Cooper
1Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Mar 24, 2005
Identified By: NRC
Item Type: FIN Finding
Inadequate Maintenance Resulted in Failure of Reactor Protection System Power Supply
A self-revealing finding was identified regarding the failure to perform adequate maintenance on the reactor protection system motor generator. Inadequate maintenance on reactor protection system Motor Generator B resulted in a winding failure and internal fault on the motor. The licensee failed to incorporate vendor recommendations to periodically disassemble, clean, and inspect the motor into maintenance activities.

This finding was considered more than minor since it affected the initiating events cornerstone attribute of availability, reliability, and maintenance of equipment. This finding was determined to have very low safety significance since it did not contribute to the likelihood of a primary or secondary system loss of coolant accident, did not contribute to a loss of mitigation equipment, and did not increase the likelihood of a fire or internal/external flood.
Inspection Report# : 2005002*(pdf)*

Significance: G Sep 23, 2004
Identified By: Self Disclosing
Item Type: FIN Finding
Inadequate preventive maintenance on reactor feed pump limit switches.
A self-revealing finding was identified for the failure to perform adequate maintenance on reactor feed pump limit switches. Inadequate maintenance on the Reactor Feed Pump B limit switch resulted in the Reactor Feed Pump B turbine speed decrease and an unplanned reduction in reactor power. The licensee failed to implement preventive maintenance requirements to ensure appropriate industry recommendations were incorporated in the preventive maintenance program.

This finding was more than minor since it affected the reactor safety initiating events cornerstone attribute of equipment performance. It was considered to be of very low safety significance since it did not contribute to the likelihood of a loss of coolant accident, did not contribute to the loss of mitigation equipment, and did not increase the likelihood of a fire or flooding event. This finding has cross-cutting aspects associated with problem identification and resolution based on the fact that corrective actions for a similar limit switch failure were never implemented.
Inspection Report# : 2004004*(pdf)*

Significance: G Sep 23, 2004
Identified By: Self Disclosing
Item Type: FIN Finding
Inadequate preventive maintenance on service aire Compressor A
A self-revealing finding was identified associated with the licensee's failure to perform adequate maintenance on service air compressors. Inadequate maintenance on the motor resulted in damage to the motor windings and the compressor was declared inoperable. The licensee failed to implement preventive maintenance requirements that incorporated vendor recommendations for the motor windings.

This finding was more than minor since it affected the reactor safety initiating events cornerstone attribute of equipment performance. It was considered to be of very low safety significance since it did not contribute to the likelihood of a loss of coolant accident, did not contribute to the loss of mitigation equipment, and did not increase the likelihood of a fire or flooding event.
Inspection Report# : 2004004*(pdf)*

Significance: G Jul 23, 2004
Identified By: NRC
Item Type: FIN Finding
Inadequate PM Results in Plant Transient
A self-revealing finding was identified associated with the licensee's failure to perform adequate maintenance on Reactor Recirculation Motor Generator A. Inadequate maintenance on the motor generator field brushes resulted in the loss of field voltage, an unexpected trip of the motor generator, and an unplanned reduction in reactor power. The licensee failed to change their preventive maintenance requirements to incorporate vendor recommendations following modification of the brushes. This finding was more than minor since it affected the Reactor Safety Initiating Events cornerstone attribute of design control and resulted in a plant transient. It was considered to be of very low safety significance

since it did not contribute to the likelihood of a loss-of-coolant accident, did not contribute to the loss of mitigation equipment, and did not increase the likelihood of a fire or flooding event.
Inspection Report# : 2004003*(pdf)*

Mitigating Systems

Significance: G Mar 24, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Instructions for Restoration of the Service Water System Following Maintenance
NRC Inspection Report 05000298/2004014 documented an apparent violation associated with inadequate instructions for restoration of the gland water supply to SW Pumps B and D following maintenance. This finding had the potential to render the pumps incapable of performing their safety function during a postulated accident and was determined to have a preliminary safety significance of greater than very low safety significance.
Inspection Report# : 2005002*(pdf)*

Significance: G Mar 24, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Operability Determination Procedure
A noncited violation of Technical Specification 5.4.1 was identified regarding the failure to implement the operability determination procedure. The licensee failed to meet timeliness goals and documentation requirements for evaluating the operability of the service water discharge strainers following a high differential pressure condition.
This finding was more than minor since it was associated with the operability of mitigating equipment and could become a more significant safety concern if left uncorrected. This finding was determined to have very low safety significance since the licensee was ultimately able to demonstrate operability of the affected equipment. This finding had cross-cutting aspects associated with human performance.

Inspection Report# : 2005002*(pdf)*

Significance: G Dec 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement the Station Fire Watch Procedure
The inspectors identified a noncited violation of Technical Specification 5.4.1.d for failure to implement the station's fire watch procedure. Specifically, on October 22, 2004, the inspectors identified that a compensatory fire watch, responsible for protecting equipment important to safety from fire damage, was not alert and therefore was inattentive to the areas assigned as directed by procedural requirements.
This finding was considered more than minor since the finding would become a more significant safety concern if left uncorrected, but it was determined to have very low safety significance since the finding was assigned a moderate fire protection barrier degradation rating and did not degrade the automatic water-based fire suppression system in the fire area. This finding had crosscutting aspects associated with problem identification and resolution due to the licensee's failure to enter this condition into the corrective action program until prompted by the inspectors approximately 10 days following its identification.
Inspection Report# : 2004005*(pdf)*

Significance: G Dec 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Plant Temperatures Outside Updated Safety Analysis Report Limits
The inspectors identified a noncited violation of 10 CFR 50, Appendix B, Criterion XVI, in that the licensee failed to promptly identify conditions adverse to quality when plant temperatures were outside the Updated Safety Analysis Report specifications. The system engineer knew of the problems but was not aware of program requirements. The failure to properly identify conditions adverse to quality in the corrective action program involved cross-cutting aspects of problem identification.
The inspectors determined that the issue had more than minor safety significance because it impacted the mitigating systems cornerstone objective and could have affected the ability of safety-related systems to perform their design basis functions. The finding was of very low risk significance because it was a design/qualification deficiency that did not result in a loss of function per Generic Letter 91-18, "Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions," Revision 1.

Inspection Report# : 2004005*(pdf)*

Significance: G Sep 23, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to follow temporary shielding procedure.
The inspectors identified Green noncited violation of 10 CFR Part 50, Appendix B, Criterion V, for the failure to follow procedures for the installation of temporary shielding. During a plant tour, the inspectors identified that temporary shielding was in contact with residual heat removal system components resulting in residual heat removal shutdown cooling being declared inoperable.

This finding was more than minor since it affected the reactor safety mitigating systems cornerstone attribute of configuration control but it was considered to have very low safety significance since the condition did not involve any actual loss of function to the safety-related components and did not screen as risk significant due to seismic, fire, flooding or severe weather event. This finding has crosscutting aspect associated with problem identification and resolution based on the fact that the licensee missed several opportunities to identify and evaluate the shielding.
Inspection Report# : 2004004*(pdf)*

Significance: G Jul 10, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate instructions for restoration of the SW system following maintenance
A self-revealing apparent violation of 10 CFR Part 50, Appendix B, Criterion V, was identified for the failure to provide adequate instructions for restoring the service water system to an operable configuration following the completion of maintenance activities. This condition existed from January 21 through February 11, 2004, and resulted in Division 2 of the service water system as well as Emergency Diesel Generator 2 being inoperable for 21 days. The finding was greater than minor because it affected the reliability of the service water system, which is relied upon to mitigate the effects of an accident. The finding was determined to have a potential safety significance greater than very low significance (i.e., Greater than Green) because it caused an increase in the likelihood of an initiating event, namely, a loss of service water, as well as increasing the probability that the service water system would not be available to perform its mitigating systems function.
Inspection Report# : 2004014*(pdf)*

Significance: N/A May 12, 2004
Identified By: NRC
Item Type: VIO Violation
Failure to maintain a systems approach to training led to high failure rates on the biennial requalification examinations
A violation of 10 CFR 55.59(c) was identified. Specifically, the licensee failed to adequately implement a systems approach to training for licensed operator requalification training during the February 25, 2002, through January 11, 2004, requalification training cycle. Reduction of training on plant systems and technical specifications, lack of periodic examinations to test training effectiveness, examination administration issues, and other failures to follow program guidance resulted in a high failure rate on requalification examinations administered in November and December 2003. The failure rate on the biennial written examination exceeded 25 percent. Immediate corrective actions implemented by the licensee included remedial training and retesting those operators who failed prior to returning operators to licensed duties. The licensee also conducted a root-cause analysis, identified several programmatic failures, and initiated corrective actions to address those programmatic issues.

Since this violation was associated with the previously issued White finding, described in Section 1R11 of NRC Inspection Report 05000298/2004-009, it is not being considered as a separate escalated enforcement action.
Inspection Report# : 2004015*(pdf)*

Significance: G May 12, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Take Corrective Actions for Safety-Related Relay Actuations
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the failure to correct a condition adverse to quality regarding inadvertent actuations of safety-related relays. In May 2004, an additional inadvertent relay actuation during a maintenance activity caused Service Water Pump B to trip.
This finding was more than minor since it affected the availability and reliability of an operating service water pump, but it was considered to have very low safety significance since it did not represent the loss of a safety function. This finding also had crosscutting aspects associated with problem identification and resolution based on the fact that the condition was entered into the corrective action program but no corrective actions were ever implemented.
Inspection Report# : 2004003*(pdf)*

Significance: N/A May 12, 2004
Identified By: NRC
Item Type: VIO Violation
Failure to maintain a systems approach to training led to high failure rates on the biennial requalification examinations
A violation of 10 CFR 55.59(c) was identified. Specifically, the licensee failed to adequately implement a systems approach to training for licensed operator requalification training during the February 25, 2002, through January 11, 2004, requalification training cycle. Reduction of

training on plant systems and technical specifications, lack of periodic examinations to test training effectiveness, examination administration issues, and other failures to follow program guidance resulted in a high failure rate on requalification examinations administered in November and December 2003. The failure rate on the biennial written examination exceeded 25 percent. Immediate corrective actions implemented by the licensee included remedial training and retesting those operators who failed prior to returning operators to licensed duties. The licensee also conducted a root-cause analysis, identified several programmatic failures, and initiated corrective actions to address those programmatic issues.

Since this violation was associated with the previously issued White finding, described in Section 1R11 of NRC Inspection Report 05000298/2004-009, it is not being considered as a separate escalated enforcement action.
Inspection Report# : 2004011*(pdf)*

Significance: G May 12, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Errors in written examination grading resulted in six operators passing who should have failed, three of which were returned to licensed duties.
A noncited violation of 10 CFR 55.59(b) was identified. Specifically, due to errors in resolution of regrading the 2003 licensed operator requalification biennial written examinations, three licensed operators were returned to licensed duties, but were later determined to have failed their requalification examinations. As a result, remedial training and re-examination was not completed before returning the affected operators to licensed duties.

The failure to accurately grade the requalification written examinations was a performance deficiency that was more than minor because the licensee did have an opportunity to identify and correct the grading errors prior to returning operators to licensed duties. If this performance deficiency was left uncorrected it could result in inadequately trained or incompetent operators performing licensed duties. The finding is of very low safety significance because it resulted in six operators passing the requalification examination who should have been evaluated as failed.
Inspection Report# : 2004011*(pdf)*

Significance: G Apr 23, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to ensure redundant safe shutdown systems located in the same fire area are free of fire damage.
The team identified a noncited violation of Section III.G.2 of Appendix R to 10 CFR Part 50 for failure to ensure that redundant trains of safe shutdown systems in the same fire area were free of fire damage. For example, cables associated with the automatic depressurization system were not physically protected from fire damage, leaving them vulnerable to spurious operation. The licensee credited manual actions to mitigate the effects of fire damage in lieu of providing the physical protection required by 10 CFR Part 50, Appendix R, Section III.G.2.

This finding is of greater than minor safety significance because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to external events (such as fire) to prevent undesirable consequences. The team found that the manual operator actions implemented to mitigate the effects of fire damage were reasonable (as defined in Enclosure 2 of NRC Inspection Procedure 71111.05, "Fire Protection"), and could be performed within the analyzed time limits. Therefore, in accordance with Enclosure 2 of NRC Inspection Procedure 71111.05, the finding was determined to be of very low safety significance (green), and the significance determination process was not entered.
Inspection Report# : 2004008*(pdf)*

Significance: G Apr 23, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Three examples of a noncited violation of Technical Specification 5.4.1.d for failure to provide adequate instructions in Emergency Procedure 5.4 Fire-S/D, "Fire Induced Shutdown From Outside Control.
The team identified three examples of a noncited violation of Technical Specification 5.4.1.d for failure to provide adequate instructions in Emergency Procedure 5.4 Fire-S/D, "Fire Induced Shutdown From Outside Control Room," Revision 3. In the first example, the licensee failed to provide adequate instructions to operators to assure that high pressure coolant injection flow would be secured within analyzed times in order to prevent reactor vessel overfill and subsequent damage to safety relief valves. In the second example, the licensee failed to provide adequate instructions to operators to ensure the main steam isolation valves were closed in order to prevent feedwater from overfilling the reactor vessel and damaging safety relief valves. In the third example, the licensee failed to provide adequate instructions to ensure operators would correctly position 14 motor-operated valves (required for achieving and maintaining safe shutdown) from motor-control centers. Operating motor-operated valves in this manner bypasses the valves' protective features, leaving them vulnerable to damage by over-thrust. This finding has cross-cutting aspects in the area of human performance.
This finding is of greater than minor safety significance because it impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to external events (such as fire) to prevent undesirable consequences. The team leader and the senior reactor analyst, performed a Phase 3 risk assessment for each of these examples using INEEL/EXT-02-10307, "SPAR-H Human Reliability Method," dated May 2004, and determined that the significance of each of these findings was very low (green). This very

low significance can be attributed to a low initiating event frequency and low probability of circuit failures which would cause spurious operation.
Inspection Report# : 2004008*(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: G Mar 24, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Emergency Plan During a Fire
The inspectors identified a noncited violation of 10 CFR 50.54(q) for the failure to implement the emergency plan during an actual plant event. On March 14, 2005, at approximately 2:51 a.m. station operators reported to the control room that there was a fire in a trash bin in the multi-purpose facility inside the protected area. At approximately 3:08 a.m., heavy smoke and flames were seen inside a container near the trash bin and the fire brigade leader reported to the control room that the fire was not out. The fire was declared out at 3:13 a.m. Emergency classification requirements state that a fire within the protected area which takes longer than 10 minutes to extinguish meets the criteria for a Notification of Unusual Event. No such declaration was made by the control room.
This finding affected the Emergency Preparedness cornerstone was more than minor because it affected the cornerstone attribute of emergency response organization performance during actual event response. This finding was determined to be of very low safety significance since it only involved the failure to declare a Notification of Unusual Event during an actual plant event. This finding had cross-cutting aspects associated with human performance.

Inspection Report# : 2005002*(pdf)*

Occupational Radiation Safety

Significance: G Mar 24, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Conspicuously Post and Barricade Two Areas in the Drywell as a Locked High Radiation Area in Accordance with Technical Specification 5.7.2.
Green: Two examples of a self-revealing non-cited violation of Technical Specification 5.7.2 were reviewed where individuals entered locations in the drywell that were not barricaded and posted as locked high radiation areas. On January 18, 2005, at approximately 2:25 a.m. a worker who entered the drywell, unexpectedly received an electronic dosimeter dose rate alarm. Additionally, at approximately 4:23 a.m. a second worker also received a dose rate alarm. Radiation protection technicians measured 1,500 millirem per hour at 30 centimeters on the 943 foot elevation and 1,200 millirem per hour at 30 centimeters on the 901 foot elevation. This occurrence was entered into the licensee's corrective action program. However, immediate corrective actions taken from the first event were not adequate to prevent the second event.

The issues are greater than minor because they were associated with a cornerstone attribute (exposure control) and affected the associated cornerstone objective because failure to control locked high radiation areas have the potential to cause unplanned and unintended personnel dose. Using the Occupational Radiation Safety Significance Determination Process, the inspector determined that the finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. Additionally, this finding had human performance and problem, identification, and resolution associated aspects.

Inspection Report# : 2005002*(pdf)*

Significance: G Mar 24, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform an Adequate Survey to Evaluate Radiogical Hazards per 10 CFR 20.1501
Green: A self-revealing non-cited violation of 10 CFR 20.1501(a) was reviewed when the radiation protection staff failed to perform an

adequate survey of the radiological hazards associated with the movement of the reactor transfer canal. On January 19, 2005, two workers' electronic dosimeters unexpectedly alarmed after they entered the dryer/separator pool and began moving the reactor fuel transfer canal. The licensee's investigation revealed that radiation protection staff allowed the lifting and movement of the transfer canal before surveys were performed on the bottom of the transfer canal. Radiation levels were as high as 700 millirem per hour at 30 centimeters and 1,200 millirem per hour on contact with the bottom of the transfer canal. This occurrence was entered into the licensee's corrective action program.

The issue is greater than minor because it was associated with a cornerstone attribute Program and Process Attribute and affected the associated cornerstone objective because inadequate radiation surveys have the potential to cause unplanned and unintended personnel dose. Using the Occupational Radiation Safety Significance Determination Process, the inspector determined that the finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. This finding also had crosscutting aspects associated with human performance.
Inspection Report# : 2005002*(pdf)*

Significance: G Mar 24, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Gain Authorized Access to a High Radiation Area in Accordance with Technical Specification 5.7.1
A self-revealing non-cited violation of Technical Specification 5.7.1 was reviewed. Specifically, on January 5, 2005, an individual entered a properly posted and controlled high radiation area in the condenser bay without authorization and without observing the access controls that were in-place. Licensee staff determined that the individual entered the high radiation area without being logged on the proper special work permit, and without being made knowledgeable of the radiological conditions in the area as required by the Technical Specifications. The general radiation levels were found to be as high as 300 millirem per hour. This occurrence was entered into the licensee's corrective action program.

The failure to notify radiation protection staff and to be briefed on the radiological conditions before entering a high radiation area is greater than minor because it was associated with the cornerstone attribute Program and Process Attribute and affected the cornerstone objective to ensure the adequate protection of the worker's health and safety from exposure to radiation because unauthorized entry into a high radiation area could increase personnel dose. Using the Occupational Radiation Safety Significance Determination Process, the inspector determined that the finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. This finding also had crosscutting aspects associated with human performance.
Inspection Report# : 2005002*(pdf)*

Significance: G Dec 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Barricade and Conspicuously Post a High Radiation Area
The inspector identified a non-cited violation of Technical Specification 5.7.1, since the licensee failed to barricade and conspicuously post a high radiation area. On November 30, 2004, the inspector identified piping located in the Residual Heat Removal "B" heat exchanger room that had dose rates elevated to greater than 100 millirem per hour. The licensee performed a survey and confirmed dose rates were 600 millirem per hour on contact with the pipe and 160 millirem per hour at 12 inches from the pipe. The area was immediately barricaded and posted. The licensee entered this issue into its corrective action program.
This finding is greater than minor because it was associated with the cornerstone attribute (exposure control) and affected the cornerstone objective because failure to post a high radiation area with dose rates greater than 100 millirem per hour could increase the risk of personnel dosage. The finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose.

Inspection Report# : 2004005*(pdf)*

Significance: G Dec 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide a Radiation Monitoring Device that Could Detect High Radiation in a Work Area
The inspector reviewed a self-revealing non-cited violation of Technical Specification 5.7.1 because the licensee failed to provide an individual a radiation monitoring device that could be detected when a preset integrated dose alarm was received. On December 15, 2003, an individual unknowingly exceeded the alarm setpoint of a required electronic dosimeter while working in an area with radiation levels as high as 200 millirem per hour. The electronic dosimeter was set to alarm at 20 millirem, but upon exiting the area the electronic dosimeter read 31 millirem and was alarming. The individual did not hear the alarm until the area was exited. The licensee entered this issue into its corrective action program.
This finding is greater than minor because it was associated with the cornerstone attribute (exposure control) and affected the cornerstone objective because the inability to detect an alarming device in a high radiation area could increase personnel dose. The finding was of very low safety significance because it did not involve (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. This finding also had crosscutting aspects associated with human performance.

Inspection Report# : 2004005*(pdf)*

Significance: G Sep 16, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to perform an adequate survey.
The inspector identified a non-cited violation of 10 CFR 20.1501(a) for failure to perform an adequate survey that resulted in a radiation area not being posted as required by regulations. On March 31, 2004, the licensee identified an unposted radiation area on the inside of the rain ring of the "B" Condensate Storage Tank. The survey discovered a spot near the base of the tank that read 160 millrem per hour on contact and 8 millirem per hour at 30 centimeters. The inspector determined that the radiation area had not been identified for approximately one year.

The finding is more than minor because it affected the cornerstone attribute (exposure control) and affected the associated cornerstone objective because it resulted in a radiation area not being posted. The finding was evaluated using the Occupational Radiation Safety Cornerstone because the finding involved the potential for unplanned or unintended dose which could have been significantly greater as a result of a single minor alteration of the circumstances. When processed through the Occupational Radiation Safety Significance Determination Process, the finding was found to have very low safety significance because it was not an ALARA finding, there was no overexposure or substantial potential for an overexposure and the ability to assess dose was not compromised. This finding also had crosscutting aspects associated with human performance.
Inspection Report# : 2004004*(pdf)*

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Jun 26, 2004
Identified By: NRC
Item Type: FIN Finding
6th Quarterly CAL Inspection
In the area of emergency preparedness, the licensee's performance indicators, NRC performance indicators, and baseline inspection results indicated a satisfactory level of performance. Also in the area of engineering programs, improvements are in place and an improving trend has been noted in licensee performance indicators and no significant findings have been identified during NRC baseline inspections. In the area of human performance, baseline inspection findings continue to be identified in which personnel errors have contributed to plant performance issues. TIP action steps implemented and ongoing have provided some improvement as evidenced by two of four licensee performance indicators performing satisfactorily and the other two requiring further improvement but trending in a positive direction.

In the three remaining Confirmatory Action Letter areas, the team concluded, by reviewing licensee performance indicators, NRC performance indicators, licensee self-assessments, and NRC baseline inspection results, that a number of positive actions have been implemented but they have not yet resulted in sustained improved performance. Specifically, in the area of material condition and equipment reliability, actions completed to date have provided the necessary processes for improvement, and numerous equipment improvements have been recently completed. However, a number of the licensee's performance indicators did not meet their performance goals. In the area of plant modifications and configuration control, progress in operability determination screening and lesson learned training was noted and provides potential for enhancing the licensee's ability to prioritize and perform operability determinations by emphasizing knowledged based tools. This conclusion was reinforced through interviews with operations and engineering personnel. Lastly, in the area of corrective action, a new "take action now" philosophy has also been implemented to increase manager ownership of corrective action performance indicators, through presentations of performance indicator status to senior management on a regular basis. The early trending information or the effectiveness of the "take action now" philosophy has shown a marked improvement in timely corrective actions.

Inspection Report# : 2004007*(pdf)*

Significance: N/A May 12, 2004
Identified By: NRC

Item Type: FIN Finding

5th Quarterly CAL Inspection

In the area of emergency preparedness, the licensee's performance indicators, NRC performance indicators, and baseline inspection results indicated a satisfactory level of performance. Also, in the area of engineering programs improvements are in place and an improving trend has been noted in licensee performance indicators and no significant findings have been identified during NRC baseline inspections. Engineering programs have been effectively developed and the implementation process is ongoing. In the area of human performance, TIP action steps implemented and ongoing have provided continued improvement as evidenced by an improving trend in human performance data over the last 6 months. Despite these improvements, baseline inspection findings continue to be identified in which personnel errors have contributed to plant performance issues. In the three remaining Confirmatory Action Letter areas, the team concluded, by reviewing licensee performance indicators, NRC performance indicators, licensee self-assessments, and baseline inspection results, that actions implemented have not resulted in sustained improved performance. Specifically, in the area of material condition and equipment reliability, actions completed to date have provided the necessary processes for improvement, and numerous equipment improvements have been recently completed. However, a number of the licensee's performance indicators did not meet their performance goals. Implementation issues have continued to be identified in the areas of operability determinations, problem evaluation, and effectiveness of corrective actions. While the NRC acknowledges that some implementation issues are not unexpected, the types of recent problems within these areas, some of which have been repetitive, should have been prevented.

Inspection Report# : 2004006*(pdf)*

Last modified : June 17, 2005