

D.C. Cook 1

4Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Establish Procedures for Vacuum Fill

. A finding and associated non-cited violation of technical specification (TS) 5.4.1, Procedures, self revealed pertaining to establishing and maintaining procedures to ensure reliable indication of reactor vessel level during reduced RCS inventory and vacuum fill operations. Specifically, the licensee failed to include in procedures for vacuum fill methods to ensure the level detection system sensing lines were vacuum tight and to include provisions to normalize level indications. During the vacuum fill evolution for Unit 1, the licensee made 5 attempts to draw vacuum because of diverging level indications. The additional time spent in reduced inventory as well as the additional drain downs resulted in increased plant risk. As immediate corrective actions, the licensee corrected the leaking fitting, normalized level readings, and completed the vacuum fill evolution. The licensee has entered this issue into the corrective action program (CAP) as action request (AR) 2013-6907.

The inspectors concluded the finding was more than minor because it adversely affected the Initiating Event cornerstone objective of limiting the likelihood of events that upset plant stability while shutdown. Specifically, the issue impacted the Procedure Quality attribute. Based on the screening criteria of IMC 0609, the inspectors and regional SRA concluded a phase 2 or 3 evaluation was needed. The Office of Nuclear Reactor Regulatory (NRR) performed a phase 3 assessment and estimated the conditional core damage probability at $5.9E 7$. Therefore, the finding is of very low safety significance (Green). The finding included a cross-cutting aspect of H.9, Training, in the human performance area because the licensee lacked understanding of the precision level instruments.

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

Significance: G Mar 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Establish Procedures for Vacuum Fill

A finding and associated non-cited violation of TS 5.4.1, Procedures, self revealed pertaining to establishing and maintaining procedures to ensure reliable indication of reactor vessel level during reduced RCS inventory and vacuum fill operations. Specifically, the licensee failed to include in procedures for vacuum fill methods to ensure the level detection system sensing lines were vacuum tight. Although the licensee implemented some corrective actions prior to the scheduled vacuum fill evolution, the actions taken failed to prevent recurrence. During the vacuum fill evolution for Unit 2, the licensee made 2 attempts to draw vacuum because of diverging level indications. The additional time spent in reduced inventory as well as the additional drain down resulted in increased plant risk. As immediate corrective actions, the licensee corrected the leaking fitting, normalized level readings, and completed the vacuum fill evolution. The licensee has entered this issue into the CAP as AR 2013-18146.

The inspectors concluded the finding was more than minor because it adversely affected the Initiating Event cornerstone objective of limiting the likelihood of events that upset plant stability while shutdown. Specifically, the

issue impacted the Procedure Quality attribute. Based on the screening criteria of IMC 0609, the inspectors and regional SRA concluded a phase 2 or 3 evaluation was needed. Since the issue in Unit 2 was bounded by the phase 3 assessment performed for Unit 1, the inspectors and SRA concluded the finding was of very low safety significance, (Green). The finding included a cross-cutting aspect of P.3, Resolution, in the corrective action area because the licensee failed to implement corrective actions that prevented recurrence.

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

Mitigating Systems

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify Conditions Adverse to Quality Associated with the Unit 1 TDAFW Pump Turbine Oil system

A finding of very low safety significance, with an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion 16, “Corrective Actions,” was identified by the inspectors for the licensee’s failure to promptly identify and correct a condition adverse to quality (CAQ) associated with Unit 1 Turbine Driven Auxiliary Feedwater (TDAFW) pump turbine bearing oil. Specifically, the licensee failed to identify that water was entering the oil system after leakage had been identified directly above one of the TDAFW pump turbine bearings. On April 7, 2014, a cooling water leak was identified above the outboard turbine bearing. The leak was classified as about 1 drop per minute (dpm). On April 11, 2014, the licensee discovered the turbine bearing oil level was above the maximum mark on an attached sight glass. Several possible reasons were postulated for the high level (which had been steady in band for over a year), such as rising turbine building temperatures and the fact that it was not uncommon for personnel to do ‘unnecessary’ oil adds to the machine. Oil was drained out until level returned to the maximum mark. On May 22, 2014, the licensee again noted oil level to be above the maximum mark. Oil was drained again, and similar reasons provided for the level increase. Further, a statement was made that oil level had been steady for the past month, neglecting the previous high level condition. In parallel, NRC inspectors had questioned why level was being maintained at the maximum mark when the operator logs and a sign stated level should be kept at the minimum mark. On May 23, the licensee decided to drain the oil system; 620 ml of water was found. New oil was added, and a temporary modification was installed which directed leakage away from the bearing. The issue was entered into the Corrective Action Program (CAP), and an apparent cause evaluation later determined the leakage to be the primary intrusion pathway for the water.

The issue was more than minor because it adversely affected the Configuration Control attribute of the Mitigating Systems Cornerstone, whose objective is to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, if left uncorrected, the issue could lead to a more significant safety concern. The inspectors assessed the finding for significance using IMC 0609, “Significance Determination Process.” Per Appendix A, the finding screened as Green, or very low safety significance, in Exhibit 2. Specifically, all questions were answered ‘no’ under Section A for findings related to Mitigating Structures, Systems and Components (SSCs) and Functionality. The inspectors reviewed the licensee’s past operability evaluation and concluded that given the projected amount of water that could be entrained in the oil during operation, along with the duration of operation assumed in the safety analyses, that operability of the pump would be maintained. The finding had an associated cross-cutting aspect in the Human Performance area, specifically, H.11, Challenge the Unknown. Regarding the TDAFW oil system, the licensee rationalized why the level was increasing without sufficient investigation given the significance of the system, and did not seek further information that was readily available regarding appropriate oil levels.

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

Significance:  Dec 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Unplanned Inoperability of the AB Fuel Oil Storage Tank Durung Maintenance

A finding of very low safety significance, with an associated non-cited violation of Technical Specification (TS) 5.4, "Procedures," was self revealed when a vacuum was inadvertently drawn on the AB Fuel Oil Storage Tank (FOST) during preparations for surveillance activities. The vacuum caused an indication of lowering level in the tank, alarms, and an unplanned TS Limiting Condition for Operation (LCO) action statement entry. The licensee was performing work activities in preparation for a leak test of the FOST. The general sequence of activities should have been a loosening of the vent filter for the tank, a transfer of fuel from the FOST to the Emergency Diesel Generator (EDG) day tanks, removal of the FOST from service, and finally removal of the vent filter so test equipment could be connected to the tank. Due to ambiguous work instruction steps and activities not being adequately controlled to ensure the proper sequence occurred, workers first removed the vent filter completely and placed a Foreign Material Exclusion (FME) bag over the vent. When operators later transferred fuel, a vacuum was drawn in the tank and level appeared to be going down. Utilizing a manual method of level measurement (which had also been affected by the vacuum), operators determined fuel was actually being lost from the tank to the environment. Shortly thereafter, the bag was found and removed, and level restored to normal (there was no actual loss of fuel). Technical Specification 5.4, "Procedures," states, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33. Regulatory Guide 1.33 states, in part, that maintenance that can affect the performance of safety related equipment should be properly preplanned and performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances. Contrary to these requirements, the FOST surveillance was performed with inadequate instructions and was not coordinated appropriately. The licensee entered the issue into the CAP and performed a root cause analysis.

The performance deficiency was more than minor because it adversely impacted the Configuration Control attribute of the Mitigating Systems cornerstone, whose objective is ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding screened as Green, or very low safety significance, utilizing IMC 0609, Appendix A, "The Significance Determination Process for Findings at Power." Specifically, all questions were answered 'no' under Section A of Exhibit 2 for Mitigating Systems, since that was the affected cornerstone. The FME bag was installed, which rendered the AB FOST inoperable, for approximately 16 hours. This was less than the TS allowed outage time of 48 hours. The finding had an associated cross cutting aspect in the human performance area, specifically, H.5, Work Management. Work activities should be planned, controlled, and executed with nuclear safety as the overriding priority. Contrary to the tenets of the cross cutting aspect, the work was planned and executed with inadequate work instructions. Further, there was a lack of coordination between a number of work groups and activities associated with the test.

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

Significance:  Dec 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadvertent Trip of the Unit 1 TDAFW Pump

A finding of very low safety significance, with an associated non- violation of TS 5.4, "Procedures," was self revealed on November 1, 2014, when the Unit 1 TDAFW pump tripped during an emergent dual unit shutdown. Both units were taken offline by operators due to debris intrusion from Lake Michigan

into the cooling water screenhouse. The TDAFW pump started as expected but shutdown after a few minutes of operation. Investigation by the licensee revealed that a cover for the trip solenoid had been installed incorrectly. The cover was relatively loose and had been placed near components involved with the proper latching of the Trip and Throttle valve (TTV) (the valve which opens to let steam in to turn the pump on). After refuting several possible causes and running the pump several times for testing, the licensee determined the likely cause of the trip was the misplaced enclosure, which could have interfered with the proper latching of the TTV. Technical Specification 5.4, "Procedures," states, in part, that written procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33. Regulatory Guide 1.33 states, in part, that maintenance that can affect the performance of safety related equipment should be properly preplanned and performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances. Contrary to these requirements, the cause of the misplaced enclosure was due to a lack of detailed instructions regarding the installation and removal of the enclosure. The enclosure was most recently affected by maintenance performed during the fall 2014 refueling outage. The licensee worked with the vendor and reinstalled the enclosure correctly. The Unit 2 TDAFW pump trip solenoid enclosure was also found out of position and corrected. The licensee entered the issue into the Corrective Action Program.

The performance deficiency was more than minor because it adversely impacted the Configuration Control attribute of the Mitigating Systems cornerstone, whose objective is ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors utilized IMC 0609 Appendix A, "The Significance Determination Process for Findings at Power," to assess the significance of the finding. Per Exhibit 2, the finding represented a loss of function for one train of Auxiliary Feedwater (AFW) for greater than the TS allowed outage time. Therefore, the inspectors consulted the regional Senior Reactor Analyst for a detailed risk evaluation. The inspectors considered the Unit 1 TDAFW pump inoperable since the last successful surveillance on October 23, 2014. Given the evidence available, this was the likely opportunity for the conditions to be established to set up the improper engagement between the TTV and the trip hook. In the detailed analysis, the finding screened as Green, or very low safety significance. The finding had an associated cross cutting aspect in the area of human performance, specifically, H.8, Procedure Adherence. During maintenance, work proceeded on the trip enclosure despite a lack of detailed instructions on the removal/installation of the enclosure.

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

Significance: G Sep 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Operability Determination Procedure

A finding of very low safety significance with an associated non-cited violation of 10 CFR 50, Appendix B, Criterion V, Procedures, was identified by the inspectors for the failure to follow the Operability Determination Procedure, PMP-7030-OPR-001. Specifically, for instances of high oil level in the turbine-driven auxiliary feedwater (TDAFW) pump governor sight-glasses and high water concentrations in motor-driven auxiliary feedwater (MDAFW) pump bearings, components were assumed to be operable without supporting technical justification. Further, past operability assessments were not assigned for the conditions. During a review of action requests (AR's) associated with the auxiliary feedwater (AFW) system, the inspectors identified four instances since 2008 when the licensee identified that oil level was high-out-of-sight in a TDAFW pump governor sight-glass. The licensee did not assess certain impacts on operability even though several references identified potential adverse impacts with the noted oil level. The operations logs set an appropriate level as being between half-full (minimum) and "visible" in the sight-glass (maximum). The logs also contained a note stating if level was visible in the sight-glass, the pump was operable. Additionally, the vendor manual and a maintenance procedure cautioned against the level being high in the system. No documentation was provided that addressed these concerns. In regards to the MDAFW pumps, the inspectors identified AR's documenting periodic instances of high water concentrations in the pump bearings. When subsequent licensee analysis confirmed significantly high concentrations of water,

no past operability assessments were done to assess any impacts the moisture may have had. In each instance of a high oil level or high moisture result, the licensee corrected the condition after discovery. The licensee also generated an AR to explore the inspectors' concerns with regard to a lack of documented justification for operability while the conditions existed.

The issue was more than minor because it adversely affected the Equipment Performance attribute of the Mitigating Systems Cornerstone. Specifically, the failure to properly assess the operability of safety related components (with all relevant information) can impact the availability, reliability, and capability of systems that respond to initiating events, in that components assumed to be operable may actually be in a condition where they cannot reliably perform their safety functions. Further, if left uncorrected, the issue could become a more significant safety concern as future operability determinations could also be deficient. The inspectors were also informed by IMC 0612, Appendix E, examples 3.j and 3.k, in that equipment inoperability is not a prerequisite for an issue being more than minor. Per the guidance, the inspectors determined reasonable doubt existed regarding the operability of components. The finding screened as Green, or very low safety significance, because the performance deficiency of failing to follow the Operability Determination procedure did not in itself represent a loss of system and/or function. The inspectors determined the finding had an associated cross-cutting aspect in the area of Problem Identification and Resolution. Specifically, the organization did not thoroughly evaluate issues to ensure resolutions address causes and extent of conditions commensurate with their safety significance (P.2). P.2, Evaluation, aligns with the Safety Culture Common Language attribute of PI.2, Evaluation, outlined in NUREG-2165. Examples under PI.2 include prioritizing and thoroughly investigating issues with regard to their safety significance. The licensee did not address all of the relevant information which could impact the operability determinations associated with the AFW pumps.

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

Significance:  Sep 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Classify the Internal Piping in the Auxiliary Feedwater Pump Room Coolers as ASME Code Class 3 Piping

The inspectors identified a finding of very low safety significance (Green) with an associated non-cited violation of 10 CFR 50, Appendix B, Criterion III, for failure to correctly translate regulatory requirements related to the American Society for Mechanical Engineers (ASME) code class boundary to the AFW pump room cooler. Specifically, the licensee failed to classify the internal piping in the AFW pump room coolers as ASME code class 3 piping when it should have been classified as such. As immediate action, the licensee declared the affected room cooler inoperable and repaired the leak. Because of low room temperature, the supported TDAFW pump remained operable.

The inspectors determined that the failure of the licensee to correctly translate regulatory requirements for a safety related system into a drawing, as described in 10 CFR 50, Appendix B, Criterion III, Design Control, was a performance deficiency warranting further evaluation in the Significance Determination Process (SDP). The issue screened as more than minor because it adversely affected the Design Control attribute of the Mitigating Systems cornerstone. Using Appendix A of IMC 0609, the inspectors concluded the finding was of very low safety significance, Green, because the supported AFW system remained operable. Because the performance deficiency occurred in 2000, the finding does not reflect current performance and no cross-cutting aspect exists. Because the violation was of very low safety significance and promptly entered into the licensee's Corrective Action Program (CAP) (AR 2014 7570), and the violation was not repetitive or willful, this violation is being treated as an NCV, consistent with Section of 2.3.2 of the NRC Enforcement Policy.

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

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Control Nonconforming Delivery Valve Holders on Emergency Diesel Generators

The inspectors identified 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, for the failure to prevent nonconforming parts from being used on the emergency diesel generators (EDGs). In 2006, the licensee changed the material used to manufacture delivery valve holders to address cracking of the component. However, the licensee failed to ensure all delivery valve holders were replaced. In 2009 and in 2013, the licensee identified installed delivery valve holders made from the susceptible material. In addition, the licensee determined in 2013 that a manufacturing defect impacted a lot of delivery valve holders. The licensee failed to control the non conforming components and installed one in an EDG. In both cases, although the licensee found the discrepant parts, the site failed to explore broader programmatic issues with nonconforming material control or shortfalls in the root cause evaluation done to address previous issues with cracking. As corrective actions, the licensee has since replaced all suspect pumps and generated action requests to assess programmatic issues with nonconforming material control.

The inspectors determined the finding to be more than minor because it adversely affected the Design Control attribute of the Mitigating Systems cornerstone. Specifically, allowing nonconforming parts to be installed on safety-related equipment without proper controls or review adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The issue screened as Green, or very low safety significance, utilizing IMC 0609 Attachment 4, Initial Characterization of Findings. Specifically, per Exhibit 2, the finding was determined to be a deficiency affecting the design or qualification of a mitigating system, structure or component where operability was maintained. The inspectors determined the finding had an associated cross cutting aspect in the area of Problem Identification and Resolution. Specifically, programmatic issues associated with material control were not identified for resolution by the corrective action program.

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

Significance: N/A Jun 30, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Missed Event Notification

The inspectors identified a Severity Level IV non-cited violation of 10 CFR 50.72, "Immediate Notification Requirements for Operating Nuclear Reactors," for the licensee's failure to make required event notifications within the specified time following the discovery of a condition which required an event report. Specifically, a member of the public informed the Berrien County Dispatcher about a sounding siren. The dispatcher notified the site; however, the license failed to notify the NRC. Because of the age of this issue; the licensee did not make a late report. Since 2012, the licensee has conducted training regarding notifications for alarming sirens.

The inspectors determined that the licensee's failure to submit an event notification within the required time was a violation of 10 CFR 50.72(b)(2)(xi). Since the failure to submit a required event report may impact the NRC's ability to regulate, the violation

was evaluated using Section 2.2.4 of the NRC's Enforcement Policy. Per the enforcement policy, this violation was of Severity Level IV. The inspectors concluded the reactor oversight process aspects of the finding were minor; therefore there is no cross-cutting aspect.

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

Significance:  Jun 30, 2014

Identified By: NRC

Item Type: FIN Finding

Deficient Annunciator/Plant Process Computer Design

The inspectors identified a finding of very low safety significance associated with the licensee's failure to design the annunciator and plant process computer (PPC) systems in accordance with design specifications. Specifically, the licensee failed to design the systems to preclude loss of the system on a single active failure. In part, this issue would result in loss of the annunciator and PPC systems following a loss of offsite power. The licensee recognized a weakness during a loss of power (LOP)/loss-of-coolant accident (LOCA) testing when the annunciator system failed about 15 minutes into the test. Although the licensee corrected the condition related to rack fans, the inspectors identified a similar issue associated with the server rooms. The annunciator and PPC systems do not have regulatory requirements; therefore this finding did not include a violation. The licensee has modified the ventilation system to provide cooling and assure operation following a loss of offsite power.

The inspectors determined that failure to design and install the annunciator system in accordance with the design description of the applicable Engineering Calculation (EC) was a performance deficiency that warranted a significance evaluation. Using IMC 0612, Appendix B, issue screening, the inspectors determined the finding was more than minor because it is associated with mitigating system cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events and is related to the human performance attribute, post event. Specifically, the annunciator and PPC systems aid human performance by alerting operators to degrading plant and equipment conditions. Using IMC 0609, Significance determination process for at power findings, the inspectors determined that the condition would result in loss of the annunciator and PPC function during some accident scenarios. Therefore the inspectors determined a detailed risk analysis was needed and forwarded the issue to the Region III Senior Reactor Analyst (SRA). The Region III SRA performed a detailed risk evaluation for the finding. To perform the risk evaluation, the SRA determined that the reliability of some operator actions modeled in the NRC's Standardized Plant Analysis Risk (SPAR) model for Donald C. Cook would be negatively impacted if annunciators were not available to cue operators to take action. The delta core damage frequency calculated was $5.5E-7$ /yr, which represents a finding of very low safety significance (Green). The SRA determined delta large early release frequency was minor as well. Because the licensee failed to identify the extent of condition, the inspectors concluded that the finding included cross cutting aspect, PI.2 Evaluation, in the area of problem identification and resolution.

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

Significance:  Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Degraded Latch Prevents Closure of Fire Door

The inspectors identified a finding of very low safety significance (Green) and associated non-cited violation of License Condition 2.C.4 for Unit 1, for the licensee's failure to ensure that a fire door would be closed at the time of a fire. Specifically, fire door 1 DR AUX387 was found with a degraded latch that prevented the door from closing. Donald C. Cook is required to comply with the National Fire Protection Association (NFPA) 80, 1970 which requires a closing device to ensure fire doors close and latch at the time of a fire. Contrary to this requirement, fire door 1 DR AUX 387 would not close and latch because the latching mechanism for the inactive leaf had failed in a manner preventing the door from closing. As immediate corrective action, the licensee started hourly fire watches on the door and performed an interim repair to restore the door to a functional status. The licensee has entered the condition into the corrective action program as AR 2014 0802.

The inspectors determined the finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Protection Against External Events (Fire) and adversely affected the cornerstone objective of ensuring the capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core

damage). Specifically, the licensee failed to maintain door 387 such that it could perform its required function as a 3 hour fire barrier. Using IMC 0609, Appendix F, the inspectors concluded that the finding was of very low safety significance (Green) because the fire loading was below the screening criteria of 120,000 btu/ft². The inspectors concluded the finding included a cross cutting aspect of H.5, Work Planning, in the area of human performance because the licensee did incorporate risk insights.

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

Significance:  Mar 27, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate the Adverse Effects of TRM Section Deletion

The inspectors identified a Severity Level IV Non-Cited Violation of 10 CFR 50.59(d)(1), “Changes, Tests, and Experiments,” and an associated finding of very low safety significance (Green) for the licensee’s failure to perform a written safety evaluation that provided the bases for the determination that the deletion of Technical Requirement Manual, Section 8.4.3, “ASME Code Class 1, 2, and 3 Components,” did not require a license amendment. Specifically, the licensee did not evaluate the adverse effects of the change. The licensee entered this issue into their Corrective Action Program and initiated corrective actions to implement compensatory measures in accordance with the deleted section of the Technical Requirement Manual.

The performance deficiency was determined to be more than minor because, if left uncorrected, it would become a more significant safety concern. In addition, the associated traditional enforcement violation was more than minor because the inspector could not reasonably determine that the changes would not have ultimately required NRC prior approval. The finding was of very low safety significance (Green) based on the inspectors’ review of corrective action documents associated with non-conforming conditions related to structural integrity of ASME components generated since the TRM removal. Specifically, the inspectors used the two most bounding cases for the evaluation and determined the issues did not result in the loss of operability or functionality, represent a loss of system and/or function, represent an actual loss of function exceeding the Technical Specification allowed outage time, or represent an actual loss of function of non-Technical Specification equipment designated as high safety significant in accordance with the licensee’s Maintenance Rule Program. This finding had a cross-cutting aspect in the area of problem identification and resolution because the licensee did not take effective corrective actions to address the issue. Specifically, the licensee identified that they had not evaluated the adverse effects of deleting Section 8.4.3 of the Technical Requirement Manual and, as a result, they performed a 50.59 evaluation. However, the evaluation did not address these adverse effects.

Inspection Report# : [2014007](#) (*pdf*)

Significance:  Mar 27, 2014

Identified By: NRC

Item Type: FIN Finding

Failure to Evaluate the Adverse Effects of TRM Section Deletion

The inspectors identified a Severity Level IV Non-Cited Violation of 10 CFR 50.59(d)(1), “Changes, Tests, and Experiments,” and an associated finding of very low safety significance (Green) for the licensee’s failure to perform a written safety evaluation that provided the bases for the determination that the deletion of Technical Requirement Manual, Section 8.4.3, “ASME Code Class 1, 2, and 3 Components,” did not require a license amendment. Specifically, the licensee did not evaluate the adverse effects of the change. The licensee entered this issue into their Corrective Action Program and initiated corrective actions to implement compensatory measures in accordance with the deleted section of the Technical Requirement Manual.

The performance deficiency was determined to be more than minor because, if left uncorrected, it would become a more significant safety concern. In addition, the associated traditional enforcement violation was more than minor because the inspector could not reasonably determine that the changes would not have ultimately required NRC prior approval. The finding was of very low safety significance (Green) based on the inspectors' review of corrective action documents associated with non-conforming conditions related to structural integrity of ASME components generated since the TRM removal. Specifically, the inspectors used the two most bounding cases for the evaluation and determined the issues did not result in the loss of operability or functionality, represent a loss of system and/or function, represent an actual loss of function exceeding the Technical Specification allowed outage time, or represent an actual loss of function of non-Technical Specification equipment designated as high safety significant in accordance with the licensee's Maintenance Rule Program. This finding had a cross-cutting aspect in the area of problem identification and resolution because the licensee did not take effective corrective actions to address the issue. Specifically, the licensee identified that they had not evaluated the adverse effects of deleting Section 8.4.3 of the Technical Requirement Manual and, as a result, they performed a 50.59 evaluation. However, the evaluation did not address these adverse effects.

Inspection Report# : [2014007](#) (*pdf*)

Significance:  Mar 27, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Heat Exchanger Inspection Procedure

The inspectors identified a finding having very low safety significance and a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to establish inspection procedures that were appropriate for the circumstances for the component cooling water heat exchangers. Specifically, the inspection procedure did not include instructions to verify the as-found essential service water flow rate through the heat exchangers met the minimum required value, which was a prerequisite for the licensee's inspection methodology. This finding was entered into the licensee's Corrective Action Program with a proposed action to revise the affected procedure.

The performance deficiency was determined to be more than minor because, if left uncorrected, it has the potential to lead to a more significant safety concern. The finding screened as of very low safety significance (Green) because it did not result in the loss of operability or functionality. Specifically, the licensee reviewed recent heat exchanger inspection results and reasonably determined the as-found macro fouling conditions did not impacted operability. The inspectors did not identify a cross-cutting aspect associated with this finding because it was confirmed not to be reflective of current performance due to the age of the performance deficiency.

Inspection Report# : [2014007](#) (*pdf*)

Barrier Integrity

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Review of Radiological Impact of the Removal of the Auxiliary Shield Blocks on the Containment Accident Shield Post LBLOCA

The inspectors identified a non- violation of 10 CFR Part 50, Appendix B, Criterion 3 "Design Control," for the

licensee's inadequate radiological review of permanently removing the Auxiliary Missile Blocks (AMBs) from the Unit 1 and Unit 2 containment accident shields. The finding was determined to be more than minor because it was associated with the Barrier Integrity Cornerstone attribute of design control; and adversely affected the cornerstone objective of maintaining radiological barrier functionality of the safety related accident shield. Specifically, the failure to control plant design and adequately evaluate the radiological effects of permanently removing the AMBs from the Unit 1 and Unit 2 containment accident shields did not ensure that the accident shield will provide its design function to ensure safe radiation levels outside the containment building following a maximum design basis accident.

The inspectors evaluated the finding using the Significance Determination Process (SDP) in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012. Because the finding impacted the Barrier Integrity Cornerstone, the inspectors screened the finding through IMC 0609, Appendix A, "The Significance Determination Process for Findings At Power," dated June 19, 2012, using Exhibit 3, "Barrier Integrity Screening Questions." The finding screened as very low safety significance (Green) because the finding only represented a degradation of the radiological barrier function provided for the Auxiliary Building. The inspectors determined the cause of this finding did not represent current licensee performance and, thus, no cross-cutting aspect was assigned.

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

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify Deficient Locked High Radiation Area Controls Due to procedure Inadequacy

The inspectors identified a finding of very low safety significance for inadequate procedures used to verify Locked High Radiation Controls in the Unit 2 Containment with an associated non- violation of TS 5.4, "Procedures." As a result, weekly, from November 1, 2013, to March 2014, multiple Radiation Protection Technicians verified the Unit 2 Upper Containment Cavity Gate was locked; however it did not secure the area against unauthorized access.

The inspectors determined that the performance deficiency was more than minor because if left uncorrected the performance deficiency could lead to a more significant safety concern. Specifically, the failure to identify deficient Locked High Radiation Area (LHRA) controls could result in unintentional exposure to high levels of radiation. The finding was determined to be of very low safety significance because the problem was not as low as is reasonably achievable (ALARA) planning issue, there was no overexposure, nor substantial potential for an overexposure, and the licensee's ability to assess dose was not compromised. The inspectors did not identify a corresponding cross cutting aspect for this performance deficiency. The licensee entered the deficiency in their Corrective Action Program as Action Request (AR) 2014 9001 immediately upon discovery and presentation by the inspectors.

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

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