Duane Arnold

Initiating Events

Significance: G May 16, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
THE INSPECTORS IDENTIFIED A NONCITED VIOLATION FOR PROCEDURAL INADEQUACIES IN THE LICENSEE'S FLOODING MITIGATION ABNORMAL OPERATING PROCEDURE.
The inspectors identified a noncited violation for procedural inadequacies in the licensee's flooding mitigation abnormal operating procedure. The issue was entered in the licensee's corrective action program (Action Request 19711) for resolution. The issue was of low safety significance due to the low probability of occurrence of a design basis flood and the amount of time available to respond to flooding conditions from the time a storm started.
Inspection Report# : 2000003*(pdf)*

Mitigating Systems

Significance: G Aug 29, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Risk Assessment due to RCIC.
A finding of very low safety significance was identified by the inspectors when the licensee failed to perform an adequate risk assessment when the reactor core isolation cooling (RCIC) system was unavailable. The overall plant risk was actually yellow when identified as green by the licensee. The finding was more than minor since it involved a change in risk level from green to yellow and, if left uncorrected, would become a more significant safety concern. The finding was of very low safety significance since the high pressure core injection (HPCI) system was working as designed and the incremental core damage probability (ICDP) of having RCIC system unavailable for 12 days was 3E-7. An NCV of 10 CFR 50.65 (a)(4) was identified for the failure to properly perform an adequate risk assessment.
Inspection Report# : 2002006*(pdf)*

Significance: G Aug 06, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Corrective Actions RHRSW Strainer.
A finding of very low safety significance was identified by the inspectors when inadequate corrective actions resulted in a repeat event where algae growth was plugging the residual heat removal service water (RHRSW) strainers. The finding was more than minor since it impacted the operability of the RHRSW system. The finding was of very low safety significance because this event did not result in the flow of any of the RHRSW pumps to decrease below the Technical Specification (TS) 3.7.1 allowable minimum flow rate of 2040 gallons per minute (GPM). An NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," was identified for the failure to properly correct the algae buildup condition.
Inspection Report# : 2002006*(pdf)*

Significance: G Sep 30, 2001

Identified By: NRC
Item Type: FIN Finding
Clogged RHR Service Water Strainer
Green. An accumulation of alga grass from the river water intake structure and stilling basin clogged a strainer during a surveillance of the "B" residual heat removal service water (RHRSW) system and was declared inoperable. Divers identified a large amount of alga grass accumulated on the floors and walls of the river water intake pits and the stilling basin. The finding was considered to be more than minor and was viewed as a precursor to a more significant event because the amount of alga grass, if liberated from the floors and walls of the river water intake pits and stilling basin, would inhibit the system's ability to remove decay heat from the reactor vessel and suppression pool during transient conditions. The finding was determined to be of very low safety significance because the "B" RHRSW train with a clogged strainer still met its minimal Technical Specification and Updated Final Safety Analysis Report flow values and the opposite train was available if needed. (Section 1R22.2)
Inspection Report# : 2001007*(pdf)*

Significance: G Jul 10, 2000
Identified By: NRC
Item Type: FIN Finding
DURING A WALKDOWN OF THE REACTOR BUILDING, THE INSPECTORS IDENTIFIED THAT SEVERAL PORTABLE FIRE EXTINGUISHERS WERE MISSING FROM THEIR ASSIGNED LOCATION.
During a walkdown of the reactor building, the inspectors identified that several portable fire extinguishers were missing from their assigned location. The vendor responsible for maintaining the fire extinguishers had an individual onsite that was removing the fire extinguishers for testing without leaving a temporary spare. Due to the short period of time the plant was missing the 12 extinguishers, this finding was viewed as being of very low safety significance.
Inspection Report# : 2000003*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: G Oct 30, 2000
Identified By: NRC
Item Type: FIN Finding
Assessment System Weakness

Green. The picture quality of a specific video monitor was marginal. The single issue, if left uncorrected, could result in a more significant problem in the assessment of adversaries (Section 3PP3.b.2.).
Inspection Report# : 2000010*(pdf)*

Significance: G Oct 30, 2000
Identified By: NRC
Item Type: FIN Finding
Exercise communication and adversary issues
Green. The inspectors observed some controller communication problems and performance problems on the part of the adversaries during the force-on-force drills conducted on September 19-20, 2000. This issue represents a matter, that if left uncorrected could result in evaluations of response performance not reflective of true capabilities (Section 40A5.4.b.2).
Inspection Report# : 2000010*(pdf)*

Significance: G Oct 30, 2000
Identified By: NRC
Item Type: FIN Finding
IDS Zone Weaknesses
Green. Challenge testing identified vulnerabilities in several intrusion detection zones where the NRC contractors circumvented the sensors. This single issue could impact required detection of an adversary and appears to affect the required response (Section 3PP3.b.1).
Inspection Report# : 2000010*(pdf)*

Significance: G Oct 30, 2000
Identified By: NRC
Item Type: FIN Finding
WEeapons Handling Issues
Green. The inspectors observed some problems with weapons familiarity and manipulation on the part of three security officers selected by the licensee to demonstrate the tactical stress fire course. This observed performance could have the potential to be a precursor of more significant safety problems relative to response performance (Section 40A5.6.c.2).
Inspection Report# : 2000010*(pdf)*

Significance: G Oct 30, 2000
Identified By: NRC
Item Type: FIN Finding
Weapons Problems
Green. The inspector observed that one of two weapons utilized during the weapons demonstration at the live-fire range was inoperable. This issue could have the potential to be a precursor of more significant problems relating to contingency response (Section 40A5.6.c.1).
Inspection Report# : 2000010*(pdf)*

Significance: G Jul 14, 2000
Identified By: NRC
Item Type: FIN Finding
Safety-Safeguards Issue relating to operators access to security keys
Additional security keys had to be provided to the control room to maximize plant personnel response capabilities in case of security computer system failure.
Inspection Report# : 2000004*(pdf)*

Significance: G Jul 14, 2000
Identified By: NRC
Item Type: FIN Finding
Vision Tests for Guards
The NRC determined that testing security force personnel for glaucoma was not being conducted. The licensee has included glaucoma testing as part of the annual physical examination for security personnel.
Inspection Report# : 2000004*(pdf)*

Significance: G Jul 14, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Implementation and reporting of occasions when required armed responders were not immediately available.
The inspector identified a Non-Cited violation for failure to maintain a minimum number of armed responders which were immediately available (Section 4OA5.2.a).
Inspection Report# : 2000004*(pdf)*

Miscellaneous

Significance: N/A May 03, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW PROCEDURE FOR FIELD VARIANCE TO ENGINEERED CHANGE PACKAGE
10 CFR Part 50, App. B, Criterion V, required in part, activities affecting quality shall be prescribed by documented procedures and shall be accomplished in accordance with thes procedures. On May 3, 2001, the licensee determined that a field variance was performed that affected the design intent for ECP 1622, "Instrument AC Upgrade." A quality level IV terminal block was used to address an engineered design change that was to upgrade the circuit to QL 1 status. The issue was corrected and documented by the licensee in AR 221719.
Inspection Report# : 2001004*(pdf)*

Significance: N/A Mar 09, 2001
Identified By: NRC
Item Type: FIN Finding
The licensee was effective at identifying, evaluating, and resolving problems within the requirements of the corrective action program.
The inspectors concluded that the licensee was effective at identifying, evaluating, and resolving problems within the requirements of the corrective action program. The inspectors found that station personnel effectively identified and entered problems into the corrective action program using action requests. The licensee's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee during the review period. The inspectors identified several examples of minor problems that did not result in any adverse consequences and which were similar to problems identified by licensee staff during recent self-assessments. The significance threshold for entering issues into the program appeared appropriate. The inspectors did not find any reluctance by the station employees to raise safety issues.
Inspection Report# : 2001003*(pdf)*

Significance: N/A Mar 09, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to perform a root cause analysis, fact finding meeting, FFQ, or provide justification in the AR.
The inspectors identified that the licensee was inconsistent in the application of station requirements for evaluating

human performance circumstances. Administrative Control Procedure (ACP) 114.5, "Action Request System," required that all human performance circumstances be investigated either by root cause analysis, fact finding meetings, or completion of fact finding questionnaires (FFQ). The inspectors identified approximately 17 examples (out of the population of 50 human performance circumstance ARs reviewed) where the licensee did not perform a root cause analysis, fact finding meeting, or FFQ and did not provide documentation in the AR to justify why a root cause analysis, fact finding meeting, or FFQ was not completed. The failure to perform a root cause analysis, fact finding meeting, FFQ, or provide justification in the AR was considered to be a violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings."
Inspection Report# : 2001003*(pdf)*

Significance: N/A Aug 28, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM PROCEDURE IN GIVEN SEQUENCE
The inspectors identified that instrument and calibration technicians performed procedural steps out of sequence for a surveillance test on water level instrument trip setpoints. The inspectors determined that the procedural steps were perforemed out of sequence due to the difference in training and the sequence of procedural steps. Also, eleven similar surveillance tests were previously completed by performing the steps out of sequence. Although the performance of the procedural steps out of sequence did not affect the operability, availabilty, or reliability of the level instruments, the finding suggested a problem that was more than an isolated case that has a potential to impact safety. A Non-Cited Violation was issued for failing to perform surveillance test procedures in the given sequence as required by procedures.
Inspection Report# : 2000009*(pdf)*

Last modified : December 02, 2002