Duane Arnold
2Q/2006 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IDENTIFY AND CONTROL TRANSIENT COMBUSTIBLES IN THE SOUTHEAST CORNER ROOM OF THE REACTOR BUILDING.
A finding of very low safety significance was identified by the inspectors for the failure to control and evaluate transient combustibles in the southeast corner room of the reactor building. The transient combustibles consisted of wood planking located on scaffolding within the room. The primary cause of this finding was related to the cross-cutting area of Human Performance for the failure to follow approved procedures. The licensee entered this issue into their corrective action program and processed the associated combustible permits.

This finding was more than minor because it matched example 4.a. in Appendix E, "Examples of Minor Issues and Cross-Cutting Aspects," of Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports." This was due to the fact that the licensee routinely failed to perform evaluations on similar issues. The finding was of very low safety significance because of the low fire degradation rating associated with wood. The issue was an NCV of License Condition 2.C.(3) that requires the licensee to implement and maintain in effect all provisions of the approved fire protection program.
Inspection Report# : 2005005*(pdf)*

Significance: G Dec 31, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CORRECTIVE ACTIONS FOR THE CONTROL OF TRANSIENT COMBUSTIBLES.
A finding of very low safety significance was identified by the inspectors for failure to correct deficiencies with the control of transient combustibles. The transient combustibles consisted of wood planking located on scaffolding. The primary cause of this finding was related to the cross-cutting area of Problem Identification and Resolution due to inadequate corrective actions for repeated deficiencies associated with the control of transient combustibles. The licensee entered this issue into their corrective action program, processed the associated combustible permits, and performed an apparent cause evaluation.

This finding was more than minor because it matched example 3.g. in Appendix E, "Examples of Minor Issues and Cross-Cutting Aspects," of IMC 0612, "Power Reactor Inspection Reports." This was due to the fact that the licensee failed to take actions to correct nonconforming conditions. The finding was of very low safety significance because of the low fire degradation rating associated with wood. The issue was an NCV of License Condition 2.C.(3), that requires the licensee to implement and maintain in effect all provisions of the approved fire protection program.
Inspection Report# : 2005005*(pdf)*

Significance: SL-IV Nov 18, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
UFSAR CHANGE REDUCING CAPABILITY OF THE AUTOMATIC RUNBACK OF THE RECIRCULATION PUMPS ON A FEEDWATER PUMP TRIP.
The inspectors identified a Severity Level IV Non-Cited Violation associated with the failure to perform an adequate safety evaluation review as required by 10 CFR 50.59 for changes made to the facility as described in the Updated Safety Analysis Report (USAR). Specifically, the licensee adversely changed the license basis function of the recirculation pump runback in the UFSAR such that the recirculation runback feature could no longer prevent a reactor scram if a feedwater pump tripped. Within the 10 CFR 50.59 evaluation, the licensee failed to provide a basis for why this malfunction of the recirculation pumps' runback logic (equipment important to safety) did not present more than a minimal increase in the likelihood of occurrence of a malfunction of a Structure, System and Component (SSC) important to safety.

Because the issue affected the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. The finding was determined to be more than minor because the inspectors could not reasonably determine that the UFSAR change, which adversely affected equipment important to safety, would not have ultimately required NRC approval. The finding was determined to be of very low safety significance (Green) based on the results of the SDP Phase 1 screening worksheet.
Inspection Report# : 2005013*(pdf)*

Significance: G Sep 30, 2005
Identified By: Self-Revealing
Item Type: FIN Finding

FAILURE TO ADEQUATELY VERIFY A VALVE LINEUP IN THE FIRE PROTECTION SYSTEM.
A finding of very low safety significance was identified through a self revealing event when an operator failed to adequately verify a valve lineup in the fire protection system. The valve that was inadvertently left open caused partial flooding and contamination of the first floor of the reactor building. The primary cause of this finding was related to the cross-cutting area of Human Performance (Personnel). The licensee entered this issue into their corrective action program and decontaminated the associated floor areas.

The finding was more than minor because the failure to verify proper a valve lineup prior to restoring the system has the potential to adversely impact plant equipment, thereby affecting plant safety. This finding was determined to be of very low safety significance since it did not impact any mitigating systems capability. Since no 10 Code of Federal Regulations (CFR) 50, Appendix B components were impacted by this finding, no violation of NRC requirements occurred.
Inspection Report# : 2005004*(pdf)*

Mitigating Systems

Significance: G Jun 30, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM AN ADEQUATE RISK ASSESSMENT.
A finding of very low safety significance was identified by the inspectors for the licensee's failure to conduct an adequate risk assessment of the Standby Liquid Control System (SLCS) which was removed from service for scheduled surveillances December 1, 2005, and March 1, 2006. This resulted in an unrecognized increase in the level of risk as determined by the licensee's Probabilistic Risk Assessment (PRA) model. This issue was documented in the licensee's corrective action program (CAP) as CAP 042499. The corrective actions taken included revising the procedure to insert detailed restoration steps, communications and dedicated operator requirements, as well as requirements for declaring the system inoperable and unavailable during performance of the surveillance test. An NCV of 10 CFR 50.65(a)(4) was identified for the failure to conduct an adequate risk assessment prior to conducting online maintenance involving the SLCS.

This finding is more than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the cornerstone objective in that the licensee failed to perform an adequate risk assessment prior to conducting online maintenance. The licensee's risk assessment did not consider the risk-significant SLCS system that was out of service which, when properly evaluated, did result in an increased level of risk from a PRA perspective and would have put the licensee in a higher risk category. However, the finding was of very low safety significance because the risk deficit for Incremental Core Damage Probability was less than 1E-6 and for Incremental Large Early Release Probability was less than 1E-7.
Inspection Report# : 2006003*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Calculation Deficiency for Potential Vortexing in CST

The team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance involving the calculation of low level setpoints for the CST. Specifically, the licensee did not include a quantitative analysis of the transfer time in the calculation and subsequently, did not fully address the potential for air entrainment in the high pressure injection pump due to vortexing. The licensee determined the high pressure injection system was operable based on available margin in the calculation. The licensee entered the finding into their corrective action program as CAP 040973.

The finding was more than minor because the failure to account for this transfer time reduced the margin available to prevent air entrainment into the high pressure coolant injection (HPCI) system and affected the Mitigating Systems cornerstone attribute of design control. The finding was of very low safety significance based on the results of the licensee's analysis and screened as Green using the SDP Phase 1 screening worksheet. The cause of the finding was related to the cross-cutting element of problem identification and resolution.

Inspection Report# : 2006007*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Torquing of 250Vdc, 125Vdc and 48Vdc Batteries Electrical Connections

The team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance involving licensee's failure to ensure that the torque values specified in the maintenance procedure for safety related and important to safety 250Vdc, 125Vdc, and 48Vdc batteries, were correctly incorporated from vendor specified design data and from the licensee's design standard into the procedure. Consequently, all 250Vdc, 125Vdc, and 48Vdc battery electrical terminal connections were under-torqued during battery

replacement activities, in 2003. The licensee's corrective action included performing a condition evaluation to determine status of the batteries, and entering this performance deficiency into their corrective action program for resolution as CAP041156, CAP041422, and CAP 041734.

This finding was more than minor because the batteries procedure deficiency affected plant equipment and was associated with the attribute of design control and equipment performance of the Mitigating Systems cornerstone. Specifically, improper torquing could result in unacceptable battery terminal connection resistance and decreased battery capacity, rendering the dc system incapable of performing its required safety function. The finding was of very low safety significance based on the results of the licensee's analysis and screened as Green using the SDP Phase 1 screening worksheet.

Inspection Report# : 2006007*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Electrical Components Downgraded from SR to NSR Without Appropriate Isolation Devices

The team identified a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion III, "Design Control," having very low safety significance for failure to ensure that proper design control was maintained. Specifically, the licensee failed to perform a comprehensive design review of a 1992 modification that had incorrectly downgraded the quality classification of two level indicating switches. As a result of this team's inquiries, four additional examples of mis-classified equipment were identified. The licensee entered the finding into their corrective action program as CAP041107 and CAP041731.

The finding was more than minor because, without proper electrical isolation devices, failure of QL4 (non-safety) classified devices could cause a loss of QL1(safety related) classified equipment. This finding was of very low safety significance based on the results of the licensee's analysis and screened as Green using the SDP Phase 1 screening worksheet. The cause of this finding was related to the cross-cutting aspect of problem identification and resolution, in that, the licensee did not fully evaluate the condition adverse to quality in 2004.
Inspection Report# : 2006007*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
UFSAR Table 8.2-1 Had No Documented Basis

The team identified a Non-Cited Violation of 10 CFR 50, Appendix B,
Criterion III, Design Control, having a very low safety significance pertaining to lack of design basis for the values listed in Updated Final Safety Analysis Report Table 8.1-2. The licensee could not identify an active calculation that supported the values listed in the table. In response to this deficiency, the licensee initiated CAP 041395 to develop the basis for the values indicated in the UFSAR table.

The finding was more than minor because control relay settings and design voltage values could be incorrectly set based on these unsupported values. The finding was of very low safety significance based on the results of the licensee's analysis and screened as Green using the SDP Phase 1 screening worksheet.
Inspection Report# : 2006007*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Non-Safety Related Charger Used to Charge a Cell of a 125Vdc SR Battery Without Electrical Isolation

The team identified a Non-Cited Violation of TS 5.4.1a, "Procedures," having a very low safety significance pertaining to licensee's failure to establish and use an appropriate procedure for charging a single cell of a safety related battery. A portable non-safety related charger was used to charge a single cell of a safety related battery without maintaining the required electrical isolation between the safety related battery and the non-safety related charger. The licensee initiated CAP 041099 to modify existing maintenance procedures.

This finding was more than minor because failure to maintain electrical isolation could render the safety related battery inoperable. The finding was of very low safety significance based on the results of the licensee's analysis and screened as Green using the SDP Phase 1 screening worksheet.
Inspection Report# : 2006007*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish a Testing Program for Molded Case Circuit Breakers (MCCBs)

The team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XI, “Test Control,” having very low safety significance for failure to implement a testing program to ensure that the installed safety related and important-to-safety molded case circuit breakers (MCCBs) will perform satisfactorily in service. This issue was entered into the licensee’s corrective action program as CAP041363. The licensee was planning to purchase new test equipment and commence testing a statistical sample of the installed MCCBs to corroborate MCCB operability.

The finding was more than minor because the installed MCCBs were not adequately exercised or tested and were beyond the manufacturer’s design life. This condition could effect breaker coordination, over-current protection, fire prevention, and multiple other safety related and important to safety functions. The finding was of very low safety significance because licensee determined the issue was a qualification deficiency confirmed not to result in loss of operability per “Part 9900, Technical Guidance, Operability Determination Process for Operability and Functional Assessment.” The cause of the finding was related to the cross-cutting aspect of problem identification and resolution.
Inspection Report# : 2006007*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Simulation of Operator response to an SBO event

The team identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” having very low safety significance for failing to maintain adequate procedures to establish alternate ventilation within a minimum time after the onset of a station blackout event. The licensee entered the finding into their corrective action program as CAP 041379 and commenced an extensive root cause investigation.

The finding was more than minor because failure to establish alternate ventilation within the analyzed time limit could result in excessive temperatures in the rooms and impact the performance of equipment. Although the use of an inadequate procedure increased the likelihood of undesirable consequences from an SBO event, the finding was of very low safety significance because it did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event. The cause of the finding is related to the cross-cutting element of problem identification and resolution.
Inspection Report# : 2006007*(pdf)*

Significance: G Mar 31, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ENSURE PROPER DESIGN CONTROL WAS MAINTAINED WITH THE SBDG.
A finding of very low safety significance was identified by the inspectors for the failure to ensure proper design control was maintained during loading of the standby diesel generators (SBDG). The licensee entered this issue into their corrective action program and performed additional analysis to verify operability.

The finding was determined to be greater than minor because the finding is associated with the design control attribute of the Mitigating Systems cornerstone and it affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance because overall system operability did not change. An NCV of 10 CFR 50, Appendix B, Criterion III, “Design Control,” was identified for the failure to verify or check the adequacy of design associated with the SBDG.
Inspection Report# : 2006002*(pdf)*

Significance: G Mar 31, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ENSURE PROPER DESIGN CONTROL WAS MAINTAINED WITH THE FEEDWATER PIPING HANGERS.
A finding of very low safety significance was identified by the inspectors for the failure to ensure proper design control was maintained with feedwater piping hangers DBD-4-H57A and DBD-4-H50A. The primary cause of this finding was related to the cross-cutting area of Human Performance because of the failure to provide adequate attention to detail during the preparation of calculations by engineering personnel. The licensee entered this issue into their corrective action program and performed additional analysis to verify operability.

The finding was determined to be greater than minor because the finding is associated with the design control attribute of the Barrier Integrity cornerstone and it affects the cornerstone objective of providing reasonable assurance that physical design barriers (containment) protect the public from radionuclide releases caused by accidents or events. The finding was of very low safety significance because overall system operability did not change. An NCV of 10 CFR 50, Appendix B, Criterion III, “Design Control,” was identified for the failure to verify or check the adequacy of design associated with feedwater piping hangers DBD-4-H57A and DBD-4-H50A.
Inspection Report# : 2006002*(pdf)*

Significance: G Nov 18, 2005
Identified By: NRC

Item Type: NCV NonCited Violation
FAILURE TO CONSIDER ADVERSE AMPACITY EFFECTS OF HIGH TEMPERATURE CONDITIONS IN THE CONDENSER AND HEATER BAY ROOM.
A finding of very low safety significance was identified by the inspectors associated with a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," where the licensee had not evaluated and updated the plant cable ampacity calculation to determine the potential consequences of adverse effects to cabling due to higher temperatures in the Condenser and Heater Bays. After identification by the team, the licensee was able to demonstrate that even though the higher temperatures decreased the ampacity margins for the effected cabling, it did not decrease the margins to the limit where the cabling would fail if called upon to provide power to equipment important to safety.

The finding was more than minor because it affected the mitigating system cornerstone attribute of "Design Control." Specifically, the licensee did not account for high temperature conditions in the Condenser and Heater Bay room that adversely affected the ampacity of cabling supplying power to equipment important to safety. This finding was of very low safety significance because it screened out using the Phase 1 worksheet. Specifically, the licensee's preliminary evaluation determined that the higher temperatures would not prevent pertinent equipment from functioning.
Inspection Report# : 2005013*(pdf)*

Significance: G Sep 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO MEET TRAVEL DISTANCE REQUIREMENTS FOR FIRE EXTINGUISHERS IN THE REACTOR BUILDING.
A finding of very low safety significance was identified by the inspectors for a violation of the fire protection license condition. The licensee failed to ensure that travel distance requirements were met for fire extinguishers in the reactor building. Once this issue was identified, the licensee entered the issue into their corrective action program and initiated work requests to provide additional fire extinguishers. The primary cause of this violation was related to the Identification subcategory of the Problem Identification and Resolution cross-cutting area. Licensee fire protection personnel failed to identify that the placement of fire extinguishers did not satisfy fire protection code requirements during a self-assessment of code compliance for fire extinguishers performed in April 2004.

This finding was more than minor because the ability to manually fight a small fire in the area of the spent fuel pool cooling and cleanup pumps was adversely affected. The issue was of very low safety significance due to the limited impact a fire would have in the affected fire zones and the relatively low ignition frequency for the affected fire zones. The finding was a Non-Cited Violation (NCV) of License Condition 2.3.(C) which required the licensee to implement and maintain in effect all provisions of the approved fire protection program as described in Safety Evaluation Report dated June 1, 1978, which specified compliance to the applicable fire protection code for fire extinguishers.
Inspection Report# : 2005004*(pdf)*

Significance: G Jun 07, 2005
Identified By: NRC
Item Type: VIO Violation
Failure to Demonstrate Adequacy of Design Assumption for Torus Attached Piping
A violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" having very low safety significance was identified by the inspector. Specifically, the licensee failed to demonstrate that a 1996 high pressure coolant injection (HPCI) modification was subjected to design control measures commensurate with those applied to the original design. The licensee also failed to apply design control measures to verify the adequacy of the design in order to assure that the design basis for torus attached piping was correctly translated into the modification's specifications, drawings, procedures and instructions.

The finding was more than minor because the finding was associated with the cornerstone attribute of design control in the mitigating system cornerstone and the finding was determined to affect the associated cornerstone objective of ensuring the availability of the HPCI system when called upon. Under the worst case scenario, movement of the torus with the additional valve weight on the HPCI turbine exhaust line would result in crimping of the line. Crimping of the line would create additional backpressure in the HPCI turbine and would result in a decrease in the amount of water being injected into the reactor vessel. The finding was determined to be of very low safety significance based upon a Phase 2 analysis of those transients which would involve movement of the torus.

The finding was cited since the licensee did not enter the issue into its corrective action program and did not take actions to correct the noncompliance.
Inspection Report# : 2005010*(pdf)*

Barrier Integrity

Significance: SL-III May 01, 2006
Identified By: NRC
Item Type: VIO Violation
Failure to complete the “Pre Fuel Move Checklist” before moving irradiated fuel bundles in the DAEC spent fuel pool
Duane Arnold Energy Center (DAEC) Refueling Procedure No. 403, “Performance of Fuel Handling Activities,” Revision No. 16, was issued on June 16, 2004, and required that the designated fuel handling supervisor complete applicable sections of the “Pre Fuel Move Checklist” before

starting fuel handling activities. On November 9, 2004, a refueling floor supervisor, who was primarily responsible for preparing Revision No. 16 to the procedure, was the designated fuel handling supervisor and he failed to complete the "Pre Fuel Move Checklist" before moving three irradiated fuel bundles in the DAEC spent fuel pool, as required by the refueling procedure.

The NRC Office of Investigations (OI) conducted an investigation of the event involving a former supervisor's apparent willful violation of a DAEC refueling procedure on November 9, 2004. The OI investigation was completed on October 26, 2005. (OI Case 3-2004-033).

Based on the information developed during the OI investigation and the information provided by the licensee in an April 7, 2006 letter, the NRC has determined that a SL III violation of NRC requirements occurred. The NRC has determined that this was a willful violation, demonstrating at least careless disregard of a procedure required by DAEC Technical Specification 5.4.1.
Inspection Report# : 2006016*(pdf)*

Significance: G Apr 21, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
RCIC Pump Suction Valves Automatic Control Logic

The team identified a Non-Cited Violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance involving the control logic of reactor core isolation cooling (RCIC) pump suction valves MO-2516 and MO-2517. Design Change Request 1040 modified the control logic and did not retain the remote-manual closure capability of these containment isolation valves. This remote-manual closure capability was specifically addressed in NRC correspondence. As an interim measure, the licensee revised an operating procedure to allow the operators to manually block specific relay contacts in the control room, allowing these valves to be closed if required. The licensee entered the finding into their corrective action program as CAP 041114.

The finding was more than minor because failure to retain the remote-manual closure capability of these valves was associated with the attribute of design control, which affected the barrier integrity cornerstone objective of ensuring the functionality of the primary containment isolation valves. The finding was of very low safety significance based on the results of the licensee's analysis and screened as Green using the SDP Phase 1 screening worksheet.

Inspection Report# : 2006007*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: SL-III May 01, 2006
Identified By: NRC
Item Type: VIO Violation
Failure to notify health physics or ensure that health physics personnel were present prior to relocating irradiated items in the cask pool
Duane Arnold Energy Center (DAEC) Control Procedure ACP1407-2, "Material Control in the Spent Fuel Pool and Cask Pool," Revision 10, dated November 4, 2002, a procedure that implemented Technical Specification 5.4.1 and Regulatory Guide 1.33, provided, in part, that health physics shall be notified and present prior to relocating or removing any item stored in the spent fuel pool and cask pool. On July 23, 2003, a Refueling Floor Supervisor directed an operator to relocate irradiated items in the cask pool without notifying health physics or ensuring that health physics personnel were present prior to relocating the irradiated items.

The NRC Office of Investigations (OI) conducted an investigation of the event involving a former supervisor's apparent deliberate violation of a radiation protection procedure on July 23, 2003. The OI investigation was completed on February 6, 2004 (OI Report No. 3-2003-021).

Based on information developed during the OI Investigation, information provided during the June 1, 2004, PEC, and all other pertinent information, the NRC determined that a SL III violation of NRC requirements occurred at DAEC on July 23, 2003. The NRC has determined that this was a deliberate violation of NRC requirements.

Inspection Report# : 2006017*(pdf)*

Significance: G Sep 30, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
RADIATION WORK PERMIT DOSE EXCEEDED THE ESTIMATE BY 61 PERCENT ON TWO SEPARATE WORK ACTIVITIES.
The inspectors reviewed a self-revealing NCV of Technical Specification (TS) 5.4.1 for the failure to follow station as-low-as-reasonably-

achievable (ALARA) procedure. During Refueling Outage (RFO) 19, the radiation dose estimate was exceeded by 61 percent and the total was greater than 5 rem on two separate work activities. The control rod drive push/pull and rebuild project was planned with a total dose of 3100 millirem, and the actual dose was 5253 millirem with no revisions to the estimate during the work implementation. The refueling project was estimated at 8500 millirem, and the actual exposure was 13648 millirem. The licensee determined that the work area dose rates were consistent with the plan, but time estimates or person-hours were not consistent with actual work implementation. The finding was entered into the licensee's corrective action program.

The finding was more than minor because it is associated with the Occupational Radiation Safety attribute of exposure control and affected the cornerstone objective of programs and procedures. The occurrence involved a failure to implement procedures needed to achieve occupational doses ALARA and that resulted in an unplanned, unintended occupational collective dose for two work activities. Using the Occupational Radiation Safety Significance Determination Process, the inspectors determined that the finding was of very low safety significance (Green) because while it did involve ALARA planning and controls, (1) the licensee three-year rolling average collective dose was less than 240 person-rem/unit, and it did not involve; (2) an overexposure; (3) a substantial potential for an overexposure; or (4) an impaired ability to assess dose.
Inspection Report# : 2005004*(pdf)*

Public Radiation Safety

Significance:  Mar 31, 2006
Identified By: NRC
Item Type: FIN Finding
FAILURE TO MEET INDUSTRY STANDARDS FOR THE UNCONDITIONAL RELEASE OF BULK AGGREGATE LIQUID AND SOLID MATERIALS.
An inspector-identified finding of very low safety significance was identified for the failure to meet the industry standard of using the environmental Lower Limit of Detection (LLD) when surveying, and analyzing bulk aggregate and liquid materials prior to unconditional release from the site.

The finding was more than minor because it was associated with the Public Radiation Safety cornerstone attribute of program and processes, and potentially affected the cornerstone objective of ensuring adequate protection of public health and safety from exposure to radioactive materials released into the public domain. The finding was of very low safety significance because public exposure resulting from the release of bulk aggregate solid or liquid materials at effluent LLD values was less than 0.005 rem, and there were less than 5 occurrences during the inspection period. The finding was based on the licensee’s failure to meet an industry standard.
Inspection Report# : 2006002*(pdf)*

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : August 25, 2006