

Point Beach 1

4Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Mar 27, 2009

Identified By: NRC

Item Type: FIN Finding

Failure To Adequately Control High Winds/Tornado Hazards

A finding of very low safety significance was identified by the inspectors for the licensee's failure to maintain control over the proper storage and placement of materials, within the risk significant areas of the outdoors protected area, that were classified as high winds/tornado hazards in accordance with station procedures PC 99, "Tornado Hazards Inspection Checklist," and NP 1.9.6, "Plant Cleanliness and Storage." Specifically, these unsecured items were identified near the Unit 1 and Unit 2 main transformer lines, auxiliary transformers, and the G 03/G 04 emergency diesel generator building. Once notified, the licensee removed or secured the materials appropriately and entered the issue into its corrective action program. At the end of the inspection period, the licensee continued to perform a root cause evaluation and develop long-term corrective actions.

The finding was determined to be more than minor because if left uncorrected, the loose items would become a more significant safety concern. The inspectors evaluated the finding using the Significance Determination Process in accordance with Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," dated January 10, 2008. The finding is of very low safety significance (Green) because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. Additionally, the inspectors determined that the finding had a cross-cutting aspect in the area of human performance, work practices component, because the licensee failed to ensure adequate supervisory and management oversight of the implementation and follow through of the corrective actions from previous related issues (H.4(c)).

Inspection Report# : [2009006](#) (*pdf*)

Mitigating Systems

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: FIN Finding

Failure To Meet Generic Letter 89-13 Program Requirement For Mussel Control

The inspectors identified a finding of very low safety significance for the failure to meet a commitment made in the Generic Letter 89-13 program. Specifically, the program states that biocide treatments at Point Beach are performed at least annually and are directly applied to the service water system for mussel control and eradication to prevent fouling of safety related heat exchangers. However, the 2008 biocide treatment for mussel control was deferred until 2009. After the treatment in 2009, greater than expected tube blockage and reduced flow to safety-related heat exchangers due to mussels was identified. In response, the licensee adjusted flow through the affected heat exchangers and opened and cleaned the heat exchangers to remove mussels that caused the tube blockage. The licensee took corrective actions to ensure that future annual biocide treatments would be conducted annually.

This finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems Cornerstone and adversely affected the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined the finding could be evaluated using the Significance Determination Process in accordance with Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 0609.04,

"Phase 1 – Initial Screening and Characterization of Findings," Table 4a, for the Mitigating Systems Cornerstone, dated January 10, 2008. The finding was determined to be of very low safety significance because the issue did not result in the actual loss of a safety function. This finding did not involve a violation of NRC regulatory requirements. The inspectors determined this performance deficiency was not indicative of current performance; therefore, no cross-cutting aspect was identified.

Inspection Report# : [2009005](#) (pdf)

Significance:  Dec 18, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Errors Found in the Room Ventilation Calculation for G-01 and G-02

A finding of very low safety-significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control" was identified by the inspectors for the licensee's failure to adequately calculate the maximum room temperature for G-01 and G-02. Specifically, the licensee's calculation 2005-0054 failed to incorporate the design basis described in Technical Specification (TS) bases 3.8.1 related to the numbers of fire dampers associated with G-01 and G-02 exhaust fans that must be opened to maintain room temperature. The calculation also failed to demonstrate that the temperature stratification close to the combustion air intake filter was acceptable. Instead, the calculation only considered the bulk air temperature in the room. The licensee subsequently entered these concerns into their corrective action program as AR 01162599 and AR 01162759.

The finding was determined to be more than minor because the finding was similar to IMC 0612, Appendix E, Example (3.J). The calculation errors were significant in that there was reasonable doubt that the maximum room temperature would not exceed the value of the Vendor Technical manual. The finding impacted the Mitigating System cornerstone of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee did not ensure that the maximum room temperature of EDG-1 and EDG-2 would not exceed 115 degrees Fahrenheit (F), which is required to be maintained to ensure that the EDGs will perform their safety function during a design basis accident when the outside air temperature was 95 degrees Fahrenheit. The finding was of very low safety-significance based on a Phase 1 screening in accordance with IMC 0609, Appendix A, A Significance Determination of Reactor Inspection Findings for At-Power Situations." This finding was not associated with a cross-cutting aspect because the finding was not indicative of the licensee's current performance.

Inspection Report# : [2009007](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Seismic Assessment Of Temporary Cable Installations Above Motor-Driven Auxiliary Feedwater Pumps

The inspectors identified a finding of very low safety significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure of the licensee's modification process to ensure that new 4160-volt cables installed for proposed auxiliary feedwater (AFW) pump motor replacements were installed in accordance with applicable regulatory requirements. Specifically, no seismic design evaluation was completed prior to the installation of the cable coils suspended above the existing motor-driven AFW pumps for over 6 months. In response to the issue, the licensee installed a new restraint designed to meet seismic criteria and completed calculations that showed the as-left condition of the modification did not challenge operability.

This performance deficiency was more than minor because it was associated with the Mitigating System Cornerstone attribute of design control and adversely affected the cornerstone objectives of ensuring the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, once identified, the modification required rework to comply with applicable design requirements. The inspectors determined the finding was of very low safety significance (Green) because the issue did not result in the actual loss of a safety function. The inspectors also determined the finding has a cross cutting aspect in the area of human performance, work control, because the licensee failed to incorporate risk insights and planned contingencies

into work plans (H.3(a)).

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Non-Conservative Technical Specification Limit Value For The 48-Hour Diesel Fuel Oil Storage Volume

The inspectors identified a finding of very low safety significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," involving the diesel fuel oil storage volume for the emergency diesel generators (EDGs). Specifically, the licensee failed to account for the fuel consumption of a second EDG when establishing the value for the Technical Specification limit for the 48-hour diesel fuel oil storage volume. In response to the issue, the licensee implemented compensatory actions to maintain an adequate fuel volume.

This performance deficiency was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the cornerstone objective of ensuring availability of the EDG to respond to initiating events to prevent undesirable consequences. This finding was of very low safety significance (Green) because the inspectors determined that the finding was a design deficiency confirmed not to result in loss of operability or functionality and the finding screened as Green using the Significance Determination Process Phase 1 screening worksheet. The inspectors did not identify a cross cutting aspect associated with this finding because the performance deficiency occurred many years ago.

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Work Instructions For South Service Water Header Work

. The inspectors identified a finding of very low safety significance (Green) and associated Non-Cited Violation of 10 CFR 50, Appendix B, Criteria V, "Instructions, Procedures and Drawings," for the failure to have work instructions and procedures commensurate with the risk associated with maintenance on the south service water (SW) system header. Specifically, the licensee did not have work instructions and procedures that assigned appropriate operator actions and contained contingency plans to rapidly restore the header to service if directed by the shift manager. The licensee entered this issue into the corrective action system and made procedure changes for work affecting the operability of a SW header.

This finding was determined to be more than minor because the finding was associated with the Mitigating System Cornerstone attribute of procedure quality and adversely affected the cornerstone objectives of ensuring the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences. Specifically, the work instructions for the maintenance activity did not incorporate the risk associated with the loss of all SW, since this system is the only safety-related system that provides cooling water to plant systems required to respond to initiating events. The inspectors determined the finding to be of very low safety significance (Green) because the issue did not result in the actual loss of a safety function. The inspectors also determined the finding has a cross-cutting aspect in the area of human performance, work control, because the licensee failed to incorporate risk insights and planned contingencies into work plans (H.3(a)).

Inspection Report# : [2009003](#) (pdf)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Of Diesel Fuel Oil Tank Vent For Tornado Protection

The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to fully incorporate applicable tornado missile protection design requirements into the design of the 'A' train diesel fuel oil storage and transfer system. Specifically,

the T-175A underground fuel oil storage tank vent line was found not capable of withstanding the effects of a design basis tornado missile strike without resulting in the subsequent loss of capability of the G 01 and G 02 emergency diesel generators to perform their safety functions. The licensee performed a prompt operability determination, concluded that the system was operable but non conforming, and put in place compensatory measures until the design deficiency had been resolved.

The finding was determined to be more than minor in accordance with Inspection Manual Chapter 0612, Appendix B, "Issue Screening," dated December 4, 2008, because the finding was associated with the Mitigating Systems Cornerstone attribute of Design Control and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, closure of the T 175A vent path would adversely affect the availability, reliability, and capability of the G 01 and G 02 emergency diesel generators to perform their safety-related functions. The inspectors determined the finding could be evaluated using the Significance Determination Process in accordance with Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a for the Mitigating Systems Cornerstone, dated January 10, 2008. The finding was determined to be of very low safety significance (Green) because the finding was a design deficiency confirmed not to result in loss of operability. The inspectors did not identify a cross-cutting aspect associated with this finding as the performance deficiency occurred in the 1990s and was not indicative of current performance.

Inspection Report# : [2009002](#) (pdf)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Recognize Unit 1 Component Cooling Water Pump Was Inoperable On January 1, 2009

The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of Technical Specification (TS) 3.7.7, "Component Cooling Water (CCW) System," for the failure to recognize that the Unit 1 1P-11B CCW pump was inoperable. Consequently, the licensee failed to take actions in accordance with TS for an inoperable CCW pump. Specifically, on January 1, 2009, auxiliary operators added a full reservoir (bubbler) of oil to the inboard bearing for the second time in 24 hours, due to an oil leak. This abnormal condition was not appropriately characterized by the licensee until after two more oil additions, when a condition report was written to document the oil addition on January 5, 2009. The licensee performed an apparent cause evaluation and implemented corrective actions to address the deficiencies and lessons learned from this finding.

The finding was determined to be more than minor in accordance with Inspection Manual Chapter 0612, Appendix B, "Issue Screening," dated December 4, 2008, because the finding was associated with the Mitigating Systems Cornerstone attribute of equipment performance and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the CCW pump was degraded with an inboard bearing oil leak and may not have been able to fulfill the 30-day mission time of the pump. The inspectors determined the finding could be evaluated using the Significance Determination Process in accordance with Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a for the Mitigating Systems Cornerstone, dated January 10, 2008.

The inspectors determined that the finding required a Phase 2 analysis since the finding represented an actual loss of a single train for greater than its TS allowed outage time. The inspectors and senior reactor analyst determined through Phase 2 analysis that this issue is best characterized as a finding of very low safety significance (Green). The inspectors also determined that this finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because personnel did not use a low threshold for identifying issues. Specifically, licensee personnel failed on three occasions to enter the oil additions into the corrective action program which would have required a Senior Reactor Operator to screen the condition for operability [P.1(a)].

Inspection Report# : [2009002](#) (pdf)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Promptly Correct Component Cooling Water Pump Oil Leak On January 27, 2009

The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to promptly correct a condition adverse to quality associated with an inboard oil leak on the Unit 1 1P11-B component cooling water (CCW) pump identified on January 27, 2009. Consequently, the CCW pump operated in a degraded condition until the pump was taken out-of-service to address inboard bearing oil leaks on January 31 and February 1, 2009. Specifically, on January 27, 2009, a condition report was written documenting an inboard bearing leak; however, the immediate operability screening was incorrect and the licensee's screening process failed to ensure prompt corrective actions were taken to address this condition adverse to quality. The licensee performed an apparent cause evaluation and implemented corrective actions to address the deficiencies and lessons learned from this finding.

The finding was determined to be more than minor in accordance with Inspection Manual Chapter 0612, Appendix B, "Issue Screening," dated December 4, 2008, because the finding was associated with the Mitigating Systems Cornerstone attribute of equipment performance and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the CCW pump was degraded with an inboard bearing oil leak and may not have been able to fulfill the 30-day mission time of the pump. The inspectors determined the finding could be evaluated using the Significance Determination Process in accordance with Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a for the Mitigating Systems Cornerstone, dated January 10, 2008. The inspectors determined that the finding required a Phase 2 analysis since the finding represented an actual loss of a single train for greater than its Technical Specification allowed outage time. The inspectors and senior reactor analyst determined through Phase 2 analysis that this issue is best characterized as a finding of very low safety significance (Green). The inspectors also determined that this finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because personnel did not thoroughly evaluate the identified problem while classifying, prioritizing and evaluating for operability and reportability of this condition adverse to quality. Specifically, licensee personnel did not thoroughly evaluate the condition adverse to quality associated with the 1P-11B CCW pump on January 27, 2009, such that the prompt corrective actions were appropriately prioritized and evaluated [P.1(c)].

Inspection Report# : [2009002](#) (pdf)

Significance:  Mar 27, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Adequately Input Mechanism Operated Control Switch Failure Evaluations and Recommendations Into Maintenance Procedures

A finding of very low safety significance (Green) and associated Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the failure to have appropriate maintenance procedures for Mechanism Operated Cell (MOC) switches. Specifically, the licensee failed to have steps in the MOC switch preventative maintenance procedures for specific inspection and verification actions at the frequency, and with actions, recommended by causal evaluations and the vendor. The licensee entered this issue into the corrective action program and was evaluating corrective actions.

The finding was determined to be more than minor because if left uncorrected the issue would lead to a more significant safety concern. Specifically, the failure to identify degraded hardware on a MOC switch could lead to the failure of associated safety related equipment and alarms. The issue 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," dated January 10, 2008. This finding has a cross-cutting aspect in the area of problem identification, corrective action program component, because the licensee failed to thoroughly evaluate problems such that the resolutions addressed causes and extent of condition as necessary (P.1(c)).

Inspection Report# : [2009006](#) (pdf)

Significance: **G** Mar 27, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inverter Maintenance Procedures Did Not Include Steps For Capacitor Replacement

. A finding of very low safety significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to have appropriate maintenance procedures and work instructions in place for certain safety-related inverters.

Specifically, the licensee failed to have steps in the routine maintenance procedure (RMP) 9036 series maintenance procedures for periodic replacement of the electrolytic capacitors in the SCI-model inverters as recommended by the vendor. The licensee entered this issue into the corrective action program, scheduled replacement of the capacitors, and was further evaluating the vendor recommendation.

The finding was more than minor because, if left uncorrected, the finding would become a more safety significant concern. Not replacing the electrolytic capacitors in the SCI inverters based on the vendor recommended life could result in the failure of the inverter to perform their safety function and respond to initiating events. The issue 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," dated January 10, 2008. This finding had a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because the licensee failed to implement and institutionalize operating experience, including vendor recommendations, through changes to station procedures (P.2(b)).

Inspection Report# : [2009006](#) (*pdf*)

Significance: **SL-III** Mar 09, 2009

Identified By: NRC

Item Type: VIO Violation

Failure to Notify NRC of Licensed Operator Medical Restrictions in accordance with 10 CFR 50.9 and 55.23.

During a U.S. Nuclear Regulatory Commission (NRC) inspection conducted on November 25, 2008 through March 9, 2009, violations of NRC requirements were identified. In accordance with the NRC Enforcement Policy, the violations are listed below:

1. Title 10 CFR 50.74(c) requires that each licensee notify the appropriate NRC Regional Administrator within 30 days of a permanent disability or illness, as described in 10 CFR 55.25, of a licensed operator or a senior operator. Contrary to the above, from May 1999 until October 20, 2008, a period greater than 30 days, the licensee failed to notify the NRC Region III Regional Administrator of a permanent disability or illness of a licensed operator. Specifically, the licensee was informed in February 1993 that the non-licensed operator was taking prescribed medication for hypertension, a permanent disability or illness. The non-licensed operator applied for an NRC operating license in May 1999. The NRC issued the operator a reactor operator license August 27, 1999, and a senior reactor operator license on February 22, 2002, with no restrictions. The licensee did not inform the NRC of the operator's medical condition until October 20, 2008.

2. Title 10 CFR 50.9 requires, in part, that information provided to the Commission by an applicant for a license or by a licensee or information required by statute or by the Commission's regulations, Orders, or license conditions to be maintained by the applicant or the licensee shall be complete and accurate in all material respects. Title 10 CFR 55.23 requires, in part, that to certify the medical fitness of the applicant, an authorized representative of the facility licensee shall complete and sign NRC Form 396, "Certification of Medical Examination by Facility Licensee." The NRC Form 396, when signed by an authorized representative of the facility licensee, certifies that a physician conducted a medical examination of the applicant and that the guidance contained in American National Standards Institute/American Nuclear Society (ANSI/ANS) Standard 3.4-1996, "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants" was followed in conducting the examination and making the determination of medical qualification.

The ANSI/ANS 3.4-1996, Section 5.3, provides, in part, that the presence of certain medical conditions, unless adequately compensated by the methods specified in Subsections 5.3.1 through 5.3.9, shall disqualify the individual.

Contrary to the above, on January 28, 2008, the facility licensee provided information to the NRC that was not complete and accurate in all material respects. Specifically, the licensee submitted an NRC Form 396 for renewal of a senior reactor operator's license and the NRC Form 396 certified that the applicant met the medical requirements of

ANSI/ANS 3.4 1996 with no restrictions. However, In February 1993, the operator was prescribed medication to adequately compensate for a disqualifying medical condition. The certification by the senior licensee facility representative was material to the NRC because the NRC relied upon this certification to renew the senior reactor operator's license pursuant to 10 CFR Part 55 when the license should have been modified with a restriction that the senior reactor operator was required to take medication as prescribed to maintain his qualification.

This is a Severity Level III problem (Supplement VII).

The associated two AVs 2009-008-01 and 2009-008-02 were combined to form this one SLiii Problem.

Inspection Report# : [2009004](#) (*pdf*)

Inspection Report# : [2009009](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure To Maintain Proper Control Of Radioactive Material Within The Radiologically Controlled Area

A self-revealed finding of very low safety significance and associated Non-Cited Violation of 10 CFR 20.1101(b) was identified for the failure to adequately control radioactive material to prevent its migration outside the radiologically controlled area (RCA), as required by licensee procedures. On May 21, 2009, a contract worker performing inspections of the main electrical transformers located outside the RCA picked-up a wadded-ball of debris (unmarked tape) and placed it in his front pants pocket. The debris was later found to be radioactively contaminated when the worker alarmed the protected area exit radiation monitors a few hours later as he attempted to leave the site. The tape was likely used to cover contaminated hoses that were previously used within the Point Beach RCA, but had escaped the licensee's control and migrated (blew) into the transformer area outdoors where it was found by the worker. The licensee's storage of radioactive material in an outdoor satellite RCA and/or the licensee's radioactive material control practices during refueling outages when the containment building equipment hatch was open to the environment led to the escape of the material outside the RCA. The contractor's assigned work duties should not have involved exposure to radioactive material; consequently, the worker was unnecessarily exposed to radiation from the contaminated tape. A dose evaluation completed by the licensee's consultant determined that the effective dose equivalent to the worker's thigh from exposure to the contaminated ball of tape was approximately one mrem. The licensee's corrective action called for expanded radiation protection oversight during movement of material in outdoor areas. Procedures were revised to include a post outage walkdown of outdoor areas near the RCA yard. Additionally, the licensee planned to construct an enclosure so that storage/transfer of contaminated materials could be performed indoors.

The finding was more than minor because it impacted the program and process attribute of the Public Radiation Safety Cornerstone and adversely affected the cornerstone objective of ensuring adequate protection of public health and safety from exposure to radiation, in that, unnecessary radiation exposure was received by an individual from inadequately controlled radioactive material. The finding was determined to be of very low safety significance

because: (1) it involved a radioactive material control problem that was contrary to NRC requirements and the licensee's procedure; and (2) the dose impact to a member of the public (the contract worker) within the licensee's restricted area was less than 5 millirem total effective dose equivalent. The cause of the radioactive material control problem involved a cross-cutting component in the human performance area for inadequate work control, in that, job site conditions including environmental conditions (high winds, night time work, etc.) impacted human performance and consequently, radiological safety, during movement of material/equipment in outdoor areas (H.3.(a)).

Inspection Report# : [2009005](#) (*pdf*)

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 Mar 27, 2009

Identified By: NRC

Item Type: FIN Finding

Biennial Problem Identification and Resolution Report Summary

Based on the samples selected for review, the inspectors concluded that implementation of the corrective action program (CAP) was adequate. The inspectors noted that the licensee has a sufficiently low threshold for identifying issues and entering them in the CAP and established additional directions to ensure a lower threshold was consistently used. Prioritization of items entered in the CAP was adequate with recent improvements that have reduced the action item backlog and allowed the station to focus on higher priority items. The inspectors noted that the licensee entered operating experience into the CAP but did not always fully evaluate the information for applicability to station components. Audits and self assessments were determined to be performed at an appropriate level to identify deficiencies. On the basis of licensee self-assessments and interviews conducted during the inspection, workers at the site expressed freedom to raise safety concerns

Inspection Report# : [2009006](#) (*pdf*)

Last modified : March 01, 2010