

Columbia Generating Station 3Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Jun 22, 2014

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Perform Adequate Verification of Breaker Cubicle Fit Results in Loss of Reactor Recirculation Pump

The inspectors reviewed a self-revealing Green finding for the licensee's failure to verify that circuit breaker E-CB-S5 was properly installed in accordance with procedure SOP-ELEC-BKR-OPS, "AC Electrical Breaker Racking," Revision 10. The improper installation of breaker E-CB-S5 resulted in an unexpected loss of bus E-SH-5 during a bus transfer and trip of reactor recirculation pump RRC-P-1A. The licensee entered this issue into their corrective action program as Action Request (AR) 302282.

The finding was more than minor because it affected the configuration control attribute of the Initiating Events Cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. This finding is of very low safety significance (Green) because it did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. This finding has a cross-cutting aspect in the area of human performance because the licensee failed to ensure that tools, equipment and other resources were available to adequately support verification of breaker racking activities [H.1].

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

Mitigating Systems

Significance: G Jun 22, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Corrective Actions to Address Extent of Cause for Service Water Pump Coupling Failures

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions" for the licensee's failure to implement corrective actions to address identified weaknesses in the preventative maintenance program. Specifically, the licensee failed to perform required inspections of the residual heat removal and low pressure core spray pumps which were identified during an extent of cause evaluation following the failure of service water pump 1A in June 2005. The licensee entered this issue into their corrective action program as Action Request AR 301887.

This finding was more than minor because, if left uncorrected, the failure to periodically inspect the residual heat removal and low pressure core spray pumps could become a more significant safety concern. Specifically, because these pumps are subject to NRC Part 21 report 1998-51-1 involving broken cast iron suction heads in type APKD pumps, the failure to inspect could result in unrecognized degraded conditions on these components that could potentially affect pump performance. The inspectors performed an initial screening of the finding in accordance with

NRC Manual Chapter IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined this finding is of very low safety significance (Green) because: (1) the finding was not a deficiency affecting the design or qualification of a mitigating system; (2) the finding did not represent a loss of system and/or function; (3) the finding did not represent an actual loss of function of a single train for greater than its technical specification allowed outage time; and (4) the finding does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule program for greater than 24 hours. The inspectors determined that this finding did not have a cross-cutting aspect since the decision to defer required inspections of the residual heat removal pumps and low pressure core spray pumps was made just prior to refueling outage R18 in May 2007 and were not reflective of current performance.

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

Significance:  Jun 22, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Procedures That Ensure Operators Could Perform Time Critical Steps For Fire Events

The inspectors identified a green non-cited violation of Columbia Generating Station Technical Specification 5.4.1.a for the failure of the licensee to implement procedures that ensure operators could perform time critical steps for fire events. The licensee restored compliance by initiating Action Request 306204 documenting the non-compliance with PPM 1.3.1 and issued Night Order 1527 reminding all operating crews of the requirements of PPM 1.3.1 for leaving the Protected Area.

This performance deficiency was more than minor because it was associated with the protection against external factors attribute of the Mitigating System 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. A senior reactor analyst assessed this finding using NRC Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination," dated September 20, 1013 and NRC Inspection Manual 0308, Attachment 3, Appendix F, "Technical Basis Fire Protection Significance Determination Process (Supplemental Guidance for Implementing IMC 0609, Appendix F) At Power Operations," dated February 28, 2005. The finding screened to Green because it had a low degradation rating. This finding had a cross-cutting aspect in the area of human performance associated with change management because the licensee failed to use a systematic process for evaluating and implementing change so that nuclear safety remains the overriding priority. By deviating from procedure PPM 1.3.1 to facilitate FFD testing and equipment logs, the licensee implemented a change that was not part of a systematic process and did not prioritize nuclear safety [H.3].

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

Significance:  Jun 22, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Procedures For a Design Basis Ashfall Event

The inspectors identified a green non-cited violation of Technical Specification 5.4.1.a for the licensee's failure to maintain procedures for mitigating a design-basis volcanic ashfall event. The licensee restored compliance by initiating AR 304380 and modifying the staged combustion filters for the emergency diesel generator. Additionally, the licensee issued night order 1520 until the ABN-ASH "Ash Fall" procedure could be updated.

This performance deficiency was more than minor because it was associated with the procedure quality attribute of the mitigating systems cornerstone and adversely affected the cornerstone's objective of ensuring the availability,

reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance (Green) because it did not involve a loss or degradation of equipment or function specifically designed to mitigate a seismic, flooding, or severe weather initiating event. This finding has a cross-cutting aspect in the area of problem identification and resolution because the licensee did not implement a corrective action program with a low threshold for issues. The licensee had several recent opportunities to identify this issue. In March 2011, a complete walkthrough of ABN-ASH "Ash Fall" was performed and problems were documented in AR 236015. Additionally, ashfall filter inventories in April 2011 under Work Order 02005018 and March 2014 under Work Order 02046624 failed to identify the issue [P.1].

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

Significance:  Mar 23, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Subject Diesel Generator Intake Air Pre-Filters to the Controls of the Quality Assurance Program

The inspectors identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion II, "Quality Assurance Program," for the licensee's failure to apply the applicable quality assurance requirements of 10 CFR 50, Appendix B, "Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants," to the diesel generator air intake pre-filters. The licensee entered this issue into their corrective action program as Action Request 301711.

The performance deficiency was more than minor because it affected the design control 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. Using NRC IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," and IMC 0609, Appendix A, Exhibit 2 – Mitigating Systems Screening Questions, the inspectors determined that the finding was of very low safety significance (Green) because it did not involve a loss or degradation of equipment or function specifically designed to mitigate a seismic, flooding, or severe weather initiating event. The finding does not have a cross-cutting aspect because the performance deficiency occurred during system design using a different process than currently exists and was therefore not reflective of current performance.

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

Significance:  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Translate Internal Flooding Design into Station Procedures

Green. The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to translate the design of water resistant doors used to protect emergency core cooling rooms from internal flooding into procedures used to control those doors. This finding was entered into the licensee's corrective action program as Action Request AR 298068.

The performance deficiency was more than minor because it affected the procedure quality attribute of the mitigating systems cornerstone objective and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, this performance deficiency resulted in guidance to operators which would allow continuous operation outside of the design basis. The inspectors performed an initial screening of the finding in accordance with NRC Manual Chapter IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined this finding is of very low safety significance (Green) because: (1) the finding was not a deficiency affecting the design or qualification of a mitigating system; (2) the finding did not represent a loss of system and/or function; (3) the finding did not represent

an actual loss of function of a single train for greater than its technical specification allowed outage time; and (4) the finding does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule program for greater than 24 hours. This finding had a cross-cutting aspect in the area of human performance associated with the decision making component because the licensee failed to verify the validity of the underlying assumptions used in the station's flooding analysis and failed to identify possible unintended consequences when making changes to the barrier impairment procedure [H.1(b)].

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

Significance:  Nov 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Determine Cause for a Significant Condition Adverse to Quality

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to perform a cause evaluation for a significant condition adverse to quality. Specifically, the licensee failed to perform a cause evaluation for degraded and nonconforming conditions identified on the Division 1 critical switchgear air handling unit. The cumulative effect of these degraded and nonconforming conditions reduced the system heat removal capability below the performance requirements specified in station calculations. The licensee entered this issue into their corrective action program as Action Request AR 298179.

This performance deficiency was more than minor because, if left uncorrected, the failure to determine the cause and take corrective action to address air- and water-side fouling of safety-related room coolers could become a more significant safety concern. The inspectors performed an initial screening of the finding in accordance with NRC Manual Chapter IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined this finding is of very low safety significance (Green) because: (1) the finding was not a deficiency affecting the design or qualification of a mitigating system; (2) the finding did not represent a loss of system and/or function; (3) the finding did not represent an actual loss of function of a single train for greater than its technical specification allowed outage time; and (4) the finding does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule program for greater than 24 hours. This finding had a cross-cutting aspect in the area of human performance associated with the work practices component in that the licensee failed to ensure appropriate supervisory and management oversight of work activities related to the screening of issues entered into the corrective action program [H.4(c)].

Inspection Report# : [2013010](#) (*pdf*)

Significance:  Nov 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate Operability of System Wide Anode Degradation in the Service Water System

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to follow Procedure PPM 1.3.66, "Operability and Functionality Evaluation," Revision 25-27. Specifically, the licensee failed to evaluate extent of condition and operability of components affected by sacrificial anode degradation in service-water-supplied air-to-water heat exchangers. The licensee entered this issue into their corrective action program as Action Request AR 290553.

The performance deficiency was more than minor because it affected the equipment performance attribute of the Mitigating Systems Cornerstone objective of ensuring the reliability of systems that respond to initiating events. The inspectors performed an initial screening of the finding in accordance with NRC Manual Chapter IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using IMC 0609, Appendix A,

Exhibit 2, “Mitigating Systems Screening Questions,” the inspectors determined this finding is of very low safety significance (Green) because: (1) the finding was not a deficiency affecting the design or qualification of a mitigating system; (2) the finding did not represent a loss of system and/or function; (3) the finding did not represent an actual loss of function of a single train for greater than its technical specification allowed outage time; and (4) the finding does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee’s maintenance rule program for greater than 24 hours. This finding had a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component because the licensee failed to periodically trend and assess information related to service water cooled heat exchangers in the aggregate to identify programmatic and common cause problems [P.1(b)].
Inspection Report# : [2013010](#) (*pdf*)

Significance:  Nov 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Adequate Testing of the Service Water Supplied Room Coolers

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XI, “Test Control,” for the licensee’s failure to maintain an adequate test program that demonstrates safety-related room coolers will perform satisfactorily in service. Specifically, recent internal operating experience revealed that macro-fouling is not appropriately accounted for in the licensee’s testing methodology which uses a representative cooler to demonstrate service water system performance. The licensee entered this issue into their corrective action program as Action Request AR 291981.

The performance deficiency was more than minor because it affected the procedure quality attribute of the Mitigating Systems Cornerstone objective and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors performed an initial screening of the finding in accordance with NRC Manual Chapter IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power.” Using IMC 0609, Appendix A, Exhibit 2, “Mitigating Systems Screening Questions,” the inspectors determined this finding is of very low safety significance (Green) because: (1) the finding was not a deficiency affecting the design or qualification of a mitigating system; (2) the finding did not represent a loss of system and/or function; (3) the finding did not represent an actual loss of function of a single train for greater than its technical specification allowed outage time; and (4) the finding does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee’s maintenance rule program for greater than 24 hours. This finding had a cross-cutting aspect in the area of problem identification and resolution associated with the operating experience component because the licensee failed to institutionalize operating experience involving macro-fouling of service water cooling coils through changes to station processes, procedures, and testing programs [P.2(b)].

Inspection Report# : [2013010](#) (*pdf*)

Significance:  Nov 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Procedures when Installing Roll-filters in Safety-related Air Handling Units

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a, “Procedures,” associated with the failure of the licensee to install roll-filters in safety-related room coolers in accordance with station procedures. Consequently, the roll-filter for the Division 1 critical switchgear air handling unit WMA-AH-53A was installed incorrectly which resulted in filter degradation and fouling of the air handling unit cooling coil. The licensee entered this issue into their corrective action program as Action Request AR 286069.

The performance deficiency was more than minor because it affected the equipment performance attribute of the

Mitigating Systems Cornerstone objective and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors performed the initial significance determination using NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions." The inspectors determined that the finding required a detailed risk evaluation because it represented a potential loss of one train of safety related equipment for longer than the technical specification allowed outage time since the ventilation system supported several pieces of safety related equipment. The most limiting technical specification allowed completion time was just a few hours. A senior reactor analyst performed a risk evaluation. The analyst determined that, although potentially inoperable per the technical specifications definition, the ventilation fan remained functional and capable of performing for at least 24 hours the function credited in the licensee's probabilistic risk assessment. Therefore the finding is of very low safety significance (Green). This finding had a cross-cutting aspect in the area of human performance associated with the work practices components because the licensee failed to implement human error prevention techniques, such as holding pre-job briefings, self and peer checking, and proper documentation of activities when installing horizontal roll-filters in safety-related applications [H.4(a)].

Inspection Report# : [2013010](#) (*pdf*)

Significance:  Nov 21, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Comply with Plant Technical Specifications for Control Room Air Conditioning System

The inspectors identified a non-cited violation of Technical Specification 3.7.4, "Control Room Air Conditioning (AC) System," involving the licensee's failure to adequately test and maintain the control room heating, ventilation, and air conditioning (HVAC) system. The licensee entered this issue into their corrective action program as Action Request AR 279768.

The performance deficiency was more than minor because it affected the equipment performance attribute of the Mitigating System Cornerstone objective and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors performed the initial significance determination for the failure of the Division 1 control room air conditioning unit using NRC Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions." The inspectors determined that the ventilation fan remained functional and capable of performing the probabilistic risk assessment function for at least 24 hours. Therefore the finding is of very low safety significance (Green). This finding had a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component because the licensee failed to thoroughly evaluate problems such that the resolutions address causes and extent of conditions, as necessary. Specifically, the licensee failed to fully evaluate the existence of degraded sacrificial anodes in safety-related room coolers such that corrective actions to address these issues were implemented in a timely manner, commensurate with their significance [P.1(c)].

Inspection Report# : [2013010](#) (*pdf*)

Barrier Integrity

Significance:  Jun 22, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Maintain Configuration Control of Reactor Building Ventilation Differential Pressure Controllers

The inspectors reviewed a self-revealing Green non-cited violation of Technical Specification 5.4.1.a, "Procedures,"

for the licensee's failure to properly pre-plan calibrations of differential pressure controllers used to maintain secondary containment pressure. Specifically, the licensee failed to establish and document the gain settings for the reactor building normal ventilation system differential pressure controllers in accordance with procedure DES-2-19, "Instrument Master Data Sheets," Revision 0.

This performance deficiency was more than minor because it affected the equipment performance attribute of the Barrier Integrity 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. Specifically, the failure to establish and maintain configuration control of reactor building ventilation differential pressure controllers resulted in multiple instances of unplanned inoperability of secondary containment. The inspectors performed an initial screening of the finding in accordance with NRC Manual Chapter IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using IMC 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," the inspectors determined this finding is of very low safety significance (Green) because the finding only represents a degradation of the radiological barrier function provided for by the standby gas treatment system. Because the cause of this finding was that the licensee had not thoroughly evaluated prior instances of loss of secondary containment pressure and concerns from licensed operators regarding the sluggish response of the train A differential pressure controller, this finding had a cross-cutting aspect in the area of problem identification and resolution in that the licensee did not thoroughly evaluate issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance [P.2].

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

Significance:  Mar 23, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Operability Evaluation of Degraded Reactor Core Isolation Cooling Valve

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," for the failure of the licensee to perform a detailed examination of a degraded condition associated with the reactor core isolation cooling system in accordance with the station operability determination Procedure PPM 1.3.66, "Operability and Functionality Determinations," Revision 29. For an immediate corrective action, the licensee reassessed the condition for operability.

The licensee entered this issue into their corrective action program as Action Request 303216.

The performance deficiency was more than minor because it affected the equipment performance attribute of the Barrier Integrity 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. The inspectors performed an initial screening of the finding in accordance with NRC Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using NRC Manual Chapter 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," the inspectors determined this finding is of very low safety significance (Green) because the finding represents only a degradation of the radiological barrier function provided for by the standby gas treatment system. This finding has a cross-cutting aspect in the area of human performance because the licensee rationalized the unexpected plant response when performing reactor core isolation cooling system surveillance testing and relied on previous, unrelated evaluations as justification of system operability instead of challenging the unknown.

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

Significance:  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Non-Conservative Error in Control Room Boundary Breach Specification.

Green. The inspectors identified a non-cited violation of 10 CFR 50 Appendix B, Criterion III, "Design Control," for the licensee's failure to translate the results of calculation NE-02-02-01, "Control Room Boundary Leakage Limitation" into allowed breach specifications for the control room ventilation boundary. Consequently, the specification used by operators in procedure PPM 1.3.57, "Barrier Impairment," Revision 29 for determining the operability of the control room envelope was non-conservative with respect to station calculations. This finding was entered into the licensee's corrective action program as Action Request AR 298914.

This performance deficiency was more than minor because it affected the design control attribute of the Barrier Integrity Cornerstone objective of providing reasonable assurance physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the non-conservative error inserted into control boundary leakage specifications resulted in periods where the maximum allowable control room breach size in station calculations was exceeded. The inspectors screened the finding in accordance with NRC Manual Chapter IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Using IMC 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," the inspectors determined this finding is of very low safety significance (Green) because the finding only represents a degradation of the radiological barrier function provided for by the control room. The finding did not have a cross-cutting aspect because the performance deficiency occurred in early 2010 using a different process than currently exists and was therefore not reflective of current performance. Inspection Report# : [2013005](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Jun 22, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to implement high radiation area controls in an area with a dose rate greater than 1 rem/hour.

The inspectors reviewed a Green, self-revealing, non-cited violation of Technical Specification 5.7.2, which was caused by licensee personnel's failure to control a high radiation area with radiation levels greater than 1 rem/hour when lifting the moisture separator during reactor vessel reassembly. Licensee personnel corrected the error by lowering the moisture separator into the reactor pool. The violation was entered into the licensee's corrective action program as AR 287521.

The performance deficiency was more than minor because it was associated with the Occupational Radiation Safety Cornerstone attribute of program and process (exposure control) and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation because licensee personnel did not implement barriers intended to prevent workers from receiving unexpected dose. Using Inspection Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated August 19, 2008, the inspectors determined the violation had very low safety significance because: (1) it was not an as low as is reasonably achievable (ALARA) finding, (2) there was no overexposure, (3) there was no substantial potential for an overexposure, and (4) the ability to assess dose was not compromised. This finding has a cross-cutting aspect in the human performance area, associated with the work management component, because the organization did not implement a process of planning, controlling, and executing work activities such that nuclear safety is the overriding

priority [H.5].

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

Significance: N/A Jun 22, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Report an Unanalyzed Condition within Required Time Limits

The inspectors identified a non-cited violation involving 10 CFR 50.73, "Licensee event report system." Specifically, the inspectors identified that the licensee failed to submit a required licensee event report, within specified time limits, for an unanalyzed condition involving unfused DC ammeters. The licensee entered this issue into their corrective action program as AR 309600.

The inspectors determined that the failure to make a required licensee event report within the time limits specified in regulations was a violation of 10 CFR 50.73. The violation was evaluated using Section 2.2.4 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. As a result, this violation was evaluated using traditional enforcement. In accordance with Section 6.9 of the NRC Enforcement Policy, this violation was determined to be a Severity Level IV, non-cited violation. The team determined that a cross-cutting aspect was not applicable because the issue involving untimely reports to the NRC was strictly associated with a traditional enforcement violation.

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

Last modified : November 26, 2014