

D.C. Cook 2

2Q/2007 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Identify Appropriate Contingency Actions During the Work Risk Review to Adjust Packing on Valve 2-NPS-121-II

On December 14, 2006, a finding of very low safety significance was self-revealed when the valve packing on 2-NPS-121-II, (instrument shutoff valve for reactor coolant system (RCS) loop 2 hot leg wide range pressure instrument), blew out during a planned maintenance activity to adjust the packing. This resulted in a 6 gallon-per-minute (gpm) RCS leak that was subsequently isolated by operations personnel. Additional planned corrective actions included revisions to work control procedures, and an engineering inspection of the valve and investigation of the failure mechanism. No violation of regulatory requirements was identified.

This finding was of more than minor significance because it is related to the Equipment Performance attribute regarding RCS Barrier Integrity in the Initiating Events Cornerstone. The cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations was affected. Specifically, the resultant 6 gallon-per-minute (gpm) RCS leak continued for approximately three hours before it was isolated because contingency actions were not identified for credible failures and problems that could occur during the work activity. The finding was not greater than Green because the leak did not exceed the Technical Specification limit for identified RCS leakage and all other mitigating systems were available. The primary cause of this finding was related to the cross-cutting area of human performance because work control risk review procedures were not complete and accurate in that they did not identify packing adjustments on manual valves in the pressurized RCS as a high risk activity with respect to nuclear safety. (IMC 0305, H.3(b))

Inspection Report# : [2007003](#) (*pdf*)

Mitigating Systems

Significance:  Jun 29, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Foreign Material Exclusion Controls During Painting Surface Preparations Affected Operability of the Unit 2 AB EDG

A finding of very low safety significance was identified through a self-revealing event. During painting surface preparation activities in the Unit 2 AB emergency diesel generator (EDG) room, the licensee failed to establish appropriate foreign material exclusion controls by allowing foreign material to collect on the EDG fuel injector pumps' metering rods. This resulted in an inoperable EDG when foreign material on one of the fuel injector pump metering rods became lodged in the pump and prevented the metering rod from further movement. No violation of regulatory requirements was identified. Corrective actions included verifying that the affected fuel injector pump metering rod was free to move, cleaning and lubricating the engine governor linkage, and cleaning other light dust from the engine and the room. The licensee also ran the other three EDGs to verify no common cause failure existed and then cleaned and lubricated the engine governor linkage after each of the runs.

This finding was of more than minor significance because it is related to the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the Unit 2 AB EDG was rendered inoperable by foreign material present on the engine. The finding was

of very low safety significance because it did not represent a design or qualification deficiency, loss of safety function for a single train for greater than its Technical Specification (TS) allowed outage time, and was not risk-significant due to external event initiators. The primary cause of this finding was not related to any of the cross-cutting areas because none of the cross-cutting aspects was determined to be a significant contributor to the finding.

Inspection Report# : [2007004](#) (*pdf*)

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Demonstrate Performance or Condition of Nuclear Instruments Were Effectively Controlled Through Performance of Appropriate Preventive Maintenance

The inspectors identified a finding of very low safety significance and an Non-Cited Violation of 10 CFR 50.65(a)(2). The licensee failed to demonstrate that the performance or condition of the Unit 1 and Unit 2 power range and intermediate range nuclear instruments was effectively controlled through appropriate preventive maintenance. As a result, the licensee failed to establish goals or monitor the performance of these instruments in accordance with paragraph (a)(1) of the Maintenance Rule to ensure that appropriate corrective actions were taken. The licensee was further evaluating corrective actions, including training, for this issue at the end of the inspection period and had placed the system into 10 CFR 50.65(a)(1) status.

This finding was of more than minor significance because violations of 10 CFR 50.65(a)(2), such as failure to demonstrate effective control of performance or condition and failure to classify the affected structure, system, or components (SSC) in (a)(1) status, involve degraded SSC performance or condition. The finding was of very low safety significance because the finding was associated with the Mitigating Systems Cornerstone and did not represent a design or qualification deficiency, loss of safety function for a train or system, and was not risk-significant due to external event initiators. The primary cause of this finding was related to the cross-cutting area of problem identification and resolution because the licensee failed to thoroughly evaluate multiple nuclear instrumentation component failures by appropriately completing the Maintenance Rule Evaluations. (IMC 0305, P.1(c))

Inspection Report# : [2007003](#) (*pdf*)

Significance: SL-IV Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Submit a Required Licensee Event Report

The inspectors identified a Severity Level IV NCV of 10 CFR 50.73(a)(1). The licensee failed to submit a required Licensee Event Report within 60 days after discovery of an event requiring a report. The licensee failed to correctly evaluate the failure of two Unit 2 Residual Heat Removal (RHR) system pressure relief valves, which affected the operability of both trains of the RHR system. This was reportable as a condition prohibited by the plant's Technical Specification and as an event where a single cause resulted in two independent trains becoming inoperable in a single system designed to remove residual heat and mitigate the consequences of an accident. The licensee implemented several corrective actions to address a potential adverse trend in correctly identifying and evaluating the reportability of plant events, including additional training for selected operations, regulatory affairs, and plant engineering department personnel.

This finding was of more than minor significance because the NRC relies on licensees to identify and report conditions or events meeting the criteria specified in the regulations and the Technical Specification in order to perform its regulatory function. Because this issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. Consistent with the guidance in Section IV.A.3 and Supplement I, Paragraph D.4, of the NRC Enforcement Policy, this finding was determined to be a Severity Level IV NCV.

Although this NRC identified violation was repetitive, the inspectors concluded that it was not due to inadequate corrective actions for the previous violation. The primary cause of this finding was related to the cross-cutting area of problem identification and resolution because the licensee did not correctly evaluate the two safety valve test failures with respect to the reporting requirements in 10 CFR 50.73. (IMC 0305, P.1(c))

Inspection Report# : [2007003](#) (*pdf*)

Significance:  Mar 02, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Correct a Condition Adverse to Quality

The inspectors identified a finding having very low safety significance and an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action" for the licensee's failure to promptly identify that the Unit 1 Train A (1-CD) emergency diesel generator (EDG) would exceed its capacity rating. Specifically, the 1-CD EDG's capacity rating would have been exceeded if the 1-CD EDG was allowed to run at the upper frequency band of 61.2 Hz as allowed by Technical Specifications (TS). As a result, the licensee performed corrective action calculations to assess the finding and on March 1, 2007, imposed an operational upper frequency limit of =60.5Hz on the station's Unit 1 EDGs. This finding has a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program because the licensee did not take appropriate corrective action to address the safety issue in a timely manner commensurate with its safety significance and complexity.

This finding was more than minor because the 1-CD EDG would have exceeded its design load rating at the maximum TS allowed frequency of 61.2Hz. Without the evaluation and imposing an administrative limit, the licensee could not ensure that the 1-CD EDG would reliably perform its safety related-function. The finding was of very low safety significance based on a Phase 1 screening in accordance with Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations."

Inspection Report# : [2007002](#) (*pdf*)

Barrier Integrity

Significance:  Mar 02, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correct Inadequate Safety Analysis Dose Calculations

The inspectors identified a finding having very low safety significance and an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action" for failure to promptly identify and correct a condition adverse to quality regarding inadequate safety analysis dose calculations. Specifically, the licensee failed to address the aggregate effect of various nonconforming conditions on containment leakage rates for offsite dose and control room calculations to ensure that accurate and adequate margin remained available for offsite dose analyses and control room habitability. The finding was entered into the licensee's corrective action program and an operability determination evaluation was initiated during the inspection. The primary cause of this violation was related to the cross-cutting area of problem identification and resolution because the licensee did not thoroughly evaluate known discrepant conditions.

This finding was more than minor because the licensee did not verify the capability of containment to maintain the offsite and control room dose within required limits under post-accident conditions to the values assumed in the analyses. The finding was of very low safety significance based on a Phase 1 screening in accordance with Inspection Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations."

Inspection Report# : [2007002](#) (*pdf*)

Significance:  Mar 02, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Previously Imposed Compensatory Measures

The inspectors identified a finding having very low safety significance and an associated Non-Cited Violation of 10 CFR Part 50.36, "Technical Specifications." Specifically, the licensee failed to maintain previously imposed administrative limits (i.e., compensatory measures) required by non-conforming Updated Final Safety Analysis Report offsite and control room dose analyses. The station operated from April 25, 2003, through February 28, 2007, based on analyses that included assumed containment leakage values that were not bounded by the licensee's TS 5.5.14, "Containment Leakage Rate Testing Program." Once the finding was identified by the inspectors, the licensee re-imposed the required compensatory measures during the inspection. The primary cause of this violation was related

to the cross-cutting area of human performance because the licensee failed to communicate decisions with respect to containment leakage and the basis for those decisions to personnel.

The finding was more than minor in accordance with Inspection Manual Chapter (IMC) 0612, Appendix B because the finding was associated with the configuration control (containment design parameters maintained) attribute of the Barrier Integrity Cornerstone and affected the cornerstone's objective of maintaining the functionality of containment. Specifically, the licensee did not re-impose compensatory measures to limit the maximum allowable containment leakage rate to the values assumed in the analyses. The finding was of very low safety significance based on a Phase 1 screening in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations."

Inspection Report# : [2007002](#) (*pdf*)

Emergency Preparedness

Significance: SL-III Oct 25, 2006

Identified By: NRC

Item Type: VIO Violation

Failure to Provide Complete and Accurate Information to the NRC Which Impacted a Licensing Decision

The inspectors identified an apparent violation of 10 CFR 50.54(q) involving 10 CFR 50.47(b)(4). Title 10, Part 50, Section 54(q) of the Code of Federal Regulations states in-part, "the nuclear power reactor licensee may make changes to these plans without Commission approval only if the changes do not decrease the effectiveness of the plans and the plans, as changed, continue to meet the standards of 10 CFR 50.47(b) and the requirements of Appendix E to this part." Title 10, Part 50, Section 47(b)(4) of the Code of Federal Regulations states in part, "a standard emergency classification and action level scheme, the bases of which include facility system and effluent parameters, is in use by the nuclear facility licensee." The licensee made and implemented a change to its emergency plan emergency action level (EAL) scheme on April 16, 2003, which appeared to decrease the effectiveness of the emergency plan without prior NRC approval.

Specifically, the licensee changed the EAL to remove the condition, "release of secondary coolant from the associated steam generator to the environment is occurring," from the Fission Product Barrier Matrix EAL for a loss of containment barrier due to a steam generator secondary side release. The revised emergency action level, "secondary line break outside containment results in release (greater than 30 minutes) to the environment," added a non-conservative 30 minutes before meeting this emergency action level. There is a potential that a release condition could have existed which would not have been declared, resulting in either no action or delayed action by off-site authorities when measures to protect the health and safety of the public were warranted. In a previous 1995 correspondence between the NRC and the licensee concerning a proposal to revise the licensee's EALs, the licensee proposed to implement a similar change to its EALs; however, the NRC specifically provided a written response to the licensee which indicated that a revision to the EAL which included a 30 minute criteria was unacceptable.

The apparent violation was considered to be more than minor because the licensee made changes to the emergency plan and procedures that decreased the effectiveness of the plan without prior approval of the NRC. Because this apparent violation affected the NRC's ability to perform its regulatory function, it was evaluated using the traditional enforcement process. There were no actual emergency events associated with this EAL during the time the change was in effect; however, the failure of the licensee to meet an emergency planning standard involving assessment does have regulatory significance.

Notice of Violation Issued October 6, 2006, ML062790406.

The VIO was opened in NRC Inspection Report 05000315/316/2006502. Apparent violation AV 0500315/316/2006501-01 is updated to VIO 05000315/316/2006502-01 (Failure to Provide Complete and Accurate Information to the NRC Which Impacted a Licensing Decision).

Inspection Report# : [2006502](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Aug 18, 2006

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution

The team identified that the licensee was effective at identifying problems and incorporating them into the corrective action program. The licensee's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by the team that had not been previously identified by the licensee during the review period. In general, the licensee was effectively prioritizing, evaluating and resolving problems. However, the inspectors found several examples where the documentation of an issue did not clearly indicate whether it had been properly evaluated, what the status of the corrective actions were, or whether it had been effectively resolved.

Operating experience usage was also effective, but the team found several examples where operating experience, primarily issued by the NRC, was not screened by the station or was not properly evaluated by the assigned department.

Licensee audit and self-assessments were generally thorough, probing, and made good use of outside resources to maintain independence. On the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the corrective action program.

Inspection Report# : [2006008](#) (*pdf*)

Last modified : August 24, 2007