

## Cooper 1Q/2014 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:** G Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Implement Risk Management Actions for Maintenance Activities**

The inspectors identified a non-cited violation of 10 CFR 50.65(a)(4), "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," for the licensee's failure to implement required risk management actions for maintenance activities affecting the flow paths credited in the internal flooding analysis on elevation 903 feet of the reactor building. The station initiated the following corrective actions for this issue: (1) provided a seminar on the requirements of Station Procedure 0-Barrier, "Barrier Control Process," to station personnel; and (2) revised maintenance work order walk down checklist pre-job brief to determine whether barrier control permits are required. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2014-00117.

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 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 19, 2005, Flowchart 2, "Assessment of Risk Management Actions," the inspectors determined the need to calculate the risk deficit to determine the significance of this issue. It was determined that the incremental core damage probability associated with this finding was less than  $1 \times 10^{-6}$ ; therefore, this finding is determined to have very low safety significance (Green). The finding has a cross-cutting aspect in the area of human performance associated with procedure adherence because the licensee failed to follow processes, procedures, and work instructions.

Inspection Report# : [2014002](#) (*pdf*)

**Significance:** G Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Operability Procedure**

The inspectors identified two examples of a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and 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 adequately evaluate the effect on operability for (1) taking electrical relays out of their seismically qualified configuration and (2) a degraded nonconforming condition created by using non-design bases inputs in a design bases analysis. To correct the first issue, the licensee will declare the

service water pumps inoperable during activities that involve opening the switchgear doors and to correct the second issue, the licensee performed subsequent analyses using Manual Chapter 0326, Section C.10, guidance to demonstrate a reasonable expectation of operability. The licensee entered these deficiencies into their corrective action program for resolution as Condition Reports CR-CNS-2014-00464, and CR-CNS-2014-01109.

The failure to properly assess and document the basis for operability when degraded or nonconforming conditions are 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 assess and document the basis for operability resulted in conditions of unknown operability for degraded nonconforming conditions. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 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 conservative bias because individuals did not use decision-making practices that emphasize prudent choices over those that are simply allowable to ensure that a proposed action was determined to be safe in order to proceed, rather than unsafe in order to stop.

Inspection Report# : [2014002](#) (pdf)

**Significance:**  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:**  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  $1 \times 10^{-6}$ , 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:**  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  $1 \times 10^{-6}$ , 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:**  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*)

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## Barrier Integrity

**Significance:**  Mar 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### Failure to Follow Tagout Procedure

Inspectors reviewed a self-revealing, non-cited violation of Technical Specification 5.4.1.a, associated with the licensee's failure to follow station procedures which resulted in secondary containment inoperability. Specifically, on January 6, 2014, a station operator failed to follow Station Procedure 0.9, "Tagouts," and closed the wrong valve while hanging a clearance order to support maintenance. This resulted in an unexpected rise in the reactor buildings differential pressure, which caused the secondary containment to be declared inoperable when pressure went above negative 0.25 inches of water. The corrective action for this issue was to open the mispositioned valve, which restored secondary containment differential pressure. The licensee entered this deficiency into their corrective action program as Condition Report CR-CNS-2014-00062.

The failure to follow Station Procedure 0.9 while hanging a clearance order was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the human performance attribute of the Barrier Integrity Cornerstone and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, inspectors determined that the finding was of very low safety significance (Green) because the finding only represented a degradation of the radiological barrier function for the reactor building. The finding has a cross-cutting aspect in the area of human performance associated with avoiding complacency because individuals failed to recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes, which resulted in individuals not implementing appropriate error reduction tools.

Inspection Report# : [2014002](#) (pdf)

## Emergency Preparedness

**Significance:**  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:**  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*)

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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:**  Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Evaluate Changes to Ensure They Did Not Require Prior Approval**

Inspectors identified a non-cited violation of 10 CFR 50.59, “Changes, Test, and Experiments,” and associated Green finding, associated with the licensee’s failure to adequately evaluate changes to determine if prior NRC approval is required. Specifically, from 1987 through February 11, 2014, the licensee failed to obtain a license amendment pursuant to Section 50.90 prior to implementing a proposed change that would result in a departure from a method of evaluation described in the Updated Safety Analysis Report. This does not represent an immediate safety concern because the licensee performed an operability assessment for the potentially undersized expansion anchors, which established a reasonable expectation for operability pending resolution of the identified issue. The licensee entered this deficiency into their corrective action program as Condition Report CR-CNS-2014-00776.

The licensee’s failure to implement the requirements of 10 CFR 50.59 and adequately evaluate changes to determine if prior NRC approval is required was a performance deficiency. Because this performance deficiency had the potential to impact the NRC’s ability to perform its regulatory function, inspectors evaluated the performance deficiency using traditional enforcement. In accordance with Section 2.1.3.E.6 of the NRC Enforcement Manual, inspectors evaluated this finding using the significance determination process to assess its significance. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” dated June 19, 2012, the finding was determined to have very low safety significance (Green) because it: (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; (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; and (5) did not involve the loss or degradation of equipment or function specifically designed to mitigate a seismic, flooding, or severe weather event. Therefore, in accordance with Section 6.1.d.2 of the NRC Enforcement Policy, inspectors characterized this performance deficiency as a Severity Level IV violation. There was no cross-cutting aspect assigned to this finding because this issue does not reflect present licensee performance.

Inspection Report# : [2014002](#) (*pdf*)

Last modified : May 30, 2014