

## Cooper

# 1Q/2015 Plant Inspection Findings

---

## Initiating Events

---

## Mitigating Systems

**Significance:**  Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Inadequate Operations Procedure**

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a, associated with the inadequate Operation's Procedure 2.2.7, "Condensate Storage and Transfer System," Revision 56. Specifically, the procedure did not require that the affected system, either the high pressure coolant injection system or the reactor core isolation cooling system, be declared inoperable when one or more of the high pressure coolant injection or reactor core isolation cooling test return line isolation valves, HPCI-MOV-21, HPCI-MOV-24, RCIC-MOV-30, or RCIC-MOV-33, were moved off of their closed (passive safety function position) seats. The license entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2015-00274.

The failure to establish and maintain a correct filling procedure required by Technical Specification 5.4.1.a. was a performance deficiency and resulted in the licensee's failure to declare the high pressure coolant injection and reactor core isolation cooling systems inoperable when required to do so. The performance deficiency is more than minor, and therefore a finding, because it is associated with the procedural quality attribute of the Mitigating Systems Cornerstone, and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the high pressure coolant injection and reactor core isolation cooling systems were not declared inoperable when their test return line isolation valves, HPCI-MOV-21, HPCI-MOV-24, RCIC-MOV-30, and RCIC-MOV-33, were taken off their normally closed (passive safety function position) seats. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Finding At-Power," dated June 19, 2012, inspectors determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design or qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did 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. The finding has a cross-cutting aspect in the area of human performance associated with 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, licensee personnel fell into a pattern of acceptance regarding Procedure 2.2.7. This resulted in a failure to question the lack of an operability caution statement, even though there was other guidance in the inservice inspection program to that effect.

Inspection Report# : [2015001](#) (*pdf*)

**Significance:**  Sep 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to Follow Operability Procedure**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, Drawings,” associated with the licensee’s failure to assess and document the basis for operability when a degraded or nonconforming condition was identified in accordance with Station Procedure 0.5OPS, “Operations Review of Condition Reports/Operability Determination.” Specifically, the licensee failed to adequately evaluate and document the basis for operability when opening the inner railroad airlock door, which serves as a tornado missile barrier for safety-related equipment inside the reactor building. To correct this issue, the licensee performed an operability evaluation and designated compensatory actions. The licensee entered this deficiency into their corrective action program for resolution as Condition Reports CR-CNS-2014-05207 and CR-CNS-2014-05366.

The failure to properly assess and document the basis for operability when a degraded or nonconforming condition was identified was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee’s failure to properly assess and document the basis for operability resulted in a condition of unknown operability for a degraded nonconforming condition. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” dated June 19, 2012, inspectors determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its technical specification allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance in accordance with the licensee’s maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with avoiding complacency because individuals did not recognize and plan for the possibility of mistakes, latent problems, or inherent risk, even while expecting successful outcomes.

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

**Significance:**  Jun 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to Correctly Translate Design Requirements into Installed Plant Configurations**

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

The failure to ensure that design requirements were correctly translated into installed plant equipment was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the associated objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee's failure to translate the design requirements into installed plant equipment resulted in a condition where structures, systems and components necessary to mitigate the effects of a high energy pipe break may not have functioned as required. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, "Mitigating Systems Screening Questions," dated June 19, 2012, inspectors determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of at least a single train for longer than its allowed outage time, or two separate safety systems out-of-service for longer than their technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. Inspectors determined that this finding did not have a cross-cutting aspect because the most significant contributor of this finding occurred in 2003, and does not reflect current licensee performance.

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

**Significance:**  Jun 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

#### **Failure to Follow Seismic Housekeeping Requirements for Scaffolding**

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," associated with the licensee's failure to follow the requirements of Station Procedure 0.41, "Seismic Housekeeping," Revision 10. Specifically, the licensee stored a rolling scaffold in the vicinity of Division II service water booster pumps and failed to properly restrain it. The licensee restrained the rolling scaffold in accordance with Station Procedure 0.41 and assessed operability of the service water booster pumps. The licensee determined that during the time the rolling scaffold was unrestrained one of the Division II service water booster pumps was inoperable. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2014-03000.

The licensee's failure to follow Station Procedure 0.41 seismic housekeeping requirements for a rolling scaffold in the vicinity of Division II service water booster pumps was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affected the associated objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the unrestrained scaffolding resulted in a condition where during a seismic event a service water booster pump may not have been able to perform its specified safety function. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, "Mitigating Systems Screening Questions," dated June 19, 2012, inspectors determined that the finding was of very low safety significance (Green) because the finding: (1) was not a deficiency affecting the design and qualification of a mitigating structure, system, or component, and did not result in a loss of operability or functionality; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of a least a single train for longer than its technical specification allowed outage time; and (4) did not represent an actual loss of function of one or more non-technical

specification trains of equipment designated as high safety-significance in accordance with the licensee's maintenance rule program. The finding has a cross-cutting aspect in the area of human performance associated with training because the organization failed to provide training and ensure knowledge transfer to maintain a knowledgeable, technically competent workforce and instill nuclear safety values [H.9].  
Inspection Report# : [2014003](#) (*pdf*)

---

## Barrier Integrity

**Significance:**  Dec 31, 2014

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

### **Failure to Follow Procedure for Post Maintenance Testing**

The inspectors reviewed a self-revealing, non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," associated with the licensee's failure to follow Special Procedure GEH-TP-116, "Procedure for the Operation and Maintenance of the REM\*TAKE-2/D-100 Modified REM\*TAKE 2," Revision 3, for postmaintenance testing following corrective maintenance. Specifically, the licensee did not follow post-maintenance testing requirements associated with the calibration of the bleeder valve for the REM\*TAKE-2/D-100 tool following corrective maintenance to address water intrusion. This resulted in the bleeder valve being misadjusted and nullifying the fail-safe feature of the REM\*TAKE-2/D-100 tool. With the fail-safe nullified, Control Rod Blade 30-47 became disengaged from the REM\*TAKE-2/D-100 tool and dropped onto the reactor core top guide when the supplemental employee inadvertently pressed the disengage button. No reactor fuel was damaged as indicated by normal radiation levels and air samples on the refuel floor and reactor water coolant samples. The licensee's immediate corrective actions for the event was to suspended all in-vessel maintenance activities and remove REM\*Take-2/D-100 grapple from service and determined functionality of the tool. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2014-06809.

The licensee's failure to follow the post-maintenance testing requirements in Special Procedure GEH-TP-116 was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the human performance attribute of the Barrier Integrity Cornerstone and affected the associated objective of maintaining functionality of fuel cladding. Specifically, with the fail-safe nullified, Control Rod Blade 30-47 became disengaged from the REM\*TAKE-2/D-100 tool and dropped onto the reactor core top guide when a supplemental employee inadvertently pressed the disengage button. Using Inspection Manual Chapter 0609, Appendix G, Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Initial Screening and Characterization of Findings," dated May 09, 2014, inspectors determined that the finding was of very low safety significance (Green) because the finding did not impact the fuel barrier because it: (1) does not increase the potential for failure of the freeze seal or if unmitigated have the potential to cause a disruption of residual heat removal/decay heat removal or a loss of inventory event; (2) does not involve two or more adjacent control rods with the potential to, or actually, add positive reactivity; and (3) does not degrade the ability to isolate a drain down or leakage path. The finding has a cross-cutting aspect in the area of human performance associated with the field presence component because the licensee failed to ensure supervisory and management oversight of work activities including contractors and supplemental personnel.

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

---

## Emergency Preparedness

**Significance:**  Sep 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to Follow a Requirement of the Emergency Plan**

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

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

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

**Significance:**  Sep 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to Correct an Inaccurate Classification During a Drill**

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

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

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

---

## Occupational Radiation Safety

---

## Public Radiation Safety

---

## Security

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

---

## Miscellaneous

**Significance:** N/A Jun 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Report Conditions Prohibited by Technical Specifications**

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

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

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

Last modified : June 16, 2015