

Cooper

3Q/2014 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2014

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 assess and document the basis for operability when a degraded or nonconforming condition was identified in accordance with Station Procedure 0.5OPS, “Operations Review of Condition Reports/Operability Determination.” Specifically, the licensee failed to adequately evaluate and document the basis for operability when opening the inner railroad airlock door, which serves as a tornado missile barrier for safety-related equipment inside the reactor building. To correct this issue, the licensee performed an operability evaluation and designated compensatory actions. The licensee entered this deficiency into their corrective action program for resolution as Condition Reports CR-CNS-2014-05207 and CR-CNS-2014-05366.

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 assess and document the basis for operability resulted in a condition of unknown operability for a degraded nonconforming condition. 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 avoiding complacency because individuals did not recognize and plan for the possibility of mistakes, latent problems, or inherent risk, even while expecting successful outcomes.

Inspection Report# : [2014004](#) (*pdf*)

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correctly Translate Design Requirements into Installed Plant Configurations

Inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," associated with the licensee's failure to assure that the applicable design basis for applicable structures, systems, and components were correctly translated into specifications, procedures, and instructions. Specifically, the licensee failed to correctly translate design requirements associated with high energy line breaks into the as-built facility for the service water pump room, diesel generator rooms 1 and 2, cable spreading room, and 4160 Vac vital switch gear room G. This does not represent an immediate safety concern because the licensee performed operability assessments for the affected areas, which established a reasonable expectation for operability pending resolution of the identified issue. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2014-01828.

The failure to ensure that design requirements were correctly translated into installed plant equipment 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. Specifically, the licensee's failure to translate the design requirements into installed plant equipment resulted in a condition where structures, systems and components necessary to mitigate the effects of a high energy pipe break may not have functioned as required. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, "Mitigating Systems Screening Questions," 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 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 non-technical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. Inspectors determined that this finding did not have a cross-cutting aspect because the most significant contributor of this finding occurred in 2003, and does not reflect current licensee performance.

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

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Seismic Housekeeping Requirements for Scaffolding

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 the requirements of Station Procedure 0.41, "Seismic Housekeeping," Revision 10. Specifically, the licensee stored a rolling scaffold in the vicinity of Division II service water booster pumps and failed to properly restrain it. The licensee restrained the rolling scaffold in accordance with Station Procedure 0.41 and assessed operability of the service water booster pumps. The licensee determined that during the time the rolling scaffold was unrestrained one of the Division II service water booster pumps was inoperable. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2014-03000.

The licensee's failure to follow Station Procedure 0.41 seismic housekeeping requirements for a rolling scaffold in the vicinity of Division II service water booster pumps 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. Specifically, the unrestrained scaffolding resulted in a condition where during a seismic event a service water booster pump may not have been able to perform its specified safety function. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, "Mitigating Systems Screening Questions," 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 a least a single train for longer than its technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more non-technical 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 training because the organization failed to provide training and ensure knowledge transfer to maintain a knowledgeable, technically competent workforce and instill nuclear safety values [H.9].

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

Significance:  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 1×10^{-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 [H.8].

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

Significance:  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 [H.14].

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

Significance: G Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify and Correct a Condition Adverse to Quality

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

The licensee’s failure to promptly identify and correct a condition adverse to quality was a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the design control attribute of the Mitigating Systems Cornerstone, and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” dated July 1, 2012, inspectors determined this finding to have very low safety significance (Green) because it: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or

function; (3) did not represent an actual loss of function of at least a single train for longer allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with 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 [H.1(b)].

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 1×10^{-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 [H4.(b)].

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 [H.1(b)].

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

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 [H.12].

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

Emergency Preparedness

Significance:  Sep 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow a Requirement of the Emergency Plan

The inspectors identified a non-cited violation for the licensee's failure to follow the site emergency plan between March 6, 2008, and June 23, 2014, as required by 10 CFR 50.54(q)(2). Specifically, the licensee failed to store respiratory protection equipment (self-contained breathing apparatus) at the on-site Communications Building in accordance with the requirements of Emergency Plan, Revision 64, Section 7.8. The condition was entered into the licensee's corrective action program as Condition Report CR-CNS-2013-07882.

The failure to follow the site emergency plan was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the facilities and equipment attribute of the Emergency Preparedness Cornerstone and adversely affected the cornerstone objective to ensure the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Specifically, the licensee failed to maintain respiratory protection equipment in the Communications Building contrary to the emergency plan requirement. This finding was evaluated using Manual Chapter 0609, "Emergency Preparedness Significance Determination Process," dated February 24, 2014, and was determined to be of very low safety significance because it was a failure to comply with an NRC requirement, was not a loss of planning standard function, and was not a degraded planning standard function. The planning standard function was not degraded because some respiratory protection equipment was available on-site for use by emergency workers. This finding has a cross-cutting aspect in the area of human performance associated with change management because the finding was caused by the licensee's failure in 2008 to complete a change to the site emergency plan.

Inspection Report# : [2014004](#) (*pdf*)

Significance:  Sep 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correct an Inaccurate Classification During a Drill

The inspectors identified a non-cited violation for the licensee's failure to correct a deficiency occurring in a drill conducted on December 18, 2013, as required by 10 CFR 50.47(b)(14). Specifically, licensee evaluators failed to identify that the shift manager declared a General Emergency during a licensed-operator training proficiency drill when the conditions did not exist. This issue has been entered into the licensee's corrective action program as Condition Reports CR-CNS-2014-05286 and CR-CNS-2014-05291.

The licensee's failure to correct a weakness in performance occurring during a drill was a performance deficiency. A weakness is defined in Manual Chapter 0609, Appendix B, as being performance, during a drill or exercise, that would have prevented the effective implementation of the emergency plan had the circumstances actually occurred. The performance deficiency was more than minor, and therefore a finding, because it was associated with the Emergency Response Organization performance attribute of the Emergency Preparedness Cornerstone and adversely affected the cornerstone objective to ensure the licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Specifically, the declaration of a General Emergency when conditions did not exist for the declaration would have prevented the effective implementation of the site emergency plan. This finding was evaluated using Manual Chapter 0609, "Emergency Preparedness Significance Determination Process," dated February 24, 2014, and was determined to be of very low safety significance because it was a failure to comply with NRC requirements, was not a loss of planning standard function, and was not a degraded planning standard function. The planning standard function was not degraded because the

failure to implement corrective actions occurred during a single-facility drill with limited number of evaluators. This finding has a cross-cutting aspect in the area of problem and identification associated with the identification of problems because the licensee failed to identify a performance problem when it occurred.

Inspection Report# : [2014004](#) (*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 [H.4(a)].

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

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related

information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Report Conditions Prohibited by Technical Specifications

Inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.73, "Licensee Event Report," associated with the licensee's failure to submit a licensee event report within 60 days following discovery of an event meeting the reportability criteria. Specifically, a condition prohibited by technical specifications existed for trip and throttle valve RCIC-MOV-14 for a period of time longer than the allowed outage time. This does not represent an immediate safety concern because this issue is only associated with reporting requirements. The licensee entered this deficiency into their corrective action program for resolution as Condition Reports CR-CNS-2014-03387 and CR-CNS-2014-03457.

The licensee's failure to submit a licensee event report within 60 days following discovery of an event meeting the reportability criteria 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. The violation was evaluated using Section 2.3.11 of the NRC Enforcement Policy, because the failure to submit a required licensee event report may impact the ability of the NRC to perform its regulatory oversight function. In accordance with Section 6.9, Example 9, of the NRC Enforcement Policy, this violation was determined to be a Severity Level IV non-cited violation. Inspectors determined that a cross-cutting aspect was not applicable to this performance deficiency because the failure to make a required report was strictly associated with a traditional enforcement violation.

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

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 Severity Level IV 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 : November 26, 2014