Cooper
2Q/2003 Plant Inspection Findings

Initiating Events

Significance: Jan 02, 2003
Identified By: NRC
Item Type: FIN Finding
Failure to take corrective or compensatory actions for a steam leak
The failure to take corrective or compensatory actions for a steam leak on Steam Jet Air Ejector A Steam Supply Valve MS-AOV-BAVA was determined to be a self-revealing, Green, finding. The steam leak was identified on September 14; however, no actions were taken to address it until October 13 when the steam leak caused a ground on a power supply which caused Valve MS-AOV-BAVA to fail closed, resulting in a plant transient. This finding was considered more than minor since it affected the availability and reliability of the power conversion system (main condenser and bypass valves), which initiated a plant transient. This finding was characterized under the significance determination process as having very low safety significance because there was no loss of safety function in either the main condenser or bypass valves
Inspection Report# : 2002004*(pdf)*

Significance: Oct 05, 2002
Identified By: NRC
Item Type: FIN Finding
Green finding regarding an inadequate modification package which inadvertently de-energized control room equipment.
The unplanned loss of power to four effluent radiation monitors during the installation of a service water radiation monitoring system modification was considered to be a self-revealing finding. The modification package required lifting an energized lead to de-energize a portion of the old service water radiation monitoring system; however, due to errors made by design engineering, this step unintentionally de-energized four other effluent radiation monitors which were required to be operable per the Technical Requirements Manual. The finding was considered more than minor since the modification package required lifting energized leads in control room panels which could reasonably be viewed as a precursor to a significant event if not adequately controlled. The finding was characterized as having very low safety significance since the loss of the effluent monitors did not result in a release in excess of allowable limits.
Inspection Report# : 2002003*(pdf)*

Mitigating Systems

Significance: Jun 28, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to establish adequate procedures for operation and maintenance of the service water system

Two examples of a noncited violation of Technical Specification 5.4.1 were identified associated with the failure to establish an adequate procedure. The two examples included the following: The failure to establish an adequate procedure for operation of the service water system with the discharge strainers bypassed was a noncited violation of Technical Specification 5.4.1. The operating procedure did not address the modes of operation for service water during strainer bypass which contributed to degraded gland water flow to Service Water Pump B in January 2003. This finding was more than minor since it affected the cornerstone attribute of equipment performance and reliability and was of very low safety significance because there was no loss of safety function of the service water system. The failure to establish an adequate procedure for service water pump maintenance was a noncited violation of Technical Specification 5.4.1. The existing maintenance procedure did not have an adequate acceptance criterion for the replacement of corroded enveloping tube sections, which led to the failure of a tube section in Service Water Pump D in December 2002. This finding was more than minor since, if left uncorrected, it could have led to premature bearing degradation and affected long-term reliability of the pump. The finding was of very low safety significance since it did not represent an actual loss of the safety function.
Inspection Report# : 2003005*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to implement station procedures
Three examples of a noncited violation of Technical Specification 5.4.1 (two in Mitigating Systems) were identified associated with the failure to implement station procedures. The two Mitigating Systems examples included the following: The failure to implement the procedure to maintain foreign material exclusion inside the torus was a noncited violation of Technical Specification 5.4.1. During a walkdown of the torus, the inspectors discovered foreign material in the suppression pool for which there was no accounting by the licensee's foreign material control log. The licensee concluded there was a loss of foreign material control in the suppression pool based on the inspectors' observations and inadequate documentation in the foreign material exclusion control point log. This finding was considered more than minor since it affected the cornerstone attribute of equipment performance and reliability and was of very low safety significance since it did not represent an actual loss of the safety function of the suppression pool. This finding also had crosscutting aspects associated with problem identification and resolution. The failure to implement a surveillance test procedure was a noncited violation of Technical Specification 5.4.1. During the performance of a core spray logic relay test, personnel manually actuated the incorrect relays, which caused an inadvertent start of both core spray pumps and Emergency Diesel Generator 2. This finding was more than minor since it affected a shutdown equipment lineup, which is a cornerstone attribute, and was of very low safety significance since the plant was in cold shutdown so it did not significantly degrade the licensee's ability to recover shutdown cooling if it were lost. This finding had crosscutting aspects associated with human performance since the failure to use human error prevention tools such as self-checking and peer-checking was a contributing cause to the event.
Inspection Report# : 2003005*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Ineffective corrective actions resulted in recurrence of significant condition adverse to quality
Two examples of a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI (one in Mitigating Systems), were identified associated with the failure to correct a significant condition adverse to quality. The Mitigating Systems example included the following: The failure to correct a significant condition adverse to quality on the service water system was a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI. The Loop B service water pump discharge strainer was bypassed in January 2003, which introduced debris into the gland water lines for Pumps B and D. The lines were flushed; however, not all the debris was removed. Service Water Pump B was declared inoperable in

March 2003 due to degraded gland water flow caused by an additional piece of debris which was most likely introduced into the system in January. This finding was more than minor since it affected the availability and reliability of the service water system and was of very low safety significance since it did not result in the loss of a safety function of a single train of equipment for greater than the Technical Specification allowed outage time and did not screen as risk significant due to an external event. This finding also had crosscutting aspects associated with problem identification and resolution since corrective actions taken in January 2003 for blocked gland water lines were not thorough, as evidenced by the condition repeating itself in March 2003.
Inspection Report# : 2003005*(pdf)*

Significance: G Apr 03, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to implement the procedural requirements of Administrative Procedure 0.39 "Fire Watches," Revision 27, affected the mitigating systems cornerstone.
The failure to implement the requirements of the station's fire watch procedure was considered to be a Green, noncited violation of Technical Specification 5.4.1.d. The inspectors observed a fire watch who had allowed hot work to commence prior to removing all combustible materials from the area as required by station procedures. Furthermore, the fire watch procedure requires annual requalification training for fire watches. The fire watch in question had not completed this training. This finding was more than minor since failure to implement the fire watch procedure could become more safety significant if left uncorrected. This noncited violation was characterized as a "green" finding using the significance determination process. The failure to implement the station's fire watch procedure had very low safety significance since the fire ignition frequency for the area in question was low and fire mitigation capability (operator action) remained.
Inspection Report# : 2003004*(pdf)*

Significance: G Apr 03, 2003
Identified By: NRC
Item Type: FIN Finding
The failure to issue a fire protection impairment for this condition was considered to be a licensee-identified noncited violation.

Inspection Report# : 2003004*(pdf)*

Significance: G Apr 03, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to develop and implement a procedure to cope with an act of nature, such as accumulation of ice in the intake structure determined to be a violation of TS 5.4.1
Frazil ice conditions were observed on the Missouri River on February 25 as well as a patch of ice on the service water intake trash rack. The licensee was not able to support the claim that the intake structure was not susceptible to ice accumulation during shutdown conditions nor did they have a procedure to address ice accumulation or loss of service water due to blockage of the trash racks. The failure to develop and implement a procedure to cope with an act of nature, such as the accumulation of ice in the intake structure, was determined to be a violation of Technical Specification 5.4.1. This finding was considered more than minor since the formation of ice at the intake structure could reasonably be viewed as a precursor to a significant event. This noncited violation was characterized as a "green" finding using the significance determination process. The failure to develop and implement a procedure for ice accumulation had very low safety significance since there was no loss of safety function for the service water system.

Inspection Report# : 2003004*(pdf)*

Significance: G Jan 02, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to assess operability of five degraded cells in two 250 Vdc safety-related batteries
Five degraded cells in the two 250 Vdc safety-related batteries were identified by the licensee but not assessed for operability for more than 3 months when inspectors questioned why they were operable. The majority of the cells in these two batteries were identified in 1999 to be nonconforming due to improper alloying of the positive plates, which caused swelling and eventual loss of capacity. The licensee failed to promptly replace the affected cells and failed to justify not taking prompt corrective action during the two intervening refueling outages. Therefore, this was considered to be a violation of 10 CFR Part 50, Appendix B, Criterion XVI. This finding also had crosscutting aspects associated with problem identification and resolution. This finding was characterized under the significance determination process as having very low safety significance because there was no loss of function in either 250 Vdc battery. This finding was more than minor because the problem would become more significant if left uncorrected due to the time-dependent degradation mechanism. Because of the very low safety significance and because the licensee included the item in their corrective action program as Notification 10180712, this violation is being treated as a noncited violation (50-298/0204-01) consistent with Section VI.A of the NRC Enforcement Policy.
Inspection Report# : 2002004*(pdf)*

Significance: G Oct 05, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
A noncited violation for failure to correct a procedure deficiency which affected the operability of the high pressure coolant injection system.
The licensee failed to take corrective actions for a surveillance test procedure that rendered the high pressure coolant injection system and the reactor core isolation cooling system concurrently inoperable. The procedural error was identified by the licensee in 1998 but no action was taken due to an incorrect conclusion that the procedure did not actually render the high pressure core injection system inoperable. When this question was addressed again in 2002, the licensee concluded that the system was, in fact, inoperable. This configuration was allowed by Technical Specifications; however, operators failed to recognize it as an entry condition into a shutdown action statement. No violation of the action statement was identified but the failure to recognize its entry condition was considered a condition adverse to quality. Therefore, this was considered to be a violation of 10 CFR Part 50, Appendix B, Criterion XVI. This finding also had crosscutting aspects associated with problem identification and resolution. This finding was characterized under the significance determination process as having very low safety significance because the high pressure core injection system could have performed its safety function even though it was considered inoperable per Technical Specifications. The finding was more than minor since the procedural error had an adverse impact on the availability and capability of a mitigating system. Because of the very low safety significance and because the licensee included the item in their corrective action program as Notification 10193745, this violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy.
Inspection Report# : 2002003*(pdf)*

Significance: G Oct 05, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Noncited violation of License Condition 2.C.(4) for failure to maintain operability of a fire suppression system.
The licensee failed to identify and correct degraded spray shields associated with sprinkler heads on Sprinkler System

29 in the cable expansion room which provides fire protection for cable trays containing redundant divisions of safety-related cables. The spray shields were identified as having holes in them which would result in decreasing the effectiveness of the shields. This was a violation of License Condition 2.C.(4). This finding had crosscutting aspects associated with problem identification and resolution since the licensee had multiple opportunities to identify and correct this condition but failed to do so. This finding was more than minor since failure of this system during a fire would have adversely impacted the availability, reliability, and capability of systems that respond to an initiating event. The finding was characterized under the significance determination process as having very low safety significance since the alternate shutdown capability was unaffected and due to the low fire ignition frequency for the cable expansion room. Because of the very low safety significance and because the licensee entered the item in their corrective action program as Notification 10190964, this violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy.
Inspection Report# : 2002003*(pdf)*

Significance: G Oct 05, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
A noncited violation for failure to take corrective actions to prevent instrument line snubber clogging which caused a failure of the reactor core isolation cooling system.
The licensee failed to take corrective actions to prevent clogging of instrument line snubbers which resulted in the inadvertent isolation of the reactor core isolation cooling system on May 14, 2002. This was an apparent violation of 10 CFR Part 50, Appendix B, Criterion XVI. This finding also had crosscutting aspects associated with problem identification and resolution. This finding was characterized under the significance determination process as having very low safety significance based on the results of a Phase 3 analysis. The finding was more than minor since it had an adverse impact on the availability, reliability, and capability of a mitigating system. Because of the very low safety significance and because the licensee included the item in their corrective action program as Resolve Condition Report 2002-0895, this violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy.
Inspection Report# : 2002003*(pdf)*

Significance: G Jul 12, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to apply required design control measures for a change to the service water system
The licensee failed to conduct required design control measures prior to implementing a design change in the service water system, in which a coating previously not evaluated was applied to the internal surface of several pipe riser columns. This was identified as a violation of Criterion III of Appendix B to 10 CFR Part 50, "Design Control." This finding is characterized under the significance determination process as having very low safety significance because there was no loss of function in the service water system. Because of the very low safety significance and because the licensee included the item in their corrective action program as Notification 10156239, this violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy.
Inspection Report# : 2002002*(pdf)*

Significance: G Jul 12, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to adequately document environmental qualification of safety-related equipment
The licensee failed to identify and correct deficient documentation supporting environmental qualification of safety-

related equipment in the steam tunnel and acceptable voltage applications for Buchanan 0241 terminal blocks. These findings were determined to be two examples of a violation of 10 CFR Part 50, Appendix B, Criterion XVI. This violation is being treated as a noncited violation, consistent with Section VI.A of the NRC Enforcement Policy. The licensee documented this issue in their corrective action process as Notifications 10163954 and 10167990. This finding also had crosscutting aspects associated with problem identification and resolution. This finding was determined to have a credible impact on safety because there was no assurance that the equipment would perform its design function during accident conditions since it was not operating in a previously tested or analyzed configuration. This noncited violation was characterized under the significance determination process as having very low safety significance based on the performance of an acceptable analysis that demonstrated the affected equipment was environmentally qualified.
Inspection Report# : 2002002*(pdf)*

Significance: SL-IV Dec 14, 2000
Identified By: NRC
Item Type: VIO Violation
Failure to Maintain Environmental Qualifications of Safety-Related Equipment
Cooper Nuclear Station NRC Inspection Report 50-298/00-07 This special inspection report covered the activities associated with inspection and assessment of environmental qualification issues. The failures to environmentally qualify, maintain the qualification of, and document qualifications in an auditable form, for equipment important to safety, constituted an apparent violation of 10 CFR 50.49 (Section 2.02). This item was orginally opened as an apparent violation in IR 00-07. It was later closed per letter from Nebraska Public Power District dated November 8, 2001, Reference #NLS2001104 and reopened as a violation, Severity Level IV.
Inspection Report# : 2000007*(pdf)*

Barrier Integrity

Significance: G Jun 28, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to implement station procedures
Three examples of a noncited violation of Technical Specification 5.4.1 (one in Barrier Integrity) were identified associated with the failure to implement station procedures. The Barrier Integrity example included the following: The failure to implement the procedure for core alterations was a noncited violation of Technical Specification 5.4.1. While performing core alterations, refueling personnel incorrectly marked a procedure step as complete. This was revealed during the next step when they discovered a fuel assembly in the core location which should have been removed by the previous step. This finding was more than minor since it affected the cornerstone attribute of design control (Core Reload Analysis) and was of very low safety significance since it did not represent an actual degradation of any fission product barriers. This finding also had crosscutting aspects associated with human performance since inadequate use of self-checking and place-keeping techniques were contributing causes.
Inspection Report# : 2003005*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Ineffective corrective actions resulted in recurrence of significant condition adverse to quality
Two examples of a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI (one in Barrier Integrity), were

identified associated with the failure to correct a significant condition adverse to quality. The Barrier Integrity example included the following: The failure to implement corrective actions to prevent dropping items in the spent fuel storage pool was a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI. During preparations for the refueling outage, the licensee dropped a control rod blade in the pool. This was similar to an event in 1999 when a shroud head bolt was dropped in the pool. The root causes of these two events were similar; however, the corrective actions for the 1999 event failed to preclude the most recent event. This finding was more than minor since dropping a control rod blade in the spent fuel pool could be viewed as a precursor to a significant event and was of very low safety significance since it did not represent an actual degradation of any fission product barriers. This finding also had crosscutting aspects associated with problem identification and resolution.
Inspection Report# : 2003005*(pdf)*

Significance: G Apr 03, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to implement a procedure affecting the fuel cladding fission product barriers as consistent with Section VI.A of the NRC Enforcement.
On February 20, the drain valve for Feedwater Heater 4A failed closed, causing a partial loss of feedwater heating. According to station procedures, reactor power should have been reduced below 25 percent within 2 hours following this valve failure. However, power was not reduced until approximately 15 hours after the partial loss of feedwater heating, and then, only after repeated questioning by the inspectors regarding procedural adherence. This was considered to be a violation of Technical Specification 5.4.1 for failure to implement a procedure. This finding was considered more than minor since, if left uncorrected, could have become a more safety significant event. This finding had cross-cutting aspects of human performance since it dealt with procedure adherence. This noncited violation was characterized as a "green" finding using the significance determination process. The failure to reduce reactor power had very low safety significance since it only affected one of the three fission product barriers.
Inspection Report# : 2003004*(pdf)*

Emergency Preparedness

Significance: G Jan 02, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to conduct emergency response organization training in accordance with emergency plan requirements
A noncited violation of 10 CFR 50.54(q) was identified by the inspector because the licensee did not conduct emergency response organization training in accordance with emergency plan requirements. Specifically, lesson plans were not developed or used to conduct emergency response organization training as required by the emergency plan for training required by 10 CFR Part 50, Appendix E.IV.F. Because lesson plans were not developed, they also were not identified, revised, and maintained as required by the emergency plan. This finding was determined to be a performance deficiency associated with the attributes of the emergency response organization readiness (training). This finding was evaluated to be more than minor using the Emergency Preparedness Significance Determination Process because it affects the emergency preparedness cornerstone objective in that a licensee may not be capable of implementing adequate measures to protect the health and safety of the public if emergency response organization training is incomplete or inadequate. This finding was evaluated as having very low safety significance (Green) since it was a failure of a regulatory requirement, but not a failure to meet an emergency planning standard as defined by 10 CFR 50.47(b). This finding is being treated as a noncited violation (50-298/0204-02) in accordance with Section VI.A

of the NRC Enforcement Policy
Inspection Report# : 2002004*(pdf)*

Significance: W Apr 01, 2002
Identified By: NRC
Item Type: VIO Violation
Failure to Perform Timely Offsite Notification during Alert
(NOTE: The Degraded Cornerstone Inspection (IR 50-298/2002-05) held this violation open pending further review of corrective actions. The original date was July 25, 2001. The event date was modified so that this item would continue to be indicated as an open White finding.) The licensee failed to notify state and local governmental agencies within 15 minutes of declaring an Alert on June 25, 2001. This was a violation of 10 CFR 50.54(q) and the licensee's emergency plan. This violation was evaluated under the risk significance determination process as having low to moderate safety significance based on the following: (1) the failure to notify state and local governmental agencies in a timely manner, following declaration of an Alert, during an actual event on June 25, 2001; and (2) this finding represents a failure to implement the risk significant planning standard 10 CFR 50.47(b)(5) (Section 4OA3.1). Final SDP letter sent March 1, 2002.
Inspection Report# : 2001009*(pdf)*

Significance: W Apr 01, 2002
Identified By: NRC
Item Type: VIO Violation
Failure to Meet Planning Standard 10 CFR 50.47(b)(2)
(NOTE: The Degraded Cornerstone Inspection (IR 50-298/2002-05) held this violation open pending further review of corrective actions. The original date was July 25, 2001. The event date was modified so that this item would continue to be indicated as an open White finding.) The licensee failed to activate the emergency response facilities within approximately one hour following declaration of an Alert on June 25, 2001. This was a violation of 10 CFR 50.54(q) and 10 CFR 50.47(b)(2). This violation was evaluated under the risk significance determination process as having low to moderate safety significance based on the following: (1) the finding is a violation of 10 CFR 50.54(q); and (2) this finding was a failure to meet nonrisk significant planning standard 10 CFR 50.47(b)(2) (Section 4OA3.2) Final SDP letter issued March 1, 2002.
Inspection Report# : 2001009*(pdf)*

Significance: W Apr 01, 2002
Identified By: NRC
Item Type: VIO Violation
Failure to correct a risk-significant EP performance weakness
(NOTE: The Degraded Cornerstone Inspection (IR 50-298/2002-05) held this violation open pending further review of corrective actions. The original date was June 27, 2001. The event date was modified so that this item would continue to be indicated as an open White finding.) Corrective actions implemented to prevent recurrence of a dose assessment performance weakness identified during the August 29, 2000, biennial exercise were not fully effective in that they were narrowly focused. The dose assessment team failed to recognize a degraded core condition and to revise its dose projections for the degraded condition. As a result, protective action recommendations were not upgraded. Corrective actions for the performance weakness concentrated on procedural inconsistencies that contributed to the failure and did not sufficiently recognize the need for additional personnel training. As a result, the performance weakness was repeated during an April 11, 2001, drill. This was an apparent violation of 10 CFR Part 50, Appendix E, Paragraph IV.F.2.g. This finding had greater than minor significance because the failure to use a degraded core in dose calculations had a credible impact on safety, in that it resulted in incorrect protective action recommendations which

could have caused offsite populations to receive unnecessary radiation dose. It had been preliminarily determined to have low to moderate safety significance (White) using the Emergency Preparedness Significance Determination Process because it represented a failure to correct a performance weakness associated with a risk-significant emergency preparedness planning standard. This violation was entered into the licensee's corrective action program as RCR 2001-0331. The final determination for a white finding and notice of violation were issued for EA-01-154 on August 13, 2001.
Inspection Report# : 2001004*(pdf)*

Occupational Radiation Safety

Significance: G Apr 03, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to follow a maintenance procedure regarding conduct of spot maintenance consistent with Section VI.A of the NRC Enforcement Policy.
On February 20, a radiation protection technician and a mechanic entered the steam jet air ejector room, which was a locked high radiation area, to perform spot maintenance on a main steam valve. Continuous coverage of the job by the technician was required due to dose rates in the room. The station's conduct of maintenance procedure prohibited the performance of spot maintenance under these conditions. This was considered to be a violation of Technical Specification 5.4.1 for failure to implement the maintenance procedure. This finding had cross-cutting aspects of human performance since it dealt with procedure adherence. The finding was considered more than minor because it affected a cornerstone objective. This noncited violation was characterized as a "green" finding using the significance determination process. The failure to follow a station maintenance procedure had very low safety significance since there was no over-exposure or substantial potential for an over-exposure and the ability to assess dose was not compromised.
Inspection Report# : 2003004*(pdf)*

Significance: G Apr 03, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to wear an alarming device that could be heard in a High Radiation Area.
A self-revealing noncited violation was identified because the licensee failed to follow the requirements of Technical Specification 5.7.1b. Specifically, a worker failed to wear an alarming dosimeter that could be heard while working in the Steam Jet Air Ejector Room, an area with general radiation levels greater than 100 millirem per hour. The failure to wear an alarming dosimeter that could be heard is a performance deficiency. The issue was more than minor because it is associated with a cornerstone attribute (program and process) and affected the occupational radiation safety cornerstone objective (to ensure the adequate protection of the worker's health and safety from radioactive material). The finding involved the failure to control radiological work that was contrary to Technical Specification requirements. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was found to have very low safety significance because there was no overexposure or substantial potential for an overexposure and the ability to assess dose was not compromised.
Inspection Report# : 2003004*(pdf)*

Public Radiation Safety

Physical Protection

Significance: N/A Dec 30, 2002
Identified By: NRC
Item Type: FIN Finding
Verification of Compliance With Interim Compensatory Measures Order
On February 25, 2002, the NRC imposed by Order, Interim Compensatory Measures to enhance physical security. The inspectors determined that, overall, the licensee appropriately incorporated the Interim Compensatory Measures into the site protective strategy and access authorization program; developed and implemented relevant procedures; ensured that the emergency plan could be implemented; and established and effectively coordinated interface agreements with offsite organizations.
Inspection Report# : 2002010*(pdf)*

Significance:  Oct 05, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
A noncited violation of 10CFR73.55(d)(3) for failure to detect prohibited contraband during a security search prior to the material entering the protected area.
The failure of the security search to detect and control a box of ammunition as it entered the protected area was considered to be a self-revealing noncited violation of 10 CFR 73.55(d)(3). This finding was characterized by the significance determination process as having very low safety significance since there were not more than two similar findings in the past four quarters. It was considered more than minor because it represented a failure to meet the requirements of 10 CFR 73.55(d) and the licensee's security plan. Because of the very low safety significance and because the licensee entered this finding into their corrective action program as Notification 10181426, this violation is being treated as a noncited violation consistent with Section VI.A of the NRC Enforcement Policy.
Inspection Report# : 2002003*(pdf)*

Significance:  Jul 12, 2002
Identified By: NRC
Item Type: FIN Finding
Inconsistent implementation of fitness-for-duty requirements
The inspectors identified a finding regarding inconsistencies in the licensee's implementation of the testing for cause requirements of 10 CFR 26.24. This finding was identified during a followup inspection of an unresolved item discussed in NRC Inspection Report 50-298/0108 (URI 50-298/0108-08). No violation of NRC requirements was identified; however, this finding had a credible impact on safety since inconsistent implementation of the fitness-for-duty requirements could reduce the effectiveness of the program in deterring and detecting potential substance abuse. Manual Chapter 0609 has no significance determination process to address fitness for duty without affects on radiological sabotage. Therefore, in accordance with Appendix B of NRC Manual Chapter 0612, this issue is considered a Green non-SDP finding.
Inspection Report# : 2002002*(pdf)*

Miscellaneous

Significance: N/A Mar 26, 2003
Identified By: NRC
Item Type: FIN Finding
1st Quarter 2003 CAL Inspection
The team concluded that the licensee completed steps in the improvement plan as scheduled and satisfied the intent of all steps reviewed during this inspection. In addition, the licensee was meeting the provisions outlined in the NRC Confirmatory Action Letter dated January 30, 2003. The team, however, identified a number of implementation problems. Of the 60 improvement plan closure packages reviewed, 5 contained insufficient documentation; additional information was required to assess completion of these items and one item was closed by the licensee with known discrepancies. Procedure revisions did not always include annotations to indicate those revisions associated with the improvement plan. The engineering evaluation performed to support improvements in the service water system did not include consistent descriptions of system parameters or a clear justification for the adequacy of replacement check valves. A Design Basis Information/Licensing Basis Information database was created; however, there was no step to require its use by engineering and operations personnel. Several completed actions did not completely address the issue or were not adequately justified. For example, preventive maintenance frequencies for the main transformers and service air compressors were not technically supported and vital bus undervoltage relay setpoints were changed but no periodic setpoint verification was established. The 67 performance indicators used by the licensee for tracking schedule completion and effectiveness of the improvement plan were appropriate. Observations identified in the Procedure 95003 supplemental inspection were incorporated into the improvement plan.
Inspection Report# : 2003008*(pdf)*

Significance: N/A Aug 22, 2002
Identified By: NRC
Item Type: FIN Finding
Summary of Assessment for Supplemental Inspection (95003)
On April 1, 2002, Cooper Nuclear Station entered the Repetitive Degraded Cornerstone Column of the Action Matrix. Upon entry into this column of the Action Matrix, and with oversight by the NRC, Nebraska Public Power District was required to develop a comprehensive improvement plan. The purposes of this inspection were to determine the breadth and depth of the performance deficiencies and to assess the adequacy of the licensee's improvement plan (The Strategic Improvement Plan, Revision 1). The inspectors found that Cooper Nuclear Station is being operated safely; however, a number of long-standing performance problems exist. Of greatest concern is the failure of Cooper Nuclear Station to correct recurring performance issues. For example, the improvement plan did not include actions to correct recurring equipment problems and was not comprehensive in addressing problems with the corrective action program. Nebraska Public Power District has been unsuccessful in efforts to improve performance with focused improvement plans. The inability to effectively correct problems has resulted in recurring problems with the reliability of safety systems, personnel errors, implementation of the emergency plan, and the quality of engineering, training, and maintenance activities. The development of the improvement plan lacked the requisite coordination between problem characterization and the corrective actions specified to correct the problem. The team found performance problem areas which were not effectively addressed by the improvement plan and one area which was missed in its entirety. Also, the improvement plan actions were not prioritized and integrated. The performance problem areas that were identified as not being effectively addressed included equipment reliability; adequacy of operability determinations; plant modification packages; management of component parts; use of industry operating experience information; effective use of performance problem trend codes; use of departmental performance indicators; conflicting departmental and station priorities, policies, and goals; effective implementation of engineering programs; entering self-assessment findings and observations into the corrective action program; coordination and integration among site organizations; procedure change requests; and conflicting departmental and station priorities, policies, and goals. The level of detail of documents reviewed by the team was frequently not sufficient to assess the effectiveness of planned actions. The improvement plan, in general, did not include adequate performance measures to evaluate the effectiveness of the

actions plans. In addition, the improvement plan had not been assessed for the resources needed for successful implementation of the planned actions.
Inspection Report# : 2002007*(pdf)*

Significance:  Aug 25, 2000
Identified By: NRC
Item Type: VIO Violation
Failure to Take Prompt Corrective Actions
The licensee did not take timely corrective actions for restoration of environmentally qualified electrical and controls equipment control panels for the high pressure coolant injection system, which were not properly secured. Furthermore, the licensee did not implement measures through maintenance procedure revisions and corrective actions to address environmental qualification aspects of maintenance on safety-related equipment. This issue had previously been identified as a Non-Cited Violation in NRC Inspection Report 50-298/9916-01, yet actions to revise maintenance procedures and restore compliance had not been promptly taken and continued to be uncorrected 9 months after initial identification. No formally reviewed and approved analysis had been performed to justify not correcting the discrepant condition, which could affect equipment operability. Nonconformance conditions are required to be promptly corrected or sufficient interim compensatory measures established, or technical evaluations performed to justify the existing condition. The failure to establish prompt corrective actions for conditions adverse to quality was a violation of 10 CFR Part 50, Appendix B, Criterion XVI (50-298/0010-03) (Section 4OA2.3.b). This issue was characterized as a green finding using the significance determination process. The issue was determined to have very low risk significance because of redundant systems and the actual impact on the affected equipment was low.
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Last modified : September 04, 2003