Fermi 2
3Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2014
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Incorporate Operating Experience into Preventive Maintenance Activities
A finding of very low safety significance with an associated non-cited violation of 10 CFR 50.65, "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was self-revealed on March 18, 2014, when the failure of a reactor protection system (RPS) power contactor caused an invalid half-scram due to loss of power and the resultant closure of several containment isolation valves during the Cycle 16 refueling outage. The licensee failed to incorporate operating experience into its preventive maintenance practices and implement preventive maintenance activities to inspect and replace RPS power contactors susceptible to age-related degradation and failure. The licensee replaced the failed contactor and initiated a corrective action to create preventive maintenance activities for inspecting and replacing the two RPS power contactors.
The finding was of more than minor safety significance because if left uncorrected it would have the potential to lead to a more significant safety concern. Under different plant operating conditions, the RPS power contactor failure and loss of power could have resulted in a reactor scram or loss of shutdown cooling event. In addition, the finding was sufficiently similar to Inspection Manual Chapter 0612, "Power Reactor Inspection Reports," Appendix E, "Examples of Minor Issues," Example 7(c), in that this violation of 10 CFR 50.65(a)(3) had a consequence "…such as equipment problems attributable to failure to take industry operating experience into account when practicable." The finding was determined to be a licensee performance deficiency of very low safety significance during a detailed quantitative Significance Determination Process review since the delta core damage frequency was determined to be much less than 1.0E-6/year. The inspectors concluded this finding affected the cross cutting area of problem identification and resolution. Specifically, in the area of operating experience (P.5), the licensee did not appropriately evaluate and implement relevant external operating experience in a timely manner. A licensee review of preventive maintenance activities for RPS logic relays was performed following an RPS response time test failure in November 2010, during which the licensee identified that preventive maintenance activities to replace the two RPS power contactors were never created in response to operating experience it had received in 1990. Corrective actions from the November 2010 evaluation to perform the RPS power contactor replacements were still open when the event occurred in March 2014. The licensee completed two refueling outages in the interim, which would have afforded opportunities to replace the RPS power contactors.
Inspection Report# : 2014004 *(pdf)*

Mitigating Systems

Significance: G Sep 30, 2014
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Promptly Correct a Condition Adverse to Quality on EDG 11
A finding of very low safety significance with an associated non-cited violation of 10 CFR 50, Appendix B, Criterion

XVI, “Corrective Action,” was self-revealed on March 20, 2014, when operators manually shut down emergency diesel generator (EDG) 11 while it was running for surveillance testing during the Cycle 16 refueling outage. A fire had ignited due to oil pooling underneath insulation on the engine exhaust manifold from a gasket leak on the front engine cover. The licensee failed to take timely corrective action after increased smoke was previously observed coming from underneath the exhaust manifold insulation on December 12, 2012. As immediate corrective actions, the licensee replaced insulation on the exhaust manifolds of all 4 EDGs with a different configuration to eliminate the seam that was located right under the corner of the front cover, retightened the bolts on the front engine covers of all four EDGs, and applied sealant to the area of the leak on the EDG 11 front engine cover until the gasket could be replaced.
The finding was of more than minor significance because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the failure to promptly initiate corrective action when a degraded condition was identified on EDG 11 resulted in a fire, manual engine shutdown, and an Alert emergency declaration during a surveillance test run. The finding was a licensee performance deficiency of very low safety significance because it: (1) was not a deficiency affecting the design or qualification of a mitigating SSC, (2) did not represent a loss of system safety function, (3) did not represent an actual loss of safety function of at least a single train for greater than its Technical Specification (TS)-allowed outage time, (4) did not represent an actual loss of safety function of one or more non TS trains of equipment designated as risk significant for greater than 24 hours during shutdown with the reactor cavity flooded, (5) did not degrade a functional auto-isolation of RHR on low reactor vessel level, and (6) did not screen as potentially risk significant due to a fire, seismic, flooding, or severe weather initiating event. The inspectors determined this finding affected the cross-cutting area of human performance due to the licensee’s failure to implement a process of planning, controlling, and executing work activities such that safety is the overriding priority. The work management process (H.5) includes the identification and management of risk commensurate to the work; however, due to complacency and failure to appropriately apply operating experience involving EDG exhaust manifold fires on Fairbanks-Morris engines, the licensee did not appropriately manage the risk associated with delaying corrective action for the adverse condition identified about 1½ years prior to the event.
Inspection Report# : 2014004 *(pdf)*

Significance: G Sep 12, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Incorrect Valve Location in Procedure
The inspectors identified a finding of very low safety significance (Green) and associated NCV of Technical Specifications (TS) Section 5.4.1.a for the licensee’s failure to maintain Procedure 20.000.23, “High RPV [Reactor Pressure Vessel] Water Level” to address an RPV overfill event. Specifically, the licensee provided an incorrect location of a manual valve in the Standby Feedwater (SBFW) system. The procedure described the valve as being located in the turbine building basement, while the valve was actually located in a locked high radiation area in the north heater room. The licensee revised the procedure to include the correct location of the valve.

The inspectors determined that the issue was more than minor because a reactor overfill event could impair the RCIC and HPCI systems during a fire in fire zone RW. The finding affected the Mitigating Systems cornerstone. The finding was determined to be of very low safety significance based on a detailed risk-evaluation. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution because the licensee did not take effective corrective actions to address a potential reactor pressure vessel overfill event.

Inspection Report# : 2014007 *(pdf)*

Significance: G Jun 30, 2014

Identified By: NRC
Item Type: FIN Finding
Incorrect Application of TSSR 3.0.3 to Never-Performed Battery Surveillances
The inspectors identified a finding of very low safety significance. Upon discovery that surveillance testing procedures for safety-related batteries had not fully satisfied the applicable Technical Specification Surveillance Requirements (TSSRs), the licensee incorrectly used the provision of TSSR 3.0.3 to not declare the applicable Limiting Condition for Operation (LCO) not met and enter the appropriate condition(s), as required by TSSR 3.0.1 and Technical Specification (TS) 3.0.2, without considering the distinction between a missed surveillance versus a never-performed surveillance. Because the licensee subsequently completed the battery surveillance satisfactorily and the required actions of TS 3.8.5 Condition were fortuitously met, no violation of TS 3.02 or TS 3.8.5 was identified. The licensee entered this performance deficiency into its corrective action program for evaluation and identification of appropriate corrective actions. The finding was of more than minor significance because a failure to correctly implement LCO and surveillance requirements has the potential to lead to a more significant safety concern if left uncorrected. Specifically, a failure to declare an LCO not met, enter the applicable condition(s), and follow the applicable actions could reasonably result in operations outside of established safety margins or analyses. The finding was determined to be of very low safety significance because adequate mitigation capability remained, and the issue did not involve a loss of inventory control. The issue also did not involve an actual loss of function of the direct current electrical power system because battery terminal connection resistance measurements were acceptable when subsequently performed. The inspectors determined this finding affected the cross cutting area of human performance because a conservative bias in decision making was not demonstrated by the licensee's assumption that TSSR 3.0.3 would apply to the never-performed surveillances (H.14). Prior to applying TSSR 3.0.3, the licensee did not appropriately consider the distinction between a late versus a never-performed surveillance and had not prepared a basis to conclude the surveillances had been adequately demonstrated outside of routine surveillances. The licensee's position paper one month after the fact rationalized the assumption without providing objective quality evidence to support its conclusion.

Inspection Report# : 2014003 *(pdf)*

Significance:  Jun 30, 2014
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Mis-Positioned Control Switch Inadvertently Rendered the Division 2 EECW System and Supported Systems Inoperable
A finding of very low safety significance with an associated non-cited violation of Technical Specification 5.4.1.a was self-revealed on February 6, 2014, when the Division 2 emergency equipment cooling water (EECW) system and its supported systems were inadvertently rendered inoperable. Control Room operators incorrectly positioned the Division 2 EECW isolation override switch to manual override while attempting to place the system in its normal standby configuration, disabling the system's automatic initiation function. The licensee promptly restored the affected systems to an operable status by returning the override switch back to normal. The issue was entered into the licensee's corrective action program for evaluation and additional corrective actions. The finding was of more than minor significance since 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 (i.e., core damage). Specifically, the mis-positioned control switch rendered the Division 2 EECW system and its supported systems inoperable. The finding was determined to be of very low safety significance during a detailed quantitative Significance Determination Process review since the delta core damage frequency was determined to be less than 1.0E-7/year using the NRC Standardized Plant Analysis Risk model. The inspectors concluded this finding affected the cross cutting area of human performance since adequate licensee personnel work practices did not support successful human performance (H.12). Specifically, human error prevention techniques, such as pre-job briefing and peer checking, were not adequately used to ensure that the correct procedure section was performed.

Inspection Report# : 2014003 *(pdf)*

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Control the Work Hours of a Covered Worker
The inspectors identified a finding of very low safety significance with an associated non-cited violation of 10 CFR 26.205(c) and (d) for the licensee's failure to schedule and control the work hours of a covered worker directing and performing surveillance testing on a safety-related check valve during the refueling outage. Specifically, an engineer performing inservice testing was scheduled successive 12 hour shifts and was inappropriately excluded from the work hour limits specified in 10 CFR 26.205(d)(1) and (d)(2). As part of its corrective action, the licensee removed the engineer from covered work activities for the remainder of the refueling outage and reviewed the work activities of other engineers to ensure that any engineer performing covered work appropriately met work hour limits.

The finding was of more-than-minor significance since the failure to schedule and control the work hours of a worker performing covered work, if left uncorrected, would become a more significant safety concern because it could reasonably result in human performance errors that could affect the function of safety-related structures, systems, and components. Since the issue involved inservice testing on a safety-related emergency core cooling system check valve, the inspectors concluded this issue was associated with the Mitigating Systems Cornerstone. The finding was a licensee performance deficiency of very low safety significance because it: (1) was not a design or qualification deficiency; (2) did not represent an actual loss of function of a system; (3) did not represent an actual loss of function of a single train or two separate trains for greater than its Technical Specification (TS) allowed outage time; (4) did not represent an actual loss of function of one or more non TS trains of equipment designated as high safety significant; and (5) did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The inspectors concluded this finding affected the cross cutting area of human performance and the cross-cutting aspect of resources (H.1). Specifically, the engineer did not meet expectations regarding the performance of covered work activities because he did not challenge his role in directing the work activity and he assisted the maintenance craftsman while the craftsman attempted to exercise the check valve. In addition, licensee management inappropriately assigned the engineer responsibility for the test activity without ensuring he was in compliance with the 10 CFR 26.205 work hour requirements.

Inspection Report# : 2014002 *(pdf)*

Significance: G Dec 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
RHR Pump Seal Cooler Test Was Not Adequately Implemented
The inspectors identified a finding of very low safety significance with an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," for the failure to demonstrate the cooling capability of the residual heat removal pump seal coolers. Specifically, on December 4, 2013, the inspectors noted examples of missed and late inspections, and examples of as-found conditions not evaluated. This finding was entered into the licensee's corrective action program, in part, to provide additional guidance in the preventive maintenance program database to ensure the Generic Letter 89-13 Program inspection requirements were implemented for these heat exchangers.

The performance deficiency was determined to be of more than minor safety significance because it was associated with the Mitigating Systems Cornerstone attribute of Equipment Performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of the residual heat removal pumps to respond to initiating events to prevent undesirable consequences. The finding screened as very low safety significance because it

did not result in the loss of operability or functionality. Specifically, the licensee reviewed the maintenance history of the coolers and determined it provided reasonable assurance of acceptable heat transfer. The inspectors did not identify a cross-cutting aspect associated with this finding because it was confirmed to not reflect current performance due to the age of the performance deficiency.

Inspection Report# : 2013005 *(pdf)*

Significance: G Dec 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Acceptance Criteria for UHS Level and Temperature Did Not Consider Instrument Uncertainties
The inspectors identified a finding of very low safety significance with an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to include appropriate acceptance criteria for ultimate heat sink level and temperature in surveillance procedures. Specifically, as of December 5, 2013, the inspectors identified that these acceptance criteria did not account for instrument uncertainties. This finding was entered into the licensee's corrective action program, in part, to revise the acceptance criteria included in the associated surveillance procedure to account for instrument uncertainties.

The performance deficiency was determined to be of more than minor safety significance because it was associated with the Mitigating Systems Cornerstone attribute of Equipment Performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of the ultimate heat sink to respond to initiating events to prevent undesirable consequences. The finding screened as very low safety significance because it did not result in the loss of operability or functionality. Specifically, a historic review did not find an example where the Technical Specification limits were exceeded when accounting for instrument uncertainties. The inspectors did not identify a cross-cutting aspect associated with this finding because it was confirmed to not reflect current performance due to the age of the performance deficiency.

Inspection Report# : 2013005 *(pdf)*

Significance: G Dec 31, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Nonconforming Materials Used in EDG Air Coolant Piping System
A finding of very low safety significance with an associated Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XV, "Nonconforming Materials, Parts, or Components," was self-revealed on August 9, 2013, when operators had to manually shut down emergency diesel generator (EDG) 14 due to high air coolant system inlet temperature during a 24-hour surveillance test run. The high temperature condition occurred due to the licensee's failure to adequately control the installation of the EDG 14 air coolant system control air pipe fitting between the relief valve and pressure regulator to prevent the use of materials that did not conform to design requirements. The licensee completed repairs to the EDG 14 air coolant system and returned the EDG to an operable status. The issue was entered into the licensee's corrective action program for evaluation and additional corrective actions.

The finding was of more than minor safety significance since it was associated with the Design Control attribute and adversely affected the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the use of nonconforming materials led to failure of the EDG 14 air coolant system control air pipe fitting, which rendered the EDG inoperable. Although the finding involved an actual loss of function of a single train for greater than its Technical Specification allowed outage time, it was determined to be of very low safety significance during a detailed quantitative Significance Determination Process review since the delta core damage frequency was determined to be

less than 1E-7/year using the NRC Standardized Plant Analysis Risk model. The inspectors concluded that because the nonconforming control air pipe fitting was installed in the EDG 14 air coolant system in 1988 and the most recent missed opportunity to correct the problem occurred in 2005 or 2006, this issue would not be reflective of current licensee performance and no cross-cutting aspect was identified.

Inspection Report# : 2013005 *(pdf)*

Barrier Integrity

Significance: G Mar 31, 2014
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Perform Appropriate Preventive Maintenance on Reactor Building Heating, Ventilation, and Air Conditioning Components
A finding of very low safety significance with an associated non-cited violation of 10 CFR 50.65(a)(2) was self-revealed on November 24, 2013, for the licensee's failure to demonstrate that the performance of the temperature switches, steam traps, and drains of the reactor building heating, ventilation, and air conditioning (RBHVAC) system were effectively controlled through appropriate preventive maintenance or monitored as specified in 10 CFR 50.65(a)(1), such that the RBHVAC system remained capable of performing its intended function. The lack of preventive maintenance on these components for the RBHVAC system led to its failure and resulted in a loss of the safety function of secondary containment. Corrective actions included the creation of work orders to replace the remaining steam traps and reclassification of the steam traps and drains as Non-Critical in the licensee's preventive maintenance program with annual preventive maintenance activities for cleaning scheduled prior to the heating season.

The finding was of more-than-minor significance since it was associated with the Structures, Systems, and Components and Barrier Performance attribute of the Barrier Integrity Cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, inadequate preventive maintenance of the RBHVAC system components resulted in a trip of the system. Therefore, this performance deficiency had a direct effect on the licensee's ability to maintain the safety function of secondary containment. The finding was a licensee performance deficiency of very low safety significance because it represented only a degradation of the radiological barrier function provided for the Reactor Building. This finding affected the cross-cutting area of problem identification and resolution and the cross-cutting aspect of trending (P.4). Specifically, over the past several years there were multiple trips of the RBHVAC system documented in the licensee's corrective action program from failures of temperature switches, steam traps, and drains, including an event from January 22, 2013, that also resulted in a loss of the secondary containment function. The licensee failed to analyze this information in the aggregate to identify and correct the issue.

Inspection Report# : 2014002 *(pdf)*

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Unacceptable Preconditioning of High Pressure Coolant Injection System Air Operated Valve Prior to Stroke Time Test Measurement
The inspectors identified a finding of very low safety significance with an associated non-cited violation of 10 CFR

50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings.” The licensee failed to establish an adequate procedure to perform required stroke time testing for high pressure coolant injection turbine supply drain pot to main condenser drain line isolation valve E4100-F028. Specifically, the surveillance test procedure resulted in unacceptable preconditioning of the valve prior to the stroke time test measurement. The licensee entered this issue into its corrective action program for evaluation and initiated a corrective action to revise the test procedure.

The finding was of more-than-minor significance since it was associated with the Procedure Quality attribute of the Barrier Integrity Cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Because the preconditioning altered the as-found condition of the air-operated valve, the data collected through the performance of the surveillance test were not fully indicative of the true valve performance trend. Therefore, this performance deficiency had a direct effect on the licensee’s ability to trend as-found data for the purpose of assessing the reliability of the valve. The finding was a licensee performance deficiency of very low safety significance because it did not involve an actual open pathway in the physical integrity of the Auxiliary Building. The inspectors concluded that because the valve testing sequence that unacceptably preconditioned E4100-F028 had existed in the surveillance test procedure for greater than three years and no opportunity reasonably existed during that time to identify and correct it, this issue would not be reflective of current licensee performance and no cross cutting aspect was identified.
Inspection Report# : 2014002 *(pdf)*

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform Inservice Testing of High Pressure Coolant Injection and Reactor Core Isolation Cooling System Valves
The inspectors identified a finding of very low safety significance with an associated non-cited violation of 10 CFR 50.55a. The licensee failed to perform required inservice testing of high pressure coolant injection and reactor core isolation cooling turbine supply drain pot to main condenser drain line isolation valves E4100-F029, E5150-F025, and E5150-F026. The licensee entered this issue into its corrective action program for evaluation, completed an immediate operability determination, and initiated a corrective action to revise applicable test procedures to incorporate inservice testing of the valves.

The finding was of more-than-minor significance since it was associated with the Structures, Systems, and Components and Barrier Performance attribute of the Barrier Integrity Cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the licensee’s failure to perform required inservice testing had a direct effect on its ability to trend as-found performance data for the purpose of assessing the reliability of the three isolation valves, which are required by design to isolate seismically qualified portions of the piping systems from non-seismically qualified portions. The finding was a licensee performance deficiency of very low safety significance because it did not involve an actual open pathway in the physical integrity of the Reactor and Auxiliary Buildings. The inspectors concluded that because the engineering evaluation that excluded the valves from inservice testing was completed in 1999 and no recent opportunity reasonably existed to identify and correct the error, this issue would not be reflective of current licensee performance and no cross cutting aspect was identified.
Inspection Report# : 2014002 *(pdf)*

Significance: G Dec 31, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Correctly Connect Thermocouple Wiring During Maintenance Resulted in Inoperable Reactor Core Isolation Cooling System Isolation Instrumentation

A finding of very low safety significance with an associated Non-Cited Violation of Technical Specification (TS) 5.4.1.a was self-revealed on August 30, 2013, when the Division 1 Reactor Core Isolation Cooling (RCIC) Equipment Room temperature input to the associated steam line isolation logic was discovered inoperable during a scheduled surveillance test. Maintenance craftsmen had failed to correctly terminate thermocouple wiring as specified by the work instructions during maintenance to replace terminal block knife switches two weeks earlier. As a result, the Division 1 RCIC Equipment Room temperature input to the associated steam line isolation logic for RCIC steam supply primary containment outboard isolation valve 1E51-F008 was rendered inoperable for greater than the TS 3.3.6.1 completion time. The licensee promptly corrected the wiring discrepancy and restored the Division 1 RCIC system steam line isolation logic to an operable status. The issue was entered into the licensee's corrective action program for evaluation and additional corrective actions.

The finding was of more than minor safety significance since it was associated with the Human Performance attribute and adversely affected the Barrier Integrity Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the Division 1 RCIC system steam line isolation logic was rendered inoperable for greater than the TS 3.3.6.1 completion time because maintenance craftsmen failed to correctly terminate thermocouple wiring as specified by the procedure when replacing terminal block knife switches. The finding was a licensee performance deficiency of very low safety significance because it only represented a degradation of the radiological barrier function provided for the Reactor Building and was not a complete loss of the barrier function provided by the RCIC system steam line isolation instrumentation since the Division 2 RCIC system steam line isolation logic remained operable. The inspectors concluded that this finding affected the cross-cutting area of human performance since adequate licensee personnel work practices did not support successful human performance. Specifically, human error prevention techniques, such as self and peer checking, were not adequately used to ensure the thermocouple wiring was correctly terminated upon replacing the terminal block knife switches (H.4(a)).

Inspection Report# : 2013005 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Jun 30, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Disabled Respirator Safety Feature
The inspectors identified a finding of very low safety significance with an associated non-cited violation of 10 CFR 20.1703(c)(4)(vii) for defeating a safety feature for the Mururoa V4 MTH2 air-supplied suit (Delta Suit) Respirator, i.e., placement of tape over an escape zipper. This issue was entered into the licensee's corrective action program as Condition Assessment Resolution Document 14-21795. The licensee is currently evaluating necessary changes to its program. The performance deficiency was determined to be of more than minor safety significance in accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," because it was associated with the program and process attribute of the Occupational Radiation Safety Cornerstone and adversely affected the cornerstone objective to ensure worker health and safety from exposure to radioactive material. In accordance with IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," the inspectors determined the finding had very low safety significance because the finding did not involve: (1) as-low-as-is-reasonably achievable

planning or work controls, or (2) an overexposure, or (3) a substantial potential for an overexposure, or (4) a compromised ability to assess dose. The inspectors identified that the primary cause of this finding was related to the cross-cutting area of human performance with the aspect of documentation (H.7). Specifically, the licensee failed to create and maintain documentation that is consistent with manufacturer recommendations. The licensee did not ensure the procedure used for this activity was current.

Inspection Report# : 2014003 *(pdf)*

Public Radiation Safety

Security

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

Miscellaneous

Last modified : November 26, 2014