

Calvert Cliffs 2

4Q/2014 Plant Inspection Findings

Initiating Events

Mitigating Systems

Barrier Integrity

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Spent Fuel Pool Cask Handling Crane 10 CFR 50.65(a)(2) Performance Not Met

•Green: The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.65, “Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants,” paragraph (a)(2), because Exelon did not adequately demonstrate that the spent fuel pool cask handling crane (SFPCHC) (a)(2) performance was effectively controlled through performance of appropriate preventative maintenance. Specifically, Exelon did not identify and properly account for a maintenance rule functional failure (MRFF) of the SFPCHC in September 2013, and thereby did not recognize that the crane exceeded its performance criteria and required a Maintenance Rule (a)(1) determination. Exelon entered this issue in the corrective action program (CAP) as incident report (IR) 02422876. Exelon’s immediate corrective actions were to reclassify the September 2013 failure as a MRFF and conduct a Maintenance Rule (a)(1) determination on the SFPCHC.

The inspectors reviewed IMC 0612, Appendix B, “Issue Screening,” and determined the finding is more than minor because it is associated with the structure, system, and component (SSC) performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system (RCS), and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, following the MRFF of the SFPCHC in October 2014, Exelon personnel did not identify that the crane required a Maintenance Rule (a)(1) determination, to establish if the crane should be monitored in accordance with 10 CFR 50.65(a)(1). As a result, an excessive amount of time passed for Exelon to comply with the requirements of the Maintenance Rule. In accordance with IMC 0609.04, “Initial Characterization of Findings,” issued on June 19, 2012, and IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 3, “Barrier Integrity Screening Questions,” issued on June 19, 2012, the inspectors determined that the finding was of very low safety significance (Green) because the finding did not result in handling errors, dropped storage cask, or crane operations over the spent fuel pool that caused mechanical damage to fuel clad and a detectable release of radionuclides. The inspectors determined that the finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because Exelon did not thoroughly evaluate issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. Specifically, Exelon personnel failed to properly evaluate the issue that occurred in September 4, 2013 as a MRFF [P.2]. (Section 1R12)

Inspection Report# : [2014005](#) (pdf)

Significance: **G** Jun 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Main Steam Line Drain Containment Isolation Valves not Scoped in IST

•Green. The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.55a, “Codes and Standards,” for Exelon’s failure to meet the test requirements set forth in the American Society of Mechanical Engineers (ASME) Code for Operation and Maintenance of Nuclear Power Plants (OM Code) for main steam line drains (MSLDs) and containment isolation valves (CIVs) motor operated valves (MOVs) (6611, 6612, 6613, 6615, 6620, 6621). Specifically, Exelon failed to scope the MSLD MOVs in their in-service testing (IST) program. As a result, the MOVs reliability was not ensured due to valve degradation not being trended as required in the IST program. Also, the MOV operability was in question because the valves were never tested to perform their containment isolation function. Exelon entered this issue into their corrective action program (CAP) as condition report (CR)-2014-005961. Immediate corrective actions included testing the MOVs.

The inspectors determined that the failure to scope and meet the testing requirements of the OM Code for MSLD MOVs in accordance with 10 CFR 50.55a was a performance deficiency. This finding is more than minor because it was associated with the barrier performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system (RCS), and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the failure to scope and test the MSLD MOVs in accordance with the OM Code did not ensure component reliability by monitoring valve degradation and did not provide assurance that the MSLD MOVs would perform their CIV function in order to protect the public from radionuclides releases during a steam generator tube rupture (SGTR) with a loss of offsite power event. The inspectors reviewed IMC 0609.04, “Initial Characterization of Findings,” issued June 19, 2012, and IMC 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” Exhibit 3, “Barrier Integrity Screening Questions” issued June 19, 2012, and determined that the finding was of very low safety significance (Green) because the finding did not represent an actual open pathway in the physical integrity of reactor containment, containment isolation system, and heat removal components and the finding did not involve an actual reduction of hydrogen igniters in the reactor containment. The inspectors determined that this finding did

not have a cross-cutting aspect because the most significant contributor to the performance deficiency was not reflective of current licensee performance. Specifically, the 2007 IST fourth year interval submittal was the last reasonable opportunity for Exelon to identify this issue. (Section 1R04)

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

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

Emergency Preparedness

Significance: **W** Jun 30, 2014

Identified By: NRC

Item Type: AV Apparent Violation

Inaccurate EAL Threshold Values Incorporated into Site EAL Scheme Change

•Preliminary White: The inspectors documented a licensee-identified apparent violation of Title 10 of the Code of Federal Regulations (10 CFR) 50.54(q)(2), which preliminarily has been determined to be of low to moderate safety significance (White). Specifically, 10 CFR 50.54(q)(2) requires a licensee to develop and maintain an emergency plan which meets the requirements of 10 CFR 50.47(b), and 10 CFR 50, Appendix E. Contrary to this requirement, from October 11, 2013, through March 4, 2014, CCNPP failed to maintain in effect an emergency plan that met the standards in 10 CFR 50.47(b)(4) and 10 CFR 50, Appendix E, Section IV.B.1 for Unit 2. CCNPP did not maintain an adequate standard emergency level scheme because inaccurate effluent radiation monitor thresholds were incorporated into Table R-1, “Effluent Monitor Classification Threshold.” During the replacement of the Unit 2 main steam line radiation monitors (MSLRMs), CCNPP’s staff inaccurately calculated the associated emergency action levels (EALs) effluent threshold values for Alert, Site Area Emergency, and General Emergency, and incorporated these thresholds into Table R-1. This error could have resulted in an over-classification of an event and at the general emergency level potentially resulted in an unnecessary protective action recommendation and could cause offsite response organizations to implement unnecessary protective actions. Exelon identified the issue, entered it into their corrective action program (CAP), implemented appropriate compensatory actions, and initiated corrective actions to revise the EAL table. The inspectors determined the finding no longer presents an immediate safety concern since appropriate compensatory actions have been implemented.

The failure to maintain the EAL threshold values in Table R-1 of the site approved emergency plan was a performance deficiency that was within the Exelon staff ability to foresee and correct and should have been prevented. Using IMC 0612, Appendix B, “Issue Screening,” the performance deficiency was determined to be more than minor because it impacted the procedure quality attribute of the Emergency Preparedness cornerstone and adversely impacts the associated cornerstone objective “to ensure that 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, an EAL change was improperly implemented, which could result in an over-classification of an event and at the general emergency level potentially result in unnecessary protective action recommendations and movement of the public. The inspectors utilized IMC 0609, Appendix B, “Emergency Preparedness Significance Determination Process,” to determine the significance of the performance deficiency. The performance deficiency is associated with the emergency classification planning standard and is considered a risk significant planning standard (RSPS) function. This performance deficiency impacts the following required planning standard and RSPS function: 10 CFR 50.47(b)(4), “Emergency Classification System.” The inspectors were directed by the SDP to compare the performance deficiency with the examples in Section 5.4, “10 CFR 50.47(b)(4), Emergency Classification System,” to evaluate the significance of this performance deficiency. Using Table 5.4-1, “Significance Examples §50.47(b)(4),” the inspectors determined that the performance deficiency matched an example of a degraded RSPS function, which would be assessed as White. Specifically, the example states, in part, that the performance deficiency would be assessed White if the EAL classification process would result in an over-classification that would lead to off-site response organizations implementing, by procedure, unnecessary protective actions for the public. This condition should also be considered met if the licensee would make a protective action recommendation to the off-site response organizations because of the over-classification.

The inspectors determined that the cross-cutting aspect that contributed most to the root cause is H.12, “Avoid Complacency: Individuals recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes. Individuals implement appropriate error reduction techniques.” Specifically, Exelon staff did not independently validate the new EAL threshold values prior to revising and implementing the EAL scheme change. (Section 1R15)

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

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate EAL Initiating Condition HA3.1

•Green: The inspectors identified a Green NCV of 10 CFR 50.54 (q)(2) and 10 CFR 50.47(b)(4) because Exelon did not maintain the emergency plan to adequately meet the standards in 10 CFR 50.47(b)(4). Specifically, Exelon failed to include Unit 1 and Unit 2 component cooling (CC) rooms under EAL initiating condition HA3.1. As a result, an Alert declaration would have not been made during a hazardous gas event in a vital area. Exelon entered this issue into their CAP as condition report (CR)-2014-004683. Immediate corrective actions included revising EAL initiating condition HA3.1 to include the CC rooms and verify that there are no other areas that need to be included in EAL HA3.1.

The failure to update the EAL scheme the site approved emergency plan following a plant modification was a performance deficiency that was within the Exelon staff ability to foresee and correct and should have been prevented. Using IMC 0612, Appendix B, "Issue Screening," the performance deficiency was determined to be more than minor because it impacted the procedure quality attribute of the Emergency Preparedness cornerstone and adversely impacts the associated cornerstone objective "to ensure that 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, a plant modification was completed which required operators to be able to enter the CC room in order to bring the plant to cold shutdown and the EAL scheme was not updated to reflect this change. The inspectors utilized IMC 0609, Appendix B, "Emergency Preparedness Significance Determination Process," to determine the significance of the performance deficiency. The performance deficiency is associated with the emergency classification planning standard and is considered a RSFS function. This performance deficiency impacts the following required planning standard and RSFS function: The inspectors were directed by the SDP to compare the performance deficiency with the examples in Section 5.4, "10 CFR 50.47(b)(4), Emergency Classification System," to evaluate the significance of this performance deficiency. The inspectors determined that the EAL was ineffective because it, in and of itself, no longer resulted in a timely and accurate declaration of an Alert for the initiating condition. Utilizing Figure 5.4.1, an ineffective EAL where an Alert would not be declared when required would screen as a Green finding.

This finding has a cross-cutting aspect in the area of Human Performance, Change Management, because Exelon personnel didn't use a systematic process for evaluating and implementing change so that nuclear safety remains the overriding priority. Specifically, Engineering personnel did not ensure that the impact to the Emergency Plan was adequately evaluated as a result of the permanent plant change engineering change package (ECP)-11-000983 [H.3]. (Section 1R15)

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

Significance:  Mar 31, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Compensatory Actions for Out of Service Letdown Radiation Monitor

Green: The inspectors identified an NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.54, "Conditions of Licenses," paragraph (q)(2), because CENG did not maintain the Emergency Plan to adequately meet the standards in 50.47(b)(4). Specifically, following the removal of the Unit 2 letdown radiation monitor for maintenance on October 28, 2013, CENG did not establish adequate compensatory measures to ensure that a fuel clad degradation emergency action level (EAL) could be assessed in a timely manner as discussed in the Emergency Plan. This could have resulted in an unnecessary delay in the recognition of a Notice of an Unusual Event (NOUE) EAL declaration for elevated coolant reactivity. Immediate corrective actions included restoring the proper valve lineup, entering this issue into their CAP, and implementing compensatory actions, which included the use of a portable radiation monitor with appropriate alarm setpoints to initiate action to sample the RCS to determine if the specified reactor coolant activity limits are exceeded. Planned corrective actions include restoration of the Unit 2 letdown radiation monitor.

This finding is more than minor because it was associated with the emergency response organization performance

attribute of the Emergency Preparedness (EP) cornerstone and affected the cornerstone's objective to ensure that CENG is capable of implementing adequate measures to protect public health and safety in the event of a radiological emergency. Specifically, the failure to establish compensatory actions beyond the normal RCS sampling frequency could have resulted in exceeding a NOUE EAL threshold for a degraded fuel clad and the condition not becoming known until the next normal RCS sample or upon further fuel clad degradation requiring escalation under other EALs. In accordance with IMC 0609.04, "Initial Characterization of Findings," issued June 19, 2012, and IMC 0609, Appendix B, "Emergency Preparedness Significance Determination Process," issued February 24, 2012, the inspectors determined the finding is of very low safety significance (Green). Utilizing IMC 0609, Appendix B, the inspectors determined that the finding is associated with an aspect of the Emergency Plan related to the EAL Classification Scheme 10 CFR 50.47(b)(4). The inspectors determined that the EAL was ineffective because it, in and of itself, no longer resulted in a timely and accurate declaration for the initiating condition. Utilizing Figure 5.4.1, the impact of the ineffective EAL is that a NOUE would be declared in a timely manner, which screens as a Green finding. In addition, the finding is similar to a Green finding in Table 5.4.1, "Significance Examples §50.47(b)(4)," in that the EAL classification process is not capable of classifying an Alert or NOUE in a timely and accurate manner. This finding has a cross-cutting aspect in the area of Human Performance, Work Management, because CENG personnel adequately implement a work process that included the identification and management of risk commensurate to the work and the need for coordination with different groups or job activities. Specifically, Operations and Chemistry personnel did not ensure that the assigned tasks were adequate to compensate for the increased in nuclear risk associated with having the letdown radiation monitor out of service [H.5]. (Section 1R15)

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

Occupational Radiation Safety

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

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