had a cross-cutting aspect in the area of human performance, work practices, because the licensee failed to ensure supervisory and management oversight of work activities such that nuclear safety is supported (H.4(c)). Specifically, the licensee did not provide supervisory oversight to ensure that the survey program was sufficient to ensure compliance with 10 CFR Part 20 requirements.

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

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## Public Radiation Safety

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### Security

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

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### Miscellaneous

**Significance:** N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Update the External Flooding Mitigation Features in the FSAR**

An SL-IV NCV of 10 CFR Part 50.71(e), "Maintenance of Records, Making of Reports," was identified by the inspectors for the licensee's failure to comply with the requirements to periodically update the FSAR to include an accurate description of the flooding design and credited mitigation features for the site as a result of a modification made to the plant. The issue was entered into the licensee's CAP as AR01819241 for evaluation and development of corrective actions.

The inspectors used IMC 0612, Appendix B, and determined the performance deficiency could be dispositioned using traditional enforcement. Specifically, the inspectors determined that the issue was considered for traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. The inspectors concluded that the finding is more than minor because, if left uncorrected, this could lead to a more significant safety concern because future changes to the facility, procedures, and programs would not consider the licensing basis information that was removed or never inserted. The finding was determined to be an SL IV violation using Section 6.1 of the NRC's Enforcement Policy because the inaccurate information was not used to make an unacceptable change to the facility or procedures. Since this performance deficiency was dispositioned using traditional enforcement, there is no cross-cutting aspect assigned.

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

Last modified : February 24, 2014