

Cooper

2Q/2016 Plant Inspection Findings

Initiating Events

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Preclude Repetition for a Significant Condition Adverse to Quality

The inspectors reviewed a self-revealing, non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," associated with the inadequate extent of condition and extent of cause evaluations to preclude repetition for a significant condition adverse to quality identified in a 2012 root cause evaluation documented CR-CNS-2012-07174 for the isolation of shutdown cooling system isolation in valves RHR-MOV-17 and RHR-MOV-18 due to localized pressure perturbations at the pressure sensors. Specifically, in 2012, the licensee failed to conduct an adequate extent of cause and condition evaluation to preclude repetition of this event from occurring on May 30, 2015 with the reactor plant in Mode 4. On May 30, 2015, isolation of shutdown cooling system isolation valves RHR-MOV-17 and RHR-MOV-18 due to localized pressure perturbations at the pressure sensors, led to the isolation of the shutdown cooling system for approximately 22 minutes. The station entered Station Procedure 2.4SDC, "Shutdown Cooling Abnormal," Revision 14, and restored shutdown cooling. The reactor coolant system temperature increased approximately 20 degrees Fahrenheit but did not exceed 212 degrees Fahrenheit, maintaining the reactor plant in Mode 4. The licensee entered this deficiency into the corrective action program as Condition Report CR-CNS-2015-03188.

The licensee's failure to conduct an adequate extent of cause and condition evaluation to preclude repetition of a significant condition adverse to quality identified in a 2012 root cause evaluation documented in CR-CNS-2012-07174 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 Initiating Events Cornerstone, and affected the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown. Specifically, the failure to preclude repetition of the isolation of shutdown cooling system isolation valves RHR-MOV-17 and RHR-MOV-18 due to localized pressure perturbations at the pressure sensors led to the isolation of the shutdown cooling system for approximately 22 minutes when the reactor plant was in Mode 4 on May 30, 2015. Using Inspection Manual Chapter 0609, Appendix G, Attachment 1, "Shutdown Operations Significance Process Phase 1 Initial Screening and Characterization of Findings," dated May 9, 2014, inspectors determined that the finding did not require a quantitative assessment because adequate mitigating equipment remained available, and the finding did not constitute a loss of control, as defined in Appendix G. Therefore, the finding screened as a very low safety significance (Green). The inspectors determined that the finding did not have a cross-cutting aspect because the most significant contributor of this finding occurred in 2012, and does not reflect current licensee performance.

Inspection Report# : [2015003](#) (*pdf*)

Mitigating Systems

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Follow Work Instructions for Post-Maintenance Testing of Safety-Related Ventilation Systems

The inspectors identified two examples of a non-cited violation of Technical Specification 5.4.1.a, associated with the licensee's failure to perform required post-maintenance testing for safety-related ventilation systems in accordance with documented instructions, prior to system restoration. Specifically, the licensee failed to follow work order instructions contained in Work Orders 5062878 and 5065112 for (1) performing surveillance testing to measure the airflow of emergency diesel generator supply fan coil unit HV-DG-1C following maintenance, and (2) performing leak testing of a newly created control room ventilation boundary penetration. Corrective actions included performing the required surveillance test for the diesel generator ventilation unit, retesting the control room penetration in accordance with the procedure, and initiating site-wide communications discussing the errors and reemphasizing procedural adherence. The licensee entered these deficiencies into their corrective action program for resolution as Condition Reports CR-CNS-2016-02207 and CR-CNS-2016-02232.

The licensee's failure to perform required post-maintenance testing for safety-related ventilation systems, in accordance with documented instructions, was a performance deficiency. This performance deficiency was associated with multiple cornerstones. The first example of the performance deficiency was more than minor, and therefore a finding, because it was associated with the human 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 measure supply fan coil unit HV-DG-1C airflow resulted in delayed identification that the maintenance had resulted in degraded flow through the ventilation unit. The second example of 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 cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases and that the radiological barrier functionality of the control room is maintained. Specifically, the licensee's failure to follow post-maintenance testing instructions resulted in a challenge to the operability of the newly created control room boundary penetration seal. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, the inspectors determined that the finding was of very low safety significance (Green) because it did not represent a design or qualification deficiency; did not represent a loss of safety function; did not represent a loss of a single train for greater than its technical specification allowed outage time; did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating events; did not represent an actual open containment pathway; and did not involve a reduction in function of hydrogen igniters. The finding had a cross-cutting aspect in the area of human performance associated with work management, because the licensee failed to implement a process of planning, controlling, and executing work activities such that nuclear safety was the overriding priority, including the need for coordination with different work groups or job activities. Specifically, the licensee failed to control, execute, and coordinate safety-related ventilation work activities to ensure all required post-maintenance testing was completed satisfactorily prior to declaring the associated equipment operable.

Inspection Report# : [2016002](#) (*pdf*)

Significance:  Jun 30, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Maintain Design Control for High Pressure Coolant Injection System Electrical Circuit

The inspectors reviewed a self-revealed, non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for the licensee’s failure to verify the adequacy of design of the high pressure coolant injection auxiliary lube oil pump 125 Vdc starter circuit. Specifically, in 1984, the licensee modified the design of the starter circuit and eliminated a resistor that served to protect the circuit from shorting due to indication light bulb failures. As a result, on April 26, 2016, a shorted light bulb resulted in the loss of power to the auxiliary lube oil pump, rendering the high pressure coolant injection system inoperable and unavailable. Immediate corrective actions included replacing the light socket and blown fuse and changing out the nonessential light bulb with an essential bulb. This event was entered into the licensee’s corrective action program as Condition Report CR-CNS-2016-02318, and the licensee initiated a root cause evaluation to investigate the failure.

The licensee’s failure to verify the adequacy of design of the high pressure coolant injection auxiliary lube oil pump starter circuit in accordance with 10 CFR Part 50, Appendix B, Criterion III, 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 adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, at the time the modification was installed, the licensee had not taken sufficient actions to ensure that the electrical circuit was protected from light bulb shorting failures, resulting in the high pressure coolant injection system ultimately being rendered inoperable. 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 required a detailed risk evaluation because it represented a loss of the system and function of high pressure coolant injection. The inspectors determined that the finding was of very low safety significance (Green) through performing a detailed risk evaluation. A cross-cutting aspect was not assigned to this finding because the performance deficiency occurred in 1984, and therefore, is not indicative of current licensee performance.

Inspection Report# : [2016002](#) (pdf)

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Follow ASME Code Requirements when taking Corrective Actions for a Pump in the Required Action Range

The inspectors identified a non-cited violation of 10 CFR 50.55a, “Codes and Standards,” for the licensee’s failure to follow the ASME Code for Operation and Maintenance of Nuclear Power Plants when addressing the performance of reactor equipment cooling pump A within the high “required action range” of the inservice testing program. Specifically, on February 11, 2016, the licensee failed to follow ASME Subsection ISTB 6200(b) when engineering personnel, taking corrective action to address pump performance, failed to either correct the cause of the deviation or establish new reference values for the pump. Instead of establishing new reference values, the licensee performed an analysis to administratively raise the upper “required action range” limit, creating a wider range of acceptable pump operation than allowed by Table ISTB 5100 1, “Centrifugal Pump Test Acceptance Criteria.” The licensee entered this issue into the corrective action program as Condition Report CR CNS 2016 00920, took action to reevaluate and rebaseline the pump with new reference values, and performed an extent of condition review to determine if other equipment was impacted by similar interpretations of the code.

The licensee’s failure to establish new reference values for reactor equipment cooling pump A in accordance with the ASME Code was a performance deficiency. The performance deficiency was determined to be more than minor, and therefore a finding, because it was associated with the human 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 actions initially taken by the licensee would have required a relief request; could have delayed identification of a degrading pump trend due to the creation of a wider range of acceptable operation; and the licensee’s generic interpretation, that the Table ISTB 5100 1 “acceptable range” could be administratively expanded, represented a programmatic vulnerability. The

inspectors used Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” and determined that the finding had very low safety significance (Green) because it did not represent a design or qualification deficiency, did not represent a loss of safety function for a single train for greater than its technical specification allowed outage time, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of problem identification and resolution associated with evaluation. Specifically, the licensee failed to thoroughly evaluate performance of reactor equipment cooling pump A in the “required action range” to ensure that the resolution correctly addressed the causes of the degraded performance [P.2].

Inspection Report# : [2016001](#) (*pdf*)

Significance:  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Diesel Fuel Oil Cloud Point Acceptance Criteria not in accordance with ASTM D975, Revision 1989a

The inspectors identified a non-cited violation of Technical Specification 5.5.9, “Diesel Fuel Oil Testing Program,” for the licensee’s failure to establish an emergency diesel generator fuel oil cloud point acceptance criterion in accordance with ASTM D975, “Standard Specification for Diesel Fuel Oils.” Specifically, the diesel fuel oil cloud point acceptance criterion of = 32°F specified in the licensee’s diesel fuel oil testing program procedures was not in accordance with the ASTM limit of = 3.2°F and was not technically justified as described by the standard. Corrective actions included development of an evaluation which concluded that the appropriate acceptance criterion was = 15°F based on the most limiting day tank room temperatures during accident conditions; verification that the cloud point of the fuel onsite at the time was 8.6°F, which met this criterion; and establishment of compensatory measures to monitor and administratively control the cloud point until fuel oil program procedures could be revised. The licensee entered this deficiency into the corrective action program as Condition Reports CR-CNS-2015-06745, CR-CNS-2015-06717, CR-CNS-2015-06718, and CR-CNS-2015-7150.

The licensee’s failure to establish a diesel fuel cloud point acceptance criterion in accordance with ASTM D975, in violation of Technical Specification 5.5.9, was a performance deficiency. The performance deficiency was determined to be more than minor, and therefore a finding, because it was associated with the procedure quality attribute of the Mitigating Systems Cornerstone, and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, failure to establish a diesel fuel cloud point acceptance criterion in accordance with ASTM D975 could result in formation of wax crystals affecting the capability to transfer the fuel oil from the storage tanks to the emergency diesel generator engine cylinders. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process 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; 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 had a cross-cutting aspect in the area of human performance associated with documentation because the licensee failed to create and maintain complete, accurate, and up-to-date documentation for the worst case temperature at which the emergency diesel generator fuel oil would be stored.

Inspection Report# : [2015004](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Ensure Turbine Building Design Calculation was Correct and Justified

The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which states, in part, "Measures shall be established to assure that applicable regulatory requirements and the design basis, as defined in § 50.2 and as specified in the license application, for those structures, systems, and components to which this appendix applies are correctly translated into specifications, drawings, procedures, and instructions." Specifically, prior to September 29, 2015, the licensee prepared Calculation NEDC 13-028, "Ultimate Internal Pressure of Turbine Building Blowout Panels and Metal Wall System," Revision 1, in accordance with Engineering Procedure 3.4.7, to ensure pressure relief in the turbine building due to a main steam line break would occur at less than or equal to 0.5 pounds per square inch differential pressure as stated in Amendment 25 to the Cooper Nuclear Station Final Safety Analysis Report. However, the inspectors determined that the methodology and assumptions employed in Calculation NEDC 13-028 were not adequate and could not conclude that it ensured siding failure as required. In response to this issue, the licensee performed an operability determination to ensure that safety-related structures, systems, and components and the control room were not adversely affected by a main steam line break. The licensee entered this deficiency into the corrective action program as Condition Report CR-CNS-2015-05705.

The licensee's failure to ensure that a turbine building design calculation was correct and justified was a performance deficiency. The performance deficiency was 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. Specifically, Calculation NEDC 13-028 did not ensure that safety-related structures, systems, and components and the control room, which are necessary for responding to initiating events, would not be adversely affected by a main steam line break in the turbine building. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 2, "Mitigating Systems Screening Question," dated June 19, 2012, inspectors determined that the finding was 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 had a crosscutting aspect in the area of human performance associated with conservative bias because individuals failed to use decision making practices that emphasize prudent choices over those that are simply allowed.

Inspection Report# : [2015003](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Follow Primary Containment Atmosphere Sampling Procedure

The inspectors reviewed a self-revealing, non-cited violation of Technical Specification 5.4.1.a for the licensee's failure to appropriately implement a procedure required by Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Specifically, on

June 2, 2015, a chemistry technician failed to implement Station Procedure 8.8.12, “Primary Containment Oxygen or Noble Gas Activity Grab Sample Analysis,” Revision 14. This resulted in the incorrect primary containment isolation sample valve being operated, which resulted in both divisions of primary containment H₂O₂ analyzers tripping on low pressure/flow. Operations personnel declared both divisions of primary containment H₂O₂ analyzers inoperable and entered Limiting Condition for Operation 3.3.3.1, “Post Accident Monitoring Instrumentation,” Conditions A and C, and restored them to an operable status in accordance with station procedures. The licensee entered this deficiency into the corrective action program as Condition Reports CR-CNS-2015-03292.

The licensee’s failure to operate the correct primary containment isolation sample valve, in support of primary containment atmosphere sampling, in violation of Station Procedure 8.8.12, was a performance deficiency. The performance deficiency was determined to be more than minor, and therefore a finding, because it was associated with the human performance 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. Using Inspection Manual Chapter 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” Exhibit 2, “Mitigating Systems Screening Question,” dated June 19, 2012, inspectors determined that the finding was 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 finding has a human performance cross-cutting aspect within the avoid complacency area because the licensee failed to recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes, which resulted in individuals not implementing appropriate error reduction tools.

Inspection Report# : [2015003](#) (*pdf*)

Barrier Integrity

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Meet Technical Specification Requirements for Traversing In-Core Probe B Ball Valve

The inspectors identified a non-cited violation of Technical Specification 3.6.1.3, “Primary Containment Isolation Valves,” for the licensee’s failure to maintain traversing in-core probe B ball valve, a primary containment isolation valve, operable for its containment isolation function. Specifically, on May 5, 2016, from 5:20 a.m. until 1:08 p.m., the licensee failed to maintain the traversing in-core probe B ball valve operable or isolate its flow path within 4 hours of indications that the mechanical in-shield limit switch had failed. This failure prevented the ball valve from performing its containment isolation function. The licensee took immediate corrective actions upon discovery to restore compliance with Technical Specification 3.6.1.3 by de-energizing the ball valve’s solenoid operating valve,

causing it to close. The licensee entered this deficiency into their corrective action program for resolution as Condition Report CR-CNS-2016-03665.

The licensee's failure to maintain the traversing in-core probe B ball valve, a primary containment isolation valve, operable for its containment isolation function, in violation of Technical Specification 3.6.1.3, 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 adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases and that the radiological barrier functionality of containment is maintained. Specifically, the traversing in-core probe B ball valve was unable to perform its primary containment isolation function with a failed mechanical in-shield limit switch. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, the inspectors determined that the finding was of very low safety significance (Green) because it did not represent an actual open pathway in the physical integrity of reactor containment (valves, airlocks, etc.), containment isolation system (logic and instrumentation), and heat removal components; and did not involve an actual reduction in function of hydrogen igniters in the reactor containment. The finding had a cross-cutting aspect in the area of human performance associated with conservative bias because the licensee failed to use decision-making practices that emphasized prudent choices over those that were simply allowable and failed to ensure proposed actions were determined to be safe in order to proceed, rather than unsafe in order to stop. Specifically, the licensee failed to validate the assumption that the traversing in-core probe B ball valve would fulfill its containment isolation function with a failed mechanical in-shield limit switch, and failed to validate the degraded condition prior to exceeding the 4-hour completion time of Technical Specification 3.6.1.3.

Inspection Report# : [2016002](#) (*pdf*)

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Assess Operability of Technical Specification System Functions during Surveillance Testing

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a, for the licensee's failure to follow Station Procedure 0.26, "Surveillance Program," and assess the operability of high pressure coolant injection steam line isolation instrumentation during surveillance testing. Specifically, the licensee failed to assess the operability of required isolation instrumentation when maintenance personnel opened terminal box 392 during surveillance testing and temporarily invalidated its environmental qualification. Licensee procedures required operations personnel to either establish compensatory measures to restore the terminal box during an event, or declare the instrumentation inoperable and enter the applicable technical specification actions when the terminal box was opened. As an immediate corrective action, the licensee implemented Standing Order 2016 03, which directed operators to establish compensatory measures, if applicable, or declare the affected equipment inoperable when environmentally qualified terminal boxes would be opened during testing. The licensee entered this issue into their corrective action program for resolution as Condition Reports CR CNS 2016 00320 and CR CNS 2016 00476.

The licensee's failure to assess the operability of high pressure coolant injection instrumentation when the associated terminal box was opened during surveillance testing, in violation of Station Procedure 0.26, was a performance deficiency. The performance deficiency was determined to be more than minor, and therefore a finding, because it was associated with the structure, system, component, and barrier performance attribute of the Barrier Integrity Cornerstone, and adversely affected the cornerstone objective to ensure the radiological barrier functionality of containment isolation. Specifically, with terminal box 392 open, its environmental qualification was temporarily invalidated, making the high pressure coolant injection low steam pressure and high steam flow containment isolation instrumentation inoperable during surveillance testing. In addition, two other terminal boxes and their associated surveillances were impacted by the performance deficiency. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," the inspectors determined that the finding had very low safety significance (Green) because it: (1) did not represent an actual open pathway in the physical

integrity of reactor containment, containment isolation system, or heat removal components; and (2) did not involve an actual reduction in function of hydrogen igniters in the reactor containment. The finding had a cross-cutting aspect in the area of human performance associated with work management. Specifically, the licensee failed to implement a process of planning, controlling, and executing work activities such that nuclear safety was the overriding priority, including the identification and management of risk commensurate with opening terminal box 392 during surveillance testing [H.5].

Inspection Report# : [2016001](#) (*pdf*)

Emergency Preparedness

Significance:  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Perform a Complete Evaluation of the Licensee Interface With Offsite Organizations

The inspectors identified a non-cited violation of 10 CFR 50.54(t)(2), for the licensee's failure to include an evaluation of the adequacy of the interfaces with state and local governments in a review of emergency preparedness program elements in Audit 2014-06, dated November 7, 2014. Specifically, the licensee failed to include an evaluation of this interface when audit personnel did not provide offsite officials with an opportunity to provide their view of the adequacy of the interface to the audit team. Corrective actions included development of lessons learned for future audits and reengagement with state and local governments to assure adequate interface existed during the most recent emergency preparedness audits. The licensee entered this deficiency into the corrective action program as Condition Report CR-CNS-2015-06403.

The failure to perform an evaluation for adequacy of the interface with state and local governments was a performance deficiency. The performance deficiency was determined to be more than minor, and therefore a finding, because it was associated with the offsite emergency preparedness attribute of the Emergency Preparedness Cornerstone, and affected 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, the ability to implement adequate measures to protect the health and safety of the public could be affected if communication and coordination problems between the licensee and offsite agencies are not detected and corrected. The finding was evaluated using Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," dated September 22, 2015, and was determined to have very low safety significance (Green) 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 finding had a cross-cutting aspect in the area of problem identification and resolution associated with evaluation because the licensee failed to thoroughly evaluate issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. Specifically, the audit team failed to fully evaluate the potential for problems to exist with the adequacy of the interface with state and local governments.

Inspection Report# : [2015004](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Ensure Measurement Conditions were Consistent With Instrument Calibration

The inspectors identified a non-cited violation of 10 CFR 20.1501(c) for the failure to ensure measurement conditions were consistent with instrument calibration parameters for the elevated release point monitor, compromising the ability to accurately determine the concentration of radioactive effluents released. Specifically, water intrusion/condensation in the elevated release point Kaman normal range effluent monitor noble gas sample chamber introduced discrepancies relative to the calibration geometry and water in the particulate filter and iodine cartridge adversely affected the sample media collection efficiencies. Immediate corrective actions included the licensee performing a functionality assessment of the monitor. The licensee entered this deficiency into the corrective action program as Condition Reports CR-CNS-2015-05051 and CR-CNS-2015-05067.

The failure to ensure measurement conditions were consistent with instrument calibration parameters for the elevated release point monitor was a performance deficiency. The performance deficiency was more than minor, and therefore a finding, because it was associated with the Public Radiation Safety Cornerstone attribute of plant equipment/process radiation monitoring and adversely affected the cornerstone objective of ensuring adequate protection of public health and safety from exposure to radioactive materials released into the public domain as a result of routine civilian nuclear reactor operation. The inspectors used IMC 0609, "Significance Determination Process," Attachment D, "Public Radiation Safety Significance Determination Process," February 12, 2008, and determined the finding to be of very low safety significance (Green) because it was associated with the effluent program; however, it was not a substantial failure to implement the effluents program and it did not result in a public dose greater than an Appendix I criterion or 10 CFR 20.1301(e). The finding has a cross-cutting aspect in the area of problem identification and resolution associated with identification, because the organization failed to implement the corrective action program with a low threshold for identifying issues. Specifically, plant personnel failed to initiate condition reports, as required by procedure, on 89 occasions since the discovery on March 24, 2015.
Inspection Report# : [2015003](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Control Licensed Material

The inspectors reviewed a self-revealing non-cited violation of 10 CFR 20.1802 for the failure to control licensed material not in storage when the licensee sent 14 bags of radioactively contaminated dirt and debris to an off-site landfill for disposal. Immediate corrective actions included the licensee retrieving the contaminated material and returning it to site. The licensee entered this deficiency into the corrective action program as Condition Report CR-CNS-2013-03392.

The failure to control licensed material that was not in storage 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 Public Radiation Safety Cornerstone and adversely affected the cornerstone objective of assuring adequate

protection of public health and safety from exposure to radioactive materials released into the public domain as a result of routine civilian nuclear reactor operation. The inspectors used IMC 0609, “Significance Determination Process,” Attachment D, “Public Radiation Safety Significance Determination Process,” February 12, 2008. The inspectors determined the finding to be of very low safety significance (Green) because the finding involved radioactive material control but it did not result in an exposure to the public in excess of five millirem. The finding has a cross-cutting aspect in the area of human performance, associated with work management, because the licensee did not implement a process of planning, controlling, and executing work activities such that safety was the priority. Specifically, the licensee did not control work activities involving multiple organizations such that radioactive material remained controlled on site.
Inspection Report# : [2015003](#) (*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

Significance: N/A Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Make a 10 CFR 50.72(b)(2)(xi) Notification

The inspectors identified a non-cited violation of 10 CFR 50.72(b)(2)(xi) because the NRC Operations Center was not notified within four hours of a reportable event related to the health and safety of the public for which notification to other government agencies had been made. Specifically, in May 2013, the licensee did not notify the NRC of its notification to the State of Nebraska about an inadvertent release of 14 bags of radioactively contaminated dirt and debris to a public landfill. To correct this condition, the licensee notified the NRC Operations Center of this event on August 26, 2015.

This violation was evaluated using traditional enforcement because the failure to make a required report could adversely impact the NRC’s regulatory process. Using the criteria contained in Section 6.9(d)(9) of the NRC’s Enforcement Policy, this violation was determined to be Severity Level IV. The licensee entered this deficiency into the corrective action program as Condition Report CR-CNS-2015-0544. Cross-cutting aspects are not assigned to traditional enforcement violations.

Inspection Report# : [2015003](#) (*pdf*)

Last modified : August 29, 2016