

Arkansas Nuclear 2

2Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Jun 29, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedures for Through Wall Leaks

DRAFT

The inspectors identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Failure to Follow Procedures,” with two examples. Criterion V, “Instructions, Procedures, and Drawings,” states, in part, “Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.” Contrary to the above, the licensee failed to accomplish operability and functionality assessments in accordance with EN-OP-104, Revision 7, “Operability Determination Process.”

Example 1. In March of 2013, the licensee identified that the pressurizer sample cooler was leaking into the Nuclear Intermediate Cooling Water (ICW) system. In their operability/functionality assessment, the licensee stated in part, “This condition report identifies the E-30 Pressurizer Sample Cooler as the (or a) source of Reactor Coolant System (RCS) in-leakage into the Nuclear ICW System. E 30 is not required per Technical Specifications and is a Non-Safety-Related SSC. It has a QA program code of S-S1 R.G. 1.26 for compliance with Regulatory Guide 1.26 (Quality Group Classifications and Standards for Water , Steam-, and Radioactive-Waste-Containing Components of Nuclear Power Plants). R.G. 1.26 compliant components do not specifically require a functionality assessment per EN-OP-104 Section 5.1 [5]; therefore, E-30 is not within the scope of the Operability Determination Process. Technical Specification 3.4.13 (RCS Operational Leakage) requires identified leakage to be less than 10 gallons per minute and unidentified leakage to be less than 1 gallon per minute. E-30 is not considered part of the RCS pressure boundary and is normally isolated from the RCS when a sample is not being collected; therefore, the RCS is not affected by this condition and remains OPERABLE with respect to this condition. The ICW system is not within the scope of the Operability Determination Process. No Degraded or Nonconforming Condition exists per EN-OP-104 Revision 6 Attachment 9.1 Table 1.” No functionality assessment of the RCS Sample system was performed.

Example 2. Two through wall leaks in the supply line to the 2E30 cooler for the reactor coolant sample system were identified on February 3, 2014. After a visual inspection of the leaks in the reactor coolant sample system, the licensee documented the following information in the operability description of CR ANO 2-2014-00268: “For the stated condition, the Reactor Coolant System (RCS) and the Unit 2 Containment Building are OPERABLE. No Degraded or Nonconforming Condition exists per EN-OP-104 Revision 7 Attachment 9.1 Table 1.” There was no documentation that the licensee had performed a functionality assessment of the reactor coolant sample system as required by EN-OP-104, Revision 7, “Operability Determination Process.” The sample system was the system directly affected by the degraded condition. When this assessment was challenged by the NRC inspectors and the licensee’s ability to meet the Technical Specification 4.4.8.1, Surveillance for Dose Equivalent Xenon (DEX), which is required once per seven days as well as the acceptability of the system for continued service, the licensee recognized that the late date for the DEX Surveillance was Friday, February 7, at 3:50 a.m. (This included the +25 percent allowed by the Technical Specification) and that permanent repairs to the sample system would not be completed by that time.

The inspector determined that the failure to perform functional assessments of the Unit 1 and 2 Reactor Coolant Sampling Systems is a performance deficiency. The finding is more than minor because it is associated with the human performance attribute of the initiating events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the licensee failed to perform a functionality assessment for the Unit 1 Reactor Coolant Sampling System from March 2013 to February 2014 and the Unit 2 reactor coolant sample system on February 3, 2014, as required by EN OP-104, Revision 7. Using Inspection Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," and Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 1, "Initiating Events Screening Questions," the inspectors determined that the finding was of very low safety significance (Green) because the finding did not result in a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of a trip to a stable shutdown condition.

This finding has a cross-cutting aspect in the area of Human Performance, Training, because the licensee failed to provide training and ensure knowledge transfer to maintain a knowledgeable, technically competent work force and instill nuclear safety values. Specifically, the licensee failed to ensure that operators were adequately trained on the use of EN-OP-104, Revision 7, "Operability Determination Process," such that required functionality assessments for degraded and/or non-conforming non-technical specification systems were performed as required [H.9].

Inspection Report# : [2014003](#) (*pdf*)

Significance: G Mar 31, 2014

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Correctly Install Flexible Link Bolted Connection on Phase C of 6.9 kV Bus

Inspectors documented a self-revealing finding for the licensee's failure to correctly install the flexible link bolted connection on phase C of the 6.9 kV non segregated bus of the Unit 2 auxiliary transformer, which contributed to the explosion of the Unit 2 auxiliary transformer. The licensee documented the issue in Condition Report CR-ANO-2-2013-02242. The licensee aligned startup transformer 3 (preferred offsite power source) to carry the plant loads during normal power operations and restarted the plant on January 10, 2014.

Inspectors concluded that the licensee's failure to correctly install the flexible link bolted connection on phase C of the Unit 2 auxiliary transformer 6.9 kV bus was a performance deficiency. The performance deficiency was more than minor because it was associated with the human performance attribute of the initiating events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the incorrectly installed flexible link bolted connection resulted in a reactor trip. Using Inspection Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," June 19, 2012, and Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," June 19, 2012, Exhibit 1, "Initiating Events Screening Questions," the inspectors determined that the finding was of very low safety significance (Green) because the finding did not result in a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of a trip to a stable shutdown condition. Specifically, Unit 2 would have tripped without explosion of the auxiliary transformer, and without subsequent loss of power to startup transformer 3, if the differential current relay wire had been correctly landed.

This finding did not have a cross-cutting aspect associated with it because the most significant contributor was not indicative of present performance. Specifically, the flexible links and insulation had been installed in this configuration since at least 1979.

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

Significance: G Mar 31, 2014

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Land Signal Wire from Differential Relay Output to Generator Lockout Relay

Inspectors documented a self-revealing finding for the licensee's failure to correctly land the signal wire from the Unit 2 auxiliary transformer differential relay output contacts to the main generator lockout relay, which contributed to the explosion of the Unit 2 auxiliary transformer. The licensee documented the issue in Condition Report CR ANO 2 2013 02242. The licensee aligned startup transformer 3 (preferred offsite power source) to carry the plant loads during normal power operations and restarted the plant on January 10, 2014.

Inspectors concluded that the licensee's failure to correctly land the wire, in accordance with the drawing, in the common circuit for the differential current relays was a performance deficiency. The performance deficiency was more than minor because it was associated with the human performance attribute of the initiating events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the non-landed wire resulted in catastrophic failure of the Unit 2 auxiliary transformer after a fault occurred. Using Inspection Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," June 19, 2012, and Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," June 19, 2012, Exhibit 1, "Initiating Events Screening Questions," the inspectors determined that the finding was of very low safety significance (Green) because the finding did not result in a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of a trip to a stable shutdown condition. Specifically, a fault would not have originated in phase C of the 6.9 kV bus of the auxiliary transformer if the flexible link had been correctly installed; the non-landed differential current relay wire only served to increase the likelihood of transformer explosion in the event of a fault on the 6.9 kV bus.

This finding did not have a cross-cutting aspect associated with it because the most significant contributor was not indicative of present performance. Specifically, the last time the wire could have been removed was 1995.

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

Significance: Y Feb 10, 2014

Identified By: NRC

Item Type: VIO Violation

Unit 2 - Failure to Follow the Materials Handling Program during the Unit 1 Generator Stator Move

Unit 2 Apparent Violation. The inspectors reviewed a self-revealing apparent violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," which states, in part, that "activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures or drawings." The licensee did not follow the requirements specified in Procedure EN-MA-119, "Material Handling Program," in that, the licensee did not perform an adequate review of the subcontractor's lifting rig design calculation and the licensee failed to conduct a load test of the lifting rig prior to use. The licensee initiated Condition Report CR-ANO-C-2013-00888 to capture this issue in the corrective action program. The licensee's corrective actions included repairing damage to the Unit 1 turbine deck, fire main system, and electrical system. In addition, changes were made to various procedures including Procedure EN-DC-114, "Project Management," to provide guidance on review of calculations, quality requirements, and standards associated with third party reviews.

The inspectors determined that this finding was more than minor because it was associated with the procedural control attribute of the initiating event cornerstone, and adversely affected the cornerstone's objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown, as well as power operations. The stator drop caused a reactor trip on Unit 2 and damage to the fire main system which resulted in water

intrusion into the electrical equipment causing a loss of startup transformer 3. This resulted in the loss of power to various loads, including reactor coolant pumps, instrument air compressors, and the safety-related Train B vital electrical bus. The inspectors used Inspection Manual Chapter 0609, Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, to evaluate the significance of the finding. Since this was an initiating event, the inspectors used Exhibit 1 of Appendix A and determined that Section C, "Support System Initiators," was impacted because the finding involved the loss of an electrical bus and a loss of instrument air. The inspectors determined that Section E, "External Event Initiators," of Exhibit 1 should also be applied because the finding impacted the frequency of internal flooding. Since Sections C and E were impacted, a detailed risk evaluation was required. The NRC risk analyst used the Arkansas Nuclear One, Unit 2 Standardized Plant Analysis Risk Model, Revision 8.21, and hand calculation methods to quantify the risk. The model was modified to include additional breakers and switching options, and to provide credit for recovery of emergency diesel generators during transient sequences. Additionally, the analyst performed additional runs of the risk model to account for consequential loss of offsite power risks that were not modeled directly under the special initiator. The largest risk contributor (approximately 96 percent) was a loss of all feedwater to the steam generators, with a failure of once-through cooling. The result of the analysis was a conditional core damage probability of 2.8E-5; therefore, this finding was preliminarily determined to have substantial safety significance (Yellow).

This finding had a cross-cutting aspect in the area of human performance associated with field presence, because the licensee did not ensure adequate supervisory and management oversight of work activities, including contractors and supplemental personnel. Specifically, the licensee did not provide a sufficient level of oversight in that, the requirements in Procedure EN-MA-119, for design approval and load testing of the temporary hoisting assembly, were not followed.

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

Mitigating Systems

Significance:  Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Alternate ac Diesel Generator Governor

The inspectors documented a self-revealing non-cited violation of 10 CFR 50.63, "Loss of all alternating current power," for the licensee's failure to maintain the alternate ac diesel generator so that a power source would be available to withstand and recover from a station blackout. Specifically, the licensee failed to perform adequate preventive maintenance on the governor of the diesel in accordance with the recommended vendor maintenance, which resulted in an overspeed trip of the engine during testing. The licensee repaired the governor and documented the issue in Condition Report CR-ANO-C-2013-00331.

The inspectors determined that the failure to perform adequate preventive maintenance on the governor of the alternate ac diesel generator in accordance with the recommended vendor maintenance was a performance deficiency. This performance deficiency was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and was therefore a finding. Specifically, the reliability of the alternate ac diesel generator was adversely affected by the lack of governor maintenance so that the diesel was unavailable to respond to a postulated station blackout. Using Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," June 19, 2012, and Appendix A, "The Significance Determination Process (SDP) for Findings at Power," June 19, 2012, Exhibit 2, "Mitigating System

Screening Questions,” the inspectors determined that the finding required a detailed risk evaluation because it was an actual loss of function of a non-technical specification train of equipment designated as high safety-significant in accordance with the licensee’s maintenance rule program for greater than 24 hours. The Region IV senior reactor analyst performed a detailed risk evaluation in accordance with Appendix A, Section 6.0, “Detailed Risk Evaluation.” The risk was dominated by internal loss of offsite power initiators and fire-induced loss of offsite power scenarios. The calculated change in core damage frequency was 8.9×10^{-7} for Unit 1 and 5.6×10^{-7} for Unit 2. The analyst also determined that the finding would not involve a significant increase in the risk of a large, early release of radiation. This finding has been determined to be of very low safety significance (Green).

Although the performance deficiency initially occurred over three years ago, the licensee documented in Condition Report CR-ANO-C-2014-00166 that the alternate ac diesel generator was not maintained commensurate with its risk significance and that a contributing cause was that management had not implemented a comprehensive maintenance strategy in accordance with the risk significance of the diesel. Therefore, inspectors concluded that the cause of the performance deficiency was reflective of present performance. Specifically, the licensee failed to implement a comprehensive preventative maintenance strategy on the alternate ac diesel generator governor commensurate with its risk significance [H.13]

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

Significance: G Feb 10, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Develop and Implement Adequate Procedural Controls to Remediate the Anticipated Effects of Internal Flooding for Either Unit

The inspectors reviewed a self-revealing, non-cited violation of Unit 1 Technical Specification 5.4.1.a and Unit 2 Technical Specification 6.4.1.a, involving the licensee’s failure to develop and implement procedural controls for response to internal flooding. Specifically, the licensee did not incorporate any instructions for the operation of the permanently installed temporary fire pump into procedures, which resulted in flooding due to the ruptured fire main header and not securing the temporary fire pump for approximately 50 minutes. The licensee’s corrective actions included changing Checklist 1104.032, “Fire Protection Systems,” Revision 76, to include guidance for securing the temporary fire pump in the event of a leak or rupture in the fire main header and provided personnel training on this change. This issue was entered into the corrective action program as Condition Reports CR-ANO-C-2013-01072 and CR ANO-C-2013-01962.

The inspectors determined that the licensee’s failure to develop and implement adequate procedural controls for the permanently installed temporary fire pump was a performance deficiency. The performance deficiency was more than minor because it was associated with the procedural quality attribute of the mitigating systems cornerstone and affected the cornerstone’s objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, if the necessary flood prevention/mitigation actions cannot be completed in the time required, much of the station’s accident mitigation equipment could be adversely impacted.

Unit 1 Analysis:

Inspection Manual Chapter 0609, Attachment 0609.04, “Initial Characterization of Findings,” dated June 19, 2012, Table 3, Section A, directs the user to Appendix G. The inspectors used Inspection Manual Chapter 0609, Appendix G, Attachment 1, “Shutdown Operations Significance Determination Process Phase 1 Operational Checklists for Both PWRs and BWRs,” dated May 25, 2004, Checklist 4, to evaluate the significance of the finding. The inspectors determined that the finding was of very low safety significance (Green) because the finding did not: (1) increase the

likelihood of a loss of reactor coolant system inventory, (2) degrade the licensee's ability to terminate a leak path or add reactor coolant system inventory when needed, or (3) degrade the licensee's ability to recover decay heat removal once it is lost.

Unit 2 Analysis:

Inspection Manual Chapter 0609, Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, Table 3, Section E, Step 2, directs the user to Appendix F, "Fire, Protection Significance Determination Process," dated September 20, 2013. The inspectors used Appendix F, to evaluate the significance of the finding. The finding involved a fixed fire protection system and the fire water supply (temporary fire pump). The finding was screened against the qualitative screening question in Appendix F, Task 1.3.1 and the inspectors determined it was of very low safety significance (Green), because the reactor was able to reach and maintain safe shutdown.

The finding had a cross-cutting aspect in area of the human performance associated with documentation, because the licensee failed to create and maintain complete, accurate, and up-to-date documentation for the use of the temporary fire pump

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

Significance:  Feb 10, 2014

Identified By: NRC

Item Type: FIN Finding

Main Feedwater Regulating Valve Maintenance Practices

The inspectors reviewed a self-revealing finding for the licensee's failure to provide appropriate work instructions for the replacement of the main feedwater regulating valve 2CV-0748 linear variable differential transformer 2ZT-0748. Specifically, the licensee failed to translate vendor recommendations for use of a thread sealant, and torquing of the adjustment nuts on the linear variable differential transformer 2ZT-0748 into procedural steps to be accomplished and verified. The failure to follow these recommendations resulted in the nuts falling off because of vibration. The licensee initiated Condition Report CR-ANO-2-2013-00423 and Work Order WT-WTANO-2013-00039 to update the work instructions and perform maintenance to repair the valve position indication by adding thread sealant and torquing the adjustment nuts to prevent them from loosening.

The inspectors determined that the failure to provide instructions to properly perform maintenance on linear variable differential transformer 2ZT-0748 was a performance deficiency. The performance deficiency was more than minor because it was associated with the procedure quality attribute of the mitigating systems cornerstone. It adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and is therefore a finding. The inspectors used Inspection Manual Chapter 0609, Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, to evaluate the significance of the finding. The inspectors determined the finding was of very low safety significance (Green) because the finding did not: (1) result in an actual loss of operability or functionality, (2) represent a loss of system and/or function, (3) represent an actual loss of function of a single train for greater than its technical specification allowed outage time, (4) represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant for greater than 24 hours, and (5) involve the loss or degradation of equipment or function specifically designed to mitigate a seismic, flooding, or severe weather event. The finding had a cross-cutting aspect in the area of the problem identification and resolution associated with operating experience, because although the licensee had collected and evaluated the operating experience, it was not implemented as procedural steps in linear variable differential transformer replacement work instructions

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

Significance: G Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Operability Evaluation Due to Failure to Characterize Weld Flaw

Inspectors identified a non-cited violation of 10 CFR 50.55a(b)(5), “In-Service Inspection Code Cases,” for the licensee’s failure to implement ASME Code Case N-513-2, “Evaluation Criteria for Temporary Acceptance of Flaws in Moderate Energy Class 2 or 3 Piping, Section XI, Division 1.” Specifically, when a service water weld developed a leak, the licensee failed to characterize the flaw using a volumetric inspection method. The licensee corrected the condition by performing volumetric inspections of the flawed weld and then repaired the weld. The licensee entered this issue into their corrective action program as Condition Report CR-ANO-2-2013-01961.

Inspectors concluded that the licensee’s failure to characterize a service water weld flaw was a performance deficiency. The performance deficiency was more than minor because it was associated with the human performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences, and is therefore a finding. Specifically, the licensee failed to ensure the reliability of the service water system wasn’t adversely affected by a significant weld flaw. Using Manual Chapter 0609, Attachment 4, “Initial Characterization of Findings,” and Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, the inspectors determined this finding was of very low safety significance (Green) because the degraded condition was not a design deficiency that affected system operability; did not represent an actual loss of function or a system; did not represent an actual loss of function of a single train or two separate trains for greater than its technical specification allowed outage time; did not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety significant; and did not involve the loss or degradation of equipment or function specifically designed to mitigate a seismic event.

The finding was determined to have a cross-cutting aspect in the area of human performance, associated with resources, for the licensee’s failure to ensure adequate training of personnel. Specifically, personnel performing the flaw inspection were not adequately trained in the non-destructive testing requirements of the code case.

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

Significance: G Nov 19, 2013

Identified By: NRC

Item Type: FIN Finding

Emergency Lights Satisfied their Maintenance Rule Performance Criteria

The team identified a finding for the failure to provide an adequate testing scheme to demonstrate that the Appendix R emergency lights satisfied their maintenance rule performance criteria. The team determined that operators were provided flashlights when they obtained the equipment bags required to perform an alternative shutdown. The licensee entered the issue into the corrective action program.

The failure to provide an adequate testing scheme to demonstrate that the Appendix R emergency lights satisfied their maintenance rule performance criteria was a performance deficiency. The performance deficiency was more than minor because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern.

The team assigned the finding a low degradation rating since the ability to reach and maintain safe shutdown conditions in the event of a control room fire would be minimally impacted by the potential failure of the emergency lights to function for 8-hours. Specifically, the team determined that the results of the previous annual 8-hour discharge tests provided reasonable assurance that the lights would function for 8 hours since the licensee had maintained the same battery replacement frequency. Because this finding had a low degradation rating, it screened as having very low safety significance. This finding had a cross-cutting aspect in the decision making component of the human performance area because the licensee’s decisions failed to demonstrate that nuclear safety is an overriding priority.

Specifically, the licensee failed to use conservative assumptions in decision making when changing the testing scheme for the Appendix R emergency lights. The team determined that the licensee failed to use conservative assumptions in decision making because the licensee failed to consider how the revised testing scheme would impact the maintenance rule program or demonstrate compliance with 10 CFR Part 50, Appendix R, Section III.J

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

Significance:  Sep 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Perform Preventive Maintenance on Plant Protection System Test Switch

The inspectors documented a self-revealing non-cited violation of Technical Specification 6.4.1.a for the licensee's failure to implement procedures specified by Regulatory Guide 1.33, Revision 2, Appendix A, February 1978.

Specifically, the licensee failed to implement a preventive maintenance task to periodically replace matrix test switches after the switches were installed. A new test switch was installed and replacement of similar switches was scheduled for the next refueling outage. The licensee entered this issue into their corrective action program as Condition Report CR-ANO-2-2013-0005.

The inspectors determined that the failure to implement preventive maintenance to replace the matrix test switches was a performance deficiency. The performance deficiency was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and was therefore a finding. Specifically, the degraded switch caused a safety system actuation, which resulted in the high pressure safety injection and the low pressure safety injection pumps to be placed in pull-to-lock, adversely affecting the availability of this equipment. Using Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," and Appendix A, "The Significance Determination Process (SDP) for Findings at Power," the inspectors determined that the finding required a detailed risk evaluation because it represented a loss of function. A Region IV senior reactor analyst performed the detailed risk evaluation. The exposure period was 48 minutes. The change to the core damage frequency was of 2.3 E-7 (Green). The dominant core damage sequences included inadvertent safety valve openings and small break loss of coolant accidents without injection available. The inspectors determined that there was no cross-cutting aspect associated with this finding because the cause of the performance deficiency occurred more than three years ago, and was not representative of current licensee performance.

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

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Jun 29, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish, Implement, and Maintain Appropriate Changes to the Offsite Dose Calculation Manual For Airborne Sampling

DRAFT

The inspectors identified two examples of a non-cited violation of Unit 1, Technical Specification 5.5.1, "Offsite Dose Calculation Manual (ODCM)," and Unit 2, Technical Specification 6.5.1, "Offsite Dose Calculation Manual." When changes were made to the ODCM in 1999, the licensee failed to (1) perform analyses or evaluations to justify changes to airborne radionuclide and/or particulate sampling requirements related to particulate air sampling collection frequency and (2) establish an airborne sampling location for a community in the highest deposition factor (D/Q) wind sector for the site. As immediate corrective actions, the licensee evaluated their offsite dose calculation manual and developed a plan to meet the environmental sampling requirements. The issue was documented in Condition Report CR-ANO-C-2014-01380.

The failure to follow the requirements of Unit 1, Technical Specification 5.5.1, and Unit 2, Technical Specification 6.5.1, is a performance deficiency. The performance deficiency is more than minor because it adversely affects the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the environment and public domain. Specifically, the failure to maintain the Offsite Dose Calculation Manual with appropriate airborne radionuclide sampling requirements adversely impacts the licensee's ability to validate offsite radiation dose assessments for members of the public under certain effluent release conditions. Using Inspection Manual Chapter 0609, Appendix D, dated February 12, 2008, "Public Radiation Safety Significance Determination Process," the inspectors determined that the violation has very low safety significance because it involves the environmental monitoring program. The violation has a cross-cutting aspect in the area of human performance, associated with procedure adherence, because licensee personnel failed to follow procedures when they established the sampling frequency and locations for the updated Radiological Environmental Monitoring Program Inspection Report# : [2014003](#) (*pdf*)

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 : August 29, 2014