Grand Gulf 1
4Q/2015 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Have Appropriate Instructions for Preventative Maintenance on the Division I Diesel Generator Simulated Run
The inspectors reviewed a self-revealing non-cited violation of Technical Specification 5.4.1.a, for the failure to establish adequate instructions to perform a simulated surveillance on the division I diesel generator. Specifically, the simulated surveillance run instructions verified the trip high vibration (E-23H) valve was open, but it did not close the (E-23H) valve following the run to ensure the high vibration trip was bypassed. As a result, the division I diesel generator spuriously tripped on high vibrations during the November 21, 2015, run and was rendered inoperable and unavailable. On November 22, 2015, the licensee closed the trip high vibration (E-23H) valve and successfully ran the division I diesel generator to return it to operable status. The licensee entered this issue into their corrective action program as Condition Report CR-GGN-2015-6831.

The failure to establish adequate preventative maintenance instructions to perform a division I diesel generator simulated run and return the valve lineup to the required position was a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, following the division I diesel generator simulated run, the preventative maintenance instruction did not require the licensee to close the trip high vibration (E-23H) valve, and therefore the high vibration trip capability remained for a duration of approximately 16 hours. As a result, during the November 21, 2015 run, the diesel generator spuriously tripped on an invalid high vibration signal and was rendered inoperable and unavailable. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” and Inspection Manual Chapter 0609, Appendix A, Exhibit 2, “Mitigating Systems Screening Questions,” the inspectors determined that the finding is of very low safety significance (Green) because it: (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 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 inspectors determined that the finding has a design margin cross-cutting aspect within the human performance area because the licensee failed to ensure margins are carefully guarded and changed only through a systematic and rigorous process. Specifically, the licensee failed to fully implement their design change process such that all effected station documents and procedures were identified and revised after removing the high vibration trip for the division I

and division II diesel generators.
Inspection Report# : 2015004 *(pdf)*

Significance: G Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Timely Enter Technical Specification Surveillance Requirement 3.0.1
The inspectors identified a non-cited violation of Technical Specification Surveillance Requirement 3.0.1, for the failure to follow requirements when a surveillance was not performed within the specified frequency and declare the Limiting Condition for Operation not met or follow the provisions in Surveillance Requirement 3.0.3. Specifically, the licensee did not follow Technical Specification Surveillance Requirement 3.0.1, when they discovered that Surveillance Requirement 3.8.1.9 was not performed within its specified frequency and either declare Technical Specification Limiting Condition for Operation 3.8.1 not met, or perform the required actions to determine whether compliance with the requirement to declare the Limiting Condition for Operation not met may be delayed. The licensee failed to enter Technical Specification Surveillance Requirement 3.0.1, until September 29, 2015, after discussions with the NRC. On September 29, 2015, the licensee adequately performed the actions required in Technical Surveillance Requirement 3.0.3. The licensee entered this issue into their corrective action program as Condition Report CR-GGN-2015-5602.

The failure to timely enter and perform the actions as required per Technical Specification Surveillance Requirement 3.0.1 was a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to perform technical specification surveillance requirements, and associated actions, did not ensure that the diesel generator could appropriately respond to initiating events. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” and Inspection Manual Chapter 0609, Appendix A, Exhibit 2, “Mitigating Systems Screening Questions,” the inspectors determined that the finding is of very low safety significance (Green) because it: (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 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 inspectors determined that the finding has a conservative bias cross-cutting aspect within the human performance area because the licensee failed to use decision making-practices that emphasize prudent choices over those that are simply allowable. Specifically, operations personnel failed to enter Technical Specification Surveillance Requirement 3.0.1 because the operability determination alone justified operability without doing a detailed risk evaluation.
Inspection Report# : 2015004 *(pdf)*

Significance: G Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Establish Adequate Maintenance Instructions to Perform Work Activities on the Division III Diesel Generator Overspeed Trip Limit Switch
The inspectors reviewed a self-revealing non-cited violation of Technical Specification 5.4.1.a, for the failure to establish adequate maintenance instructions to perform work activities on the division III diesel generator overspeed trip limit switch. Specifically, work orders did not contain adequate instructions to check the overspeed trip switches’

alignment in accordance with vendor recommendations. As a result, the division III diesel generator was rendered inoperable and unavailable. On July 15, 2015, the licensee appropriately set the limit switch to overspeed actuating arm engagement, and returned the diesel generator to operable. The licensee entered this issue into their corrective action program as Condition Report CR-GGN-2015-3985.

The failure to establish adequate work instructions to verify the overspeed switch was properly set and adjusted was a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, work orders to check the overspeed trip switches' alignment did not contain adequate instructions to successfully perform the maintenance. The division III diesel generator was declared inoperable when the diesel spuriously tripped during the monthly surveillance run on July 13, 2015. The inspectors performed the initial significance determination for the division III emergency diesel generator failure. The inspectors used the NRC Inspection Manual 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions." The finding required a detailed risk evaluation because it involved a performance deficiency that represented a loss of the high pressure core spray system following a postulated loss of offsite power because of the failure of the division III diesel generator. The Region IV senior reactor analyst performed a detailed risk evaluation in accordance with NRC Inspection Manual 0609, Appendix A, Section 6.0, "Detailed Risk Evaluation." The detailed risk evaluation result is a finding of very low safety significance (Green). The calculated change in core damage frequency of 5.0 x 10-7 was dominated by an unrecovered station blackout beyond battery depletion. The analyst determined that the bounding risk of a large, early release of radiation was 9.6 x 10-8. For the details of the analysis, see Attachment 3.

Work orders were developed to address operating experience provided from the diesel generator vendor to the industry in December 2011. The inspectors determined that the cause of the deficiency occurred in 2011, and therefore, determined the finding did not have a cross-cutting aspect since it is not indicative of current licensee performance.
Inspection Report# : 2015004 *(pdf)*

Significance: G Oct 09, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Promptly Initiate Condition Reports
The team identified five examples of a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to promptly identify and correct conditions adverse to quality. Specifically, on October 8, 2015, the team identified five conditions adverse to quality where the licensee failed to initiate a condition report in a prompt/timely manner. The five conditions adverse to quality were associated with: (1) the short circuit analysis for the 480V motor control center breakers; (2) emergency diesel generators minimum and maximum frequency; (3) emergency diesel generators fuel consumption rate; (4) Division 3 Emergency Diesel Generator load shedding test; and (5) 120V AC power system calculations. The licensee entered this issue into their corrective action program as Condition Report CR-GGN-2015-05550.

The failure to promptly identify conditions adverse to quality and enter them into the corrective action program by initiating a condition report in a prompt/timely manner as required by Section 5.2[3] of EN-LI-102, "Corrective Action Program," Revision 24, is a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because the five examples are associated with 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 Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the team determined that the finding is of very low safety significance (Green) because it: (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 team determined that this finding has a cross-cutting aspect associated with training, in that the organization did not provide training or ensure knowledge transfer to maintain a knowledgeable, technically competent workforce and instill nuclear safety values. Specifically, when the NRC identified the five conditions adverse to quality to licensee personnel, the licensee personnel did not recognize these conditions required prompt/timely initiation of a condition report.

Inspection Report# : 2015008 *(pdf)*

Significance: G Oct 09, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Enter a Condition Adverse to Quality into the Corrective Action Program
The team identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to identify and correct a condition adverse to quality by entering it into the corrective action program for resolution. Specifically, the licensee failed to identify and correct the potential for safety-related Standby Service Water fans to rotate backwards under certain design conditions, which could affect their ability to perform their safety function when needed. The licensee entered this condition into the corrective action program as CR-GGN-2015-05509.

The failure to enter a condition adverse to quality into the corrective action program as required by station procedure EN-LI-102, "Corrective Action Program," Revision 24, is a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the design control attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective to ensure the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, not evaluating an identified nonconformance resulted in the failure to ensure the capability of safety-related Structures, Systems, and Components to respond reliably during anticipated events. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," dated July 1, 2012, the team determined that the finding is of very low safety significance (Green) because it: (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 team determined that this finding has a cross-cutting aspect associated with problem identification, specifically, individuals failed to ensure that the issue was reported and documented in the corrective action program at a low threshold.
Inspection Report# : 2015008 *(pdf)*

Significance: G Oct 01, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Ensure Safety-Related Alternating Current and Direct Current Equipment Operability and

Functionality at Maximum Allowable Voltage Levels
Green. The team identified two examples of a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states, in part, "design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, prior to September 3, 2015, the licensee failed to verify or check the adequacy of: (1) Safety-related motors and control power circuits fed from Division III 480 V ac emergency safety feature bus 17B01, which were not designed or analyzed to operate using higher voltage ranges that are supplied to the safety-related buses; and (2) safety-related equipment connected to the 125 V dc system were not verified for satisfactory operation at elevated equalizing voltage of 140 V dc. In response to this issue, the licensee performed an operability determination which determined that the condition would reduce the life of the equipment but not cause spurious malfunctions. This finding was entered into the licensee's corrective action program as Condition Reports CR GGN 2015 4413 and CR GGN 2015 5130.

The team determined that the licensee's failure to assure that allowable high voltage conditions are within alternating and direct current equipment ratings 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 adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the operation of the equipment outside of its equipment ratings adversely affects the reliability of safety-related equipment. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the finding was determined to have very low safety significance (Green) because it was a design or qualification deficiency that did not represent a loss of operability or functionality; did not represent an actual loss of safety function of the system or train; did not result in the loss of one or more trains of non-technical specification equipment; and did not screen as potentially risk significant due to seismic, flooding, or severe weather. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance. (Section 1R21.2.1.b.1)

Inspection Report# : 2015007 *(pdf)*

Significance: G Oct 01, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Ensure that Electrical Interrupting Devices are Rated for Available Fault Current Levels
Green. The team identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states, in part, "design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, from January 20, 2010, to August 26, 2015, the licensee issued Calculation EC-Q1111-90028, "AC Power Systems," Revision 6, but failed to verify that the calculated fault current levels were within the ratings of the installed Division III circuit breakers. In response to this issue, the licensee performed an operability evaluation to support an operable but degraded/nonconforming condition, recommending an action to perform a detailed fault current study, and reviewing fault current levels at maximum switchyard voltage of 105 percent to verify that they do not create additional concerns. This finding was entered into the licensee's corrective action program as Condition Reports CR-GGN-2015-4607, CR-GGN-2015-4934, and CR-GGN-2015-5112.

The team determined that failure to ensure that electrical interrupting devices are rated for available fault current levels 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 adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee's failure to verify the

design adequacy of the interrupting equipment would operate with a fault resulted in a reasonable doubt with the operability of Division III motor control center 17B01. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the finding was determined to have very low safety significance (Green) because it was a design or qualification deficiency that did not represent a loss of operability or functionality; did not represent an actual loss of safety function of the system or train; did not result in the loss of one or more trains of non-technical specification equipment; and did not screen as potentially risk significant due to seismic, flooding, or severe weather. This finding had a human performance crosscutting aspect associated with design margins, because the licensee failed to operate and maintain equipment within design margins [H.6]. (Section 1R21.2.2.b.1)

Inspection Report# : 2015007 *(pdf)*

Significance: G Oct 01, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Identify and Address Impacts of Revised Calculation Output Data
Green. The team identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," which states, in part, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings." Specifically, on January 22, 2010, the licensee issued calculation EC-Q1111-90028, "AC Power Systems," Revision 6, but failed to meet the procedural requirement that other documents impacted by the change be identified and updated. In response to this issue, the licensee reviewed the affected calculations to determine if the design bases was met and created a corrective action to update calculations. This finding was entered into the licensee's corrective action program as Condition Reports CR-GGN-2015-4647 and CR-GGN-2015-4859.

The team determined that the licensee's failure to identify and address the impacts of the revised calculation on other documents in accordance with EN-DC-126 was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, routinely failing to revise the obsolete input data in electrical calculations and other design documents was a significant programmatic deficiency which can result in incorrect conclusions regarding the ability of the equipment to meet its design bases. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the finding was determined to have very low safety significance (Green) because it was a design or qualification deficiency that did not represent a loss of operability or functionality; did not represent an actual loss of safety function of the system or train; did not result in the loss of one or more trains of non-technical specification equipment; and did not screen as potentially risk significant due to seismic, flooding, or severe weather. This finding had a human performance crosscutting aspect associated with procedure adherence, because individuals failed to follow procedures, processes, and work instructions [H.8]. (Section 1R21.2.3.b.1)

Inspection Report# : 2015007 *(pdf)*

Significance: G Oct 01, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Perform Surveillance Requirement 3.8.1.9
Green. The team identified a Green, non-cited violation of Technical Specification 3.8.1, AC Sources-Operating, LCO 3.8.1, which requires that three diesel generators be operable. Specifically, since July 1985, the licensee failed to

perform Surveillance Requirement 3.8.1.9, because surveillance testing performed did not verify that each diesel generator could reject the single largest post-accident load and maintain engine speed within the required criteria. In response to this issue, the licensee performed an immediate operability determination to confirm that test results from full load reject indicated that, if performed correctly, the results of the Surveillance Requirement 3.8.1.9 test would be acceptable. This finding was entered into the licensee's corrective action program as Condition Reports CR GGN-2015-4611 and CR-GGN-2015-4627.

The team determined that the failure to perform Technical Specification Surveillance Requirement 3.8.1.9 was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because it was associated with the procedure quality attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences. Specifically, the surveillance procedure error resulted in the acceptance of test results that did not satisfy Technical Specification Surveillance Requirement 3.8.1.9; therefore the test did not demonstrate diesel generator operability. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the finding was determined to have very low safety significance (Green) because it was a design or qualification deficiency that did not represent a loss of functionality; did not represent an actual loss of safety function of the system or train; did not result in the loss of one or more trains of non-technical specification equipment; and did not screen as potentially risk significant due to seismic, flooding, or severe weather. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance. (Section 1R21.2.4.b.1)

Inspection Report# : 2015007 *(pdf)*

Significance:  Oct 01, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Obtain a License Amendment for Use of Probabilistic Methods to Evaluate Tornado Missile Hazards
Severity Level IV/Green. The team identified a Green, Severity Level IV non-cited violation of 10 CFR 50.59, "Changes, Tests, and Experiments," paragraph c(2), (1995 version) which requires that a licensee who desires to make a change in the facility described in the final safety analysis report, which involve an unreviewed safety question shall submit an application for amendment of the license pursuant to 10 CFR 50.90. Specifically, on August 31, 1995, the licensee's incorporation of the use of probabilistic methods for evaluation of tornado missiles into the Grand Gulf Final Safety Analysis Report Section 3.5.2.5 involved an unreviewed safety question because it increased the probability of occurrence of a malfunction of equipment important to safety previously evaluated in the safety analysis report. In response to the issue, the licensee prepared a license amendment request to obtain approval to use probabilistic methods for tornado missile evaluations. This finding was entered into the corrective action program as Condition Reports CR GGN 2015 04615 and CR-GGN-2015-4760.

The team determined that the failure to obtain a license amendment prior to implementing a proposed change to the tornado missile protection design requirements was a performance deficiency. This performance deficiency was determined to be more than minor, and therefore a finding, because there was a reasonable likelihood the change would require NRC review and approval. This finding was evaluated using traditional enforcement, because the violation may impact the ability for the NRC to perform its regulatory oversight function. In accordance with the NRC Enforcement Policy, the significance determination process was used to inform the significance of the failure to obtain a license amendment prior to implementing a proposed change to the main control room design requirements. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined the finding involves the total loss of a safety function, identified by the licensee through a probabilistic risk analysis, individual plant examination for external events, or similar analysis, that contributes to external event initiated core damage accident sequences. Therefore, detailed risk evaluation was

necessary. The senior reactor analyst reviewed the Grand Gulf Individual Plant Examination for External Events because it was the best available information on missile damage to exposed safety-related equipment. The senior reactor analyst determined that the finding had very low safety significance (Green) because the probability of damage occurring to the exposed safety-related equipment was 7.7E-9/year, which is below the threshold for additional probabilistic risk evaluation. Since the violation was associated with a Green reactor oversight finding, the traditional enforcement violation was determined to be a Severity Level IV violation, consistent with paragraph 6.1.d(2) of the NRC Enforcement Policy. This finding did not have a crosscutting aspect because the most significant contributor did not reflect current licensee performance. (Section 1R21.2.19.b.1)

Inspection Report# : 2015007 *(pdf)*

Significance: G Oct 01, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Ensure Equipment Operability and Functionality of Allowable Alternating Current Frequency Range
Green. The team identified a Green, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states, in part, "design control measures shall provide for verifying or checking the adequacy of design, such as by the performance of design reviews, by the use of alternate or simplified calculational methods, or by the performance of a suitable testing program." Specifically, prior to August 14, 2015, the licensee failed to verify that the safety related alternating current equipment will operate satisfactorily at the extremes of the allowable alternating current frequency ranges as specified in the updated final safety analysis report and technical specifications. This finding was entered into the licensee's corrective action program as Condition Report CR-GGN-2015-4672.

The team determined that the failure to verify safety-related alternating current equipment for operation at the extremes of the allowed frequency range 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 adversely affected the cornerstone objective to ensure the availability, reliability, and capability of safety systems that respond to initiating events to prevent undesirable consequences. Specifically, lack of verification that the alternating current equipment would function at the extremes of the allowable frequency range can result in incorrect conclusions regarding the ability of the equipment to meet its design bases. In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the finding was determined to have very low safety significance (Green) because it was a design or qualification deficiency that did not represent a loss of operability or functionality; did not represent an actual loss of safety function of the system or train; did not result in the loss of one or more trains of non-technical specification equipment; and did not screen as potentially risk significant due to seismic, flooding, or severe weather. This finding had a problem identification and resolution crosscutting aspect associated with self-assessments, because the organization failed to conduct self-critical and objective assessment of its programs and policies [P.6]. (Section 1R21.3.2.b.1)

Inspection Report# : 2015007 *(pdf)*

Significance: G Oct 01, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Implement Equipment Control Procedures for Loose Items in Containment
Green. The team identified a Green, non-cited violation of Technical Specification 5.4, "Procedures," 5.4.1, which states, "Written procedures shall be established, implemented, and maintained covering the following activities: (a)

The applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978." Specifically, prior to August 10, 2015, the licensee failed to follow Procedures 01-S-07-43, "Control of Loose Items, Temporary Electrical Power, and Access to Equipment," GGNS CS-17 "Standard for Prevention of Potentially Hazardous Seismic II/I Situations due to Loose Items" and EN-MA-118, "Foreign Material Exclusion," when multiple loose items were left in containment since the previous refueling outage. In response to this issue, the licensee immediately removed all loose items in containment that was not permitted by an associated engineering evaluation. This finding was entered into the corrective action program as Condition Report CR-GGN-2015-4568.

The team determined that failure to implement procedures for prevention of loose items in the containment structure was a performance deficiency. This performance deficiency was more than minor, and therefore a finding, because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, the failure to control materials and temporary equipment was a significant programmatic deficiency which would have the potential to cause unacceptable or degraded conditions if left undetected (MC 0612, App E). In accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the issue screened as having very low safety significance (Green) because it was a design or qualification deficiency that did not represent a loss of operability or functionality; did not represent an actual loss of safety function of the system or train; did not result in the loss of one or more trains of nontechnical specification equipment; and did not screen as potentially risk significant due to seismic, flooding, or severe weather. This finding had a human performance crosscutting aspect associated with avoid complacency, in that the licensee failed to recognize and plan for the possibility of latent issues, even while expecting successful outcomes [H.12]. (Section 1R21.4.b.1)

Inspection Report# : 2015007 *(pdf)*

Significance: G Sep 30, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Failure to Have Appropriate Instructions for Preventative Maintenance on the Division II Diesel Generator Fuel Rack Control Lever
The inspectors reviewed a self-revealing, non-cited violation of Technical Specification 5.4.1.a, for the failure to establish appropriate maintenance instructions to perform maintenance activities on the fuel rack control lever of the division II diesel generator. Specifically, the preventative maintenance instruction did not inspect for foreign material between the fuel rack control lever and the adjacent clamp, which caused the fuel rack control lever to be stuck in the open position. As a result, the division II diesel generator was rendered inoperable and unavailable. On June 28, 2015, the licensee cleaned and lubricated the fuel rack control lever and performed the preventative maintenance instruction to return the division II diesel generator to operable status. The licensee entered this issue into their corrective action program as Condition Report CR-GGN-2015-3741.

This performance deficiency is more than minor, and therefore a finding, because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined that the finding is of very low safety significance (Green) because it: (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 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 mechanical standard was last updated in 2006, and the preventative maintenance instruction was last updated in 2012 for editorial purposes only. The inspectors determined that the cause of the deficiency occurred in 2006, and therefore, determined the finding did not have a cross-cutting aspect since it is not indicative of current licensee performance.
Inspection Report# : 2015003 *(pdf)*

Significance: G Jun 30, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Failure to Have Appropriate Instructions Resulted in the Unplanned Unavailability of the Reactor Core Isolation Cooling System
The inspectors reviewed a self-revealing, non-cited violation of Technical Specification 5.4.1.a, for failure to establish appropriate work instructions to properly preplan and perform maintenance that affected the performance of the reactor core isolation cooling system. Specifically, the work instructions failed to ensure that a steam supply drain pot drain alignment path was maintained while replacing valve packing 1-E51-F026. As a result, the drain path was isolated causing a group 4 isolation, which rendered the reactor core isolation cooling system unavailable. Operations personnel returned the reactor core isolation cooling system to operable status approximately 19 hours after the isolation occurred. This issue was entered into the licensee's corrective action program as Condition Report CR-GGN-2015-01677.
This performance deficiency is more than minor, and therefore a finding, because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to have an adequate maintenance work instruction resulted in the unplanned unavailability of the reactor core isolation cooling system. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined that the finding is of very low safety significance (Green) because it: (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. In addition, this finding has an avoid complacency cross-cutting aspect within the human performance area because the licensee failed to recognize and plan for the possibility of mistakes, inherent risks, and properly implement appropriate error reduction tools. Specifically, the licensee failed to recognize the importance of having a drain path during the entire maintenance activity to properly plan the activity using appropriate configuration control and work instructions.
Inspection Report# : 2015002 *(pdf)*

Significance: G Jun 30, 2015
Identified By: NRC

Item Type: NCV Non-Cited Violation
Failure to Identify High Vibration on the Division 3 EDG Soak Back Oil Pump
The inspectors identified a non-cited violation of Technical Specification 5.4.1.a, for the failure to have appropriate maintenance instructions to review and analyze vibration data on the division 3 emergency diesel generator soak back oil pump. Specifically, Work Order WO 52582051 failed to ensure an appropriate review and analysis of the vibration data collected on the division 3 emergency diesel generator soak back oil pump. As a result, the soak back oil pump on the division 3 emergency diesel generator failed due to high vibration and the emergency diesel generator was declared inoperable. As corrective actions, the licensee repaired soak back oil pump. This issue was entered issue into the licensee's corrective action program as Condition Report CR-GGN-2015-0071.
This performance deficiency is more than minor, and therefore a finding, because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, vibration data was collected, but was not appropriately reviewed and analyzed to identify a degrading soak back oil pump on the division 3 emergency diesel generator. The division 3 emergency diesel generator was declared inoperable when the failed pump coupling was identified by the licensee. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and Inspection Manual Chapter 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined that the finding is of very low safety significance (Green) because it: (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. This finding has an avoid complacency crosscutting aspect within the human performance area because the licensee failed to recognize and plan for the possibility of mistakes, inherent risks, and properly implement appropriate error reduction tools. Specifically, the licensee failed to recognize the importance of including complete instructions to maintenance personnel to ensure that critical steps were accomplished.
Inspection Report# : 2015002 *(pdf)*

Significance:  Jun 30, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Possible Loss of Communications Systems During Control Room Fire Scenarios
The team identified a non-cited violation of License Condition 2.C.9, "Fire Protection," for the failure to provide reliable communications systems for use by operators during control room fire scenarios. The licensee included this deficiency in their corrective action program as Condition Report CR-GGN-2014-03803, and completed actions to establish alternate communications.
The failure to provide a reliable communication system for operators to use to perform a post-fire safe shutdown outside of the control room was a performance deficiency. The performance deficiency was more than minor because it was associated with the protection against external events (fire) attribute of the Mitigating Systems Cornerstone, and it

adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences because it affected the ability to reach and maintain safe shutdown conditions in case of a fire. The team evaluated this finding using Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," dated September 20, 2013. Because it affected the ability to reach and maintain safe shutdown conditions in case of a fire that led to control room evacuation, a senior reactor analyst performed a Phase 3 evaluation that determined the deficiency had very low risk significance. The finding did not have a cross-cutting aspect since it is not indicative of current licensee performance.
Inspection Report# : 2015002 *(pdf)*

Significance: G Mar 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Take Timely Corrective Actions Associated with Division 1 and 2 Standby Service Water Pump House Ventilation System Due to Degraded Relays
The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to take timely corrective actions to correct a condition adverse to quality associated with the division 1 and 2 standby service water pump house ventilation systems. Specifically, in June 2011, the licensee identified that relays associated with the standby service water system pump house ventilation system failed due to age/environmental degradation, which resulted in an unplanned inoperability of the standby service water system. However, the licensee did not implement timely corrective actions for replacing these relays, which resulted in the inoperability of the division 1 standby service water system in December 2014, and again in January 2015. The licensee documented this issue in their corrective action program as Condition Report CR-GGN-2015-00739. The short-term corrective actions included replacing all of the division 1 and 2 standby service water ventilation pump house relays in February and early March 2015.

The inspectors determined that the failure to take timely corrective actions to replace degraded relays in the standby service water pump house ventilation system was a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the equipment performance attribute of the Mitigating System 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 Inspection Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," dated June 19, 2012, and NRC Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings at Power," dated June 19, 2012, the inspectors determined the issue to be of very low safety significance (Green) because all applicable screening questions in Manual Chapter 0609, Appendix A, Exhibit 2, were answered "no." The inspectors determined that this performance deficiency was not indicative of current plant performance, and therefore no cross-cutting aspect was considered.

Inspection Report# : 2015001 *(pdf)*

Significance: G Mar 31, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Failure to Follow a Procedure Resulting in the Unplanned Inoperability of the Reactor Core Isolation Cooling System
The inspectors reviewed a self-revealing, non-cited violation of Technical Specification 5.4.1.a, for failure to follow a procedure which resulted in the unplanned inoperability of the reactor core isolation cooling system. This occurred when licensee technicians tested for continuity between incorrect points, while performing surveillance activities

related to the residual heat removal system. This resulted in an invalid group 4 isolation signal and an isolation of the reactor core isolation cooling steam supply. The licensee entered this issue into the corrective action program as Condition Report CR-GGN-2015-01532, and took immediate corrective actions to stop the residual heat removal system surveillance activity and restore the reactor core isolation cooling system to service.
The failure to properly follow the surveillance procedure, which resulted in the unplanned inoperability of the reactor core isolation cooling system, was a performance deficiency. This performance deficiency is more than minor, and therefore a finding, because it is associated with the human performance attribute of the Mitigating Systems Cornerstone. Specifically, the licensee's failure to properly follow the surveillance procedure resulted in the unplanned inoperability of the reactor core isolation cooling system, which 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 Inspection Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," dated June 19, 2012, and 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, the inspectors determined that the finding was of very low safety significance (Green) in that the issue did not affect the design or qualification of the reactor core isolation cooling system; did not represent a loss of the reactor core isolation cooling system function (in that the isolation could have been promptly reset by procedures, had the system operation been required); and did not represent loss of function for greater than the Technical Specification allowed outage time. The inspectors determined this finding had cross-cutting aspect in the area of human performance associated with avoiding complacency, in that the I&C technicians did not implement appropriate error reduction tools to ensure the meter was connected to the correct points, which resulted in the invalid group 4 isolation signal, and inoperability of the reactor core isolation cooling system [H.12].
Inspection Report# : 2015001 *(pdf)*

Significance: G Mar 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Adequately Establish Commercial-Grade Items as Basic Components
The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to verify the suitability of replacement parts that were procured from commercial suppliers. Specifically, the inspectors noted that none of the tests specified by the licensee were sufficient to ensure that the seismic qualification of an auxiliary relay had been maintained. The finding was entered into the licensee's corrective action system as Condition Report CR-GGN-2014-05049.

The performance deficiency is more than minor, and therefore a finding, because it was associated with 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. In accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," the issue screened as having very low safety significance (Green) because the licensee performed an operability determination, which evaluated the safety impacts of postulated relay chatter during a seismic event, for the applications in which these relays were installed. The licensee's subsequent operability evaluation determined that potential relay chatter would not impact the safety-related functions of the relays in the applications in which they were installed. Thus, all applicable screening questions in Manual Chapter 0609, Appendix A, Exhibit 2, were answered "no." A cross-cutting aspect is not being assigned to this finding.

Inspection Report# : 2015001 *(pdf)*

Barrier Integrity

Significance: G Oct 09, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Declare Secondary Containment Inoperable Based on Failed Surveillance Testing
The team identified a non-cited violation of Technical Specification 3.6.4.1 Condition A, for the failure to declare secondary containment inoperable. Specifically, on August 1, 2015, the licensee failed to declare secondary containment inoperable after it failed to achieve the necessary vacuum to pass Surveillance Requirement 3.6.4.1.4. The licensee entered this issue into their corrective action program as Condition Report CR GGN 2015 05826.

The failure to declare secondary containment inoperable due to failed surveillance test and enter the appropriate action statements as required by the licensee's technical specifications is a performance deficiency. This deficiency is more than minor, and therefore a finding, because it is associated with the Structures, Systems, Components, and Barrier Performance attribute of the Barrier Integrity cornerstone. Specifically, the failure to declare secondary containment inoperable and take actions as required in Technical Specification Limiting Condition for Operation 3.6.4.1, Condition A, within four hours, adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and Inspection Manual Chapter 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," dated July 1, 2012, the team determined that the finding is of very low safety significance (Green) because it only represented a degradation of the radiological barrier function provided for the auxiliary building secondary containment. The team determined that this finding has a cross-cutting aspect associated with avoid complacency, in that individuals did not recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes. Although the surveillance test was documented as Technical Specification Acceptance Criteria Unacceptable because it did not meet the criteria defined in test procedure 06-OP-1T48-R-0002, "Standby Gas Treatment A Logic and Vacuum Test," Revision 115, the licensee did not identify it as a failed surveillance test that affected secondary containment operability
Inspection Report# : 2015008 *(pdf)*

Emergency Preparedness

Significance: G Mar 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Emergency Action Level Scheme for Nonfunctional Seismic Monitor
The inspectors identified a non-cited violation of 10 CFR 50.54(q)(2) for the licensee's failure to follow and maintain the effectiveness of an emergency plan that meets the requirements of the planning standard 50.47(b)(4), which requires that a standard emergency classification and action level scheme, is in use by the licensee. Specifically, the licensee had identified, on October 15, 2013, that the seismic monitoring instrumentation was non-functional, but had not further evaluated the plant configuration, and the effect on emergency action level declaration capabilities for seismic events. The licensee documented this issue in Condition Report CR-GGN-2015-00713. The corrective actions, based on CR-GGN-2013-06514, were implemented, and a new seismic monitor was installed, tested, and brought into service on January 30, 2015.
The licensee's inability to promptly declare Emergency Action Level (EAL) HA6, as required in the approved emergency classification and action level scheme per 10 CFR Part 50.47(b)(4), was a performance deficiency. This

performance deficiency is more than minor, and therefore a finding, because it is associated with the procedure quality attribute of the Emergency Preparedness Cornerstone and adversely affects the 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, it negatively impacts the cornerstone attribute of procedure quality in that the plant configuration prohibited the timely declaration of the facility EALs, as written. Using NRC Inspection Manual Chapter 0609, Attachment 4, "Initial Characterization of Findings," dated June 19, 2012, the inspectors determined that the issue affected the Emergency Preparedness Cornerstone. In accordance with NRC Inspection Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," dated September 23, 2014, the inspectors determined that the issue is of very low safety significance (Green) because an Emergency Action Level was rendered ineffective such that HA6 would not be declared, consistent with Table 5.4-1 and Figure 5.4-1. The inspectors determined the finding had a cross-cutting aspect in the area of problem identification and resolution associated with evaluation, in that the organization did not thoroughly evaluate issues to ensure that resolutions address causes, and extent of conditions, commensurate with their safety significance; in that while following Technical Requirements Manual requirements for a non-functional piece of equipment (seismic monitor), the complete effect was not evaluated to ensure the EALs were still capable of being implemented [P.2].

Inspection Report# : 2015001 *(pdf)*

Occupational Radiation Safety

Significance: G Mar 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Properly Calibrate Main Steam Line Radiation Monitors and Containment/Drywell High Range Radiation Monitors
The inspectors identified a non-cited violation of 10 CFR 20.1501(c) for the licensee's failure to properly calibrate the main steam line radiation monitors and the containment/drywell high range radiation monitors. The violation was of very low safety significance and was entered into the licensee's corrective action program as Condition Report CR-GGNS-2015-01832.

The failure to properly calibrate radiation monitors was a performance deficiency. The performance deficiency is more than minor, and therefore a finding, because it adversely affects the cornerstone objective to ensure adequate protection of employee health and safety and is associated with the cornerstone attribute of plant instrumentation. Specifically, the failure to properly calibrate radiation monitors impacts their ability to be used to assess dose rates. Using Inspection Manual Chapter 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated August 19, 2008, the inspectors determined the finding to be of very low safety significance because it was not an as low as reasonably achievable (ALARA) issue, there was no overexposure or substantial potential for overexposure, and the licensee's ability to assess dose was not compromised. This finding has a cross-cutting aspect in the resources component of the human performance area because the licensee did not ensure that calibration procedures were adequate, nor was proper calibration equipment designed, characterized, and made available [H.1].
Inspection Report# : 2015001 *(pdf)*

Public Radiation Safety

Significance: G Mar 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Establish, Implement, and Maintain Appropriate Changes to the Offsite Dose Calculation Manual For REMP Airborne Sampling
The inspectors identified a non-cited violation of Technical Specification 5.5.1, "Offsite Dose Calculation Manual (ODCM)." Specifically, when changes were made to the Offsite Dose Calculation Manual in 1997, the licensee failed to establish an airborne sampling location for a community with the highest deposition factor (D/Q) for the site. As immediate corrective actions, the licensee evaluated their Offsite Dose Calculation Manual, evaluated the dose differential for the monitoring locations, and developed a plan to meet the environmental sampling requirements. The issue was documented in Condition Report CR-GGNS-2015-01835.

The failure to establish an air sampling location in the vicinity of a community having the highest D/Q was a performance deficiency. The performance deficiency is more than minor, and therefore a finding, because it adversely affects the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the environment and public domain. Specifically, the failure to maintain the Offsite Dose Calculation Manual with appropriate airborne radionuclide sampling requirements adversely impacts the licensee's ability to validate offsite radiation dose assessments for members of the public under certain effluent release conditions. Using Inspection Manual Chapter 0609, Appendix D, dated February 12, 2008, "Public Radiation Safety Significance Determination Process," the inspectors determined that the violation had very low safety significance because it involved the environmental monitoring program. This finding has a cross-cutting aspect in the procedure adherence component of the human performance area because licensee personnel failed to follow procedures when they determined the airborne sampling locations for the updated Radiological Environmental Monitoring Program [H.8].
Inspection Report# : 2015001 *(pdf)*

Security

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

Miscellaneous

Last modified : March 01, 2016