



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION**

REGION III  
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May 10, 2012

Mr. David A. Heacock  
President and Chief Nuclear Officer  
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**SUBJECT: KEWAUNEE POWER STATION – NRC INTEGRATED INSPECTION REPORT  
05000305/2012002**

Dear Mr. Heacock:

On March 31, 2012, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Kewaunee Power Station. The enclosed inspection report documents the inspection results which were discussed on April 4, 2012, with Mr. A. Jordan and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations, and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

One Severity Level IV NRC-Identified violation and two NRC-Identified findings of very low safety significance (Green) were identified during this inspection. The NRC is treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington DC 20555-0001; and the NRC Resident Inspector at the Kewaunee Power Station.

D. Heacock

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In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records System (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

***/RA/ By N. Shah Acting For/***

Kenneth Riemer, Branch Chief  
Branch 2  
Division of Reactor Projects

Docket No. 50-305  
License No. DPR-43

Enclosure: Inspection Report 05000305/2012002  
w/ Attachment: Supplemental Information

cc w/encl: Distribution via ListServ

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-305  
License No: DPR-43

Report No: 05000305/2012002

Licensee: Dominion Energy Kewaunee, Inc,

Facility: Kewaunee Power Station

Location: Kewaunee, WI

Dates: January 1, 2012, through March 31, 2012

Inspectors: R. Krsek, Senior Resident Inspector  
K. Barclay, Resident Inspector  
A. Shaikh, Reactor Inspector  
D. McNeil, Senior Operations Engineer

Approved by: Kenneth Riemer, Branch Chief  
Branch 2  
Division of Reactor Projects

Enclosure

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## SUMMARY OF FINDINGS

Inspection Report (IR) 05000305/2012002, 01/01/2012 – 03/31/2012, Kewaunee Power Station (KPS); Post-Maintenance Testing; Surveillance Testing; and Follow-Up of Events and Notices of Enforcement Discretion.

This report covers a 3-month period of inspection by resident inspectors and announced baseline inspections by regional inspectors. Two Green findings and one Severity Level (SL) IV violation and were identified by the inspectors. The two findings and the SL IV violation were considered non-cited violations (NCVs) of NRC regulations. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

### A. NRC-Identified and Self-Revealed Findings

#### Cornerstone: Barrier Integrity

- Green. The inspectors identified a finding of very low safety significance and associated NCV of Technical Specification (TS) 5.4.1, "Procedures," which required, in part, that written procedures shall be implemented covering the applicable procedures recommended in Regulatory Guide (RG) 1.33, Revision 2, Appendix A. Specifically, Procedure GNP-08.02.12, "Post-Maintenance Testing/Operations Retest," stated, in part, that the post-maintenance tests (PMTs) were performed upon completion of maintenance activities, and demonstrated that the identified deficiency was repaired, and that no new deficiency was created. On July 4, 2011, the licensee replaced the spent fuel pool (SFP) pump motor B, and failed to conduct an adequate PMT, which demonstrated no new deficiency was created. The PMT only tested the replaced motor and failed to include testing of the pump to ensure that no new deficiency was created. The licensee entered the issue into its corrective action program (CAP) as condition reports (CRs) 464645, 466183, and 466215, and planned to perform an apparent cause evaluation (ACE) and take corrective actions.

The inspectors determined that the finding was more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected, the failure to perform adequate PMT on motor replacements would have the potential to lead to a more significant safety concern. The inspectors determined that the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a, for the Barrier Integrity Cornerstone, dated January 10, 2008. The inspectors answered "No" to the "Reactor Coolant System or Fuel Barrier Questions" related to "Spent Fuel Pool Issues," and screened the finding as having very low safety significance (Green). The inspectors also determined that this finding had a cross-cutting aspect in the area of human performance, resources, because the licensee did not ensure the PMT procedure guidance related to motor replacements was adequate and accurate to assure nuclear safety (H.2(c)). (Section 1R19.1)

- Green. The inspectors identified a finding of very low safety significance (Green) and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to have appropriate procedures to complete TS-required surveillances. Specifically, OSP-CCI-004, "Containment Isolation Valve Verification," did not contain adequate steps to complete a TS-required airlock door check and the procedure did not include six manual containment isolation valves (CIVs) that should have been included in the procedure for position verification. The licensee corrected the procedure and entered the issue into its CAP as CRs 464355, 464494, and 467560, and planned to perform an ACE.

The inspectors determined that the finding was more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because the finding was associated with the Barrier Integrity Cornerstone attribute of procedure quality and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, inspectors found seven examples in OSP-CCI-004 where either the procedure steps were not adequate or CIVs were missing that should have been included in the procedure for position verification. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a for the Barrier Integrity Cornerstone, dated January 10, 2008. The inspectors answered "No" to the Containment Barrier questions and screened the finding as having very low safety significance (Green). This finding has a cross-cutting aspect in the area of human performance, resources, because the licensee did not ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety was supported. Specifically, OSP-CCI-004 did not get an approval review during the procedure review process and the supervisory review that was conducted did not identify the procedural errors (H.4(c)). (Section 1R22.1)

#### **Cornerstone: Other Findings**

- SL IV. The inspectors identified an SL IV NCV of 10 CFR 50.73(a)(2)(vii) for the failure of the licensee to report an event where a single cause or condition caused two independent trains to become inoperable in a single system designed to control the release of radioactive material. Specifically, the licensee failed to report that both trains of shield building ventilation (SBV) were inoperable due to a single cause, because both trains contained unqualified control card standoffs that were needed to maintain the seismic qualification and operability of the system. The licensee entered this into their CAP as CR429469, planned to perform an ACE, and was drafting an update to Licensee Event Report (LER) 05000305/2011-005.

The inspectors determined that the failure to report the event in accordance with 10 CFR 50.73 was a performance deficiency. Because violations of 10 CFR 50.73 are considered to be violations that potentially impact the regulatory process, they are dispositioned using the traditional enforcement process instead of the Reactor Oversight Process (ROP) SDP. Because the performance deficiency, a failure to report, was not an ROP finding per IMC 0612, Appendix B, "Issue Screening," a cross-cutting aspect was not assigned to this violation. Per the NRC Enforcement Policy, Section 6.0, "Violation Examples," a failure to submit a required LER is categorized as an SL IV violation. (Section 4OA3)

**B. Licensee-Identified Violations**

Violations of very low safety significance that were identified by the licensee have been reviewed by inspectors. Corrective actions planned or taken by the licensee have been entered into the licensee's CAP. This violation and corrective action tracking number is listed in Section 4OA7 of this report.

## REPORT DETAILS

### Summary of Plant Status

Kewaunee Power Station (KPS) operated at full power for the entire inspection period, except for brief downpowers to conduct planned maintenance and surveillance activities.

#### 1. REACTOR SAFETY

##### **Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity**

#### 1R01 Adverse Weather Protection (71111.01)

##### .1 Readiness of Offsite and Alternate AC Power Systems

##### a. Inspection Scope

The inspectors verified that plant features and procedures for operation and continued availability of offsite and alternate alternating current (AC) power systems during adverse weather were appropriate. The inspectors reviewed the licensee's procedures affecting these areas and the communications protocols between the transmission system operator (TSO) and the plant to verify that the appropriate information was being exchanged when issues arose that could impact the offsite power system. Examples of aspects considered in the inspectors' review included:

- the coordination between the TSO and the plant during off-normal or emergency events;
- the explanations for the events;
- the estimates of when the offsite power system would be returned to a normal state; and,
- the notifications from the TSO to the plant when the offsite power system was returned to normal.

The inspectors also verified that plant procedures addressed measures to monitor and maintain availability and reliability of both the offsite AC power system and the onsite alternate AC power system prior to or during adverse weather conditions. Specifically, the inspectors verified that the procedures addressed the following:

- the actions to be taken when notified by the TSO that the post-trip voltage of the offsite power system at the plant would not be acceptable to assure the continued operation of the safety-related (SR) loads without transferring to the onsite power supply;
- the compensatory actions identified to be performed if it would not be possible to predict the post-trip voltage at the plant for the current grid conditions;
- a re-assessment of plant risk based on maintenance activities which could affect grid reliability, or the ability of the transmission system to provide offsite power; and,
- the communications between the plant and the TSO when changes at the plant could impact the transmission system, or when the capability of the transmission system to provide adequate offsite power was challenged.

Documents reviewed are listed in the Attachment to this report. The inspectors also reviewed CAP items to verify that the licensee was identifying adverse weather issues at an appropriate threshold and entering them into the CAP in accordance with station corrective action procedures.

This inspection constituted one readiness of offsite and alternate AC power systems sample as defined in Inspection Procedure (IP) 71111.01-05.

b. Findings

No findings were identified.

1R04 Equipment Alignment (71111.04)

.1 Quarterly Partial System Walkdowns

a. Inspection Scope

The inspectors performed partial system walkdowns of the following risk-significant systems:

- component cooling water (CCW) train A;
- the SFP system; and,
- emergency diesel generator (EDG) B.

The inspectors selected these systems based on their risk significance relative to the Reactor Safety Cornerstones at the time they were inspected. The inspectors attempted to identify any discrepancies that could impact the function of the system and, therefore, potentially increase risk. The inspectors reviewed applicable operating procedures and system diagrams to determine the appropriate system lineup. The inspectors also walked down accessible portions of the systems to verify system components and support equipment were aligned correctly and operable. The inspectors examined the material condition of the components and observed operating parameters of equipment to verify that there were no obvious deficiencies. The inspectors also verified that the licensee had properly identified and resolved equipment alignment problems that could cause initiating events or impact the capability of mitigating systems or barriers and entered them into the CAP with the appropriate significance characterization. Documents reviewed are listed in the Attachment to this report.

These activities constituted three partial system walkdown samples as defined in IP 71111.04-05.

b. Findings

No findings were identified.

.2 Semi-Annual Complete System Walkdown

a. Inspection Scope

On March 19, the inspectors performed a complete system alignment inspection of the service water (SW) system to verify the functional capability of the system. This system

was selected because it was considered both safety significant and risk significant in the licensee's probabilistic risk assessment. The inspectors walked down the system to review mechanical and electrical equipment lineups, electrical power availability, system pressure and temperature indications, as appropriate, component labeling, component and equipment cooling, hangers and supports, operability of support systems, and to ensure that ancillary equipment or debris did not interfere with equipment operation. A review of a sample of past and outstanding WOs was performed to determine whether any deficiencies significantly affected the system function. In addition, the inspectors reviewed the CAP database to ensure that system equipment alignment problems were being identified and appropriately resolved. Documents reviewed are listed in the Attachment to this report.

These activities constituted one complete system walkdown sample as defined in IP 71111.04-05.

b. Findings

No findings were identified.

1R05 Fire Protection (71111.05)

.1 Routine Resident Inspector Tours (71111.05Q)

a. Inspection Scope

The inspectors conducted fire protection (FP) walkdowns, which were focused on availability, accessibility, and the condition of firefighting equipment in the following risk-significant plant fire zones:

- TU-98, battery room B;
- TU-95A, 480-Volt switchgear bus 1-51 and 1-52 room;
- TU-94, carbon dioxide tank room; and,
- AX-23A, auxiliary building fan floor.

The inspectors reviewed areas to assess if the licensee had implemented an FP program that adequately controlled combustibles within the plant, effectively maintained fire detection and suppression capability, maintained passive FP features in good material condition, and implemented adequate compensatory measures for out-of-service, degraded or inoperable FP equipment, systems, or features, in accordance with the licensee's fire plan. The inspectors selected fire areas based on their overall contribution to internal fire risk as documented in the plant's Individual Plant Examination of External Events with later additional insights, their potential to impact equipment which could initiate or mitigate a plant transient, or their impact on the plant's ability to respond to a security event. Using the documents listed in the Attachment to this report, the inspectors verified that fire hoses and extinguishers were in their designated locations and available for immediate use; that fire detectors and sprinklers were unobstructed; that transient material loading was within the analyzed limits; and fire doors, dampers, and penetration seals appeared to be in satisfactory condition. The inspectors also verified that minor issues identified during the inspection were entered into the licensee's CAP. Documents reviewed are listed in the Attachment to this report.

These activities constituted four quarterly fire protection inspection samples as defined in IP 71111.05-05.

b. Findings

No findings were identified.

1R11 Licensed Operator Requalification Program (71111.11)

.1 Resident Inspector Quarterly Review of Licensed Operator Requalification (71111.11Q)

a. Inspection Scope

On February 13, the inspectors observed a crew of licensed operators in the plant's simulator during licensed operator requalification training to verify that operator performance was adequate, evaluators were identifying and documenting crew performance problems, and that training was being conducted in accordance with licensee procedures. The inspectors evaluated the following areas:

- licensed operator performance;
- crew's clarity and formality of communications;
- ability to take timely actions in the conservative direction;
- prioritization, interpretation, and verification of annunciator alarms;
- correct use and implementation of abnormal and emergency procedures;
- control board manipulations; and,
- oversight and direction from supervisors

The crew's performance in these areas was compared to pre established operator action expectations and successful critical task completion requirements. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one quarterly licensed operator requalification program simulator sample as defined in IP 71111.11.

b. Findings

No findings were identified.

.2 Resident Inspector Quarterly Observation of Heightened Activity or Risk (71111.11Q)

On March 16 and March 27, the inspectors observed control room operations during a reactor downpower to 97 percent, and wiring repairs on the N-35 source range test wires coincident with reactor protection train B logic testing, respectively. Both activities required heightened awareness or were related to increased risk. The inspectors evaluated the following areas, as necessary:

- licensed operator performance;
- crew's clarity and formality of communications;
- ability to take timely actions in the conservative direction;
- prioritization, interpretation, and verification of annunciator alarms (if applicable);
- correct use and implementation of procedures;
- control board (or equipment) manipulations;

- oversight and direction from supervisors; and,
- ability to identify and implement appropriate TS actions and Emergency Plan (EP) actions and notifications (if applicable).

The performance in these areas was compared to pre-established operator action expectations, procedural compliance and task completion requirements. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one quarterly licensed operator heightened activity/risk sample as defined in IP 71111.11.

b. Findings

No findings were identified.

.3 Conformance with Operator License Conditions (71111.11B)

a. Inspection Scope

The inspector reviewed the licensee's corrective actions and documents associated with an improper license application submission. The inspectors reviewed an individual operator license application and the licensed operator's medical history to determine the application's accuracy.

b. Findings

The licensee identified a failure to provide the NRC with complete and accurate information regarding the submission of an NRC Form 396, Personnel Qualification Statement, for one of the station's operator license applicants in March 2011.

The licensee identified a licensed operator that had been prescribed, and was using a CPAP (Continuous Positive Airway Pressure) device – a device used to treat sleep apnea. The licensed operator's condition was not included on the operator license application as a needed license restriction.

The inspector's review of this issue was considered to be a part of the original inspection effort, and as such did not constitute any additional inspection samples. (See Section 4OA7 for Licensee-Identified Violations for details).

1R12 Maintenance Effectiveness (71111.12)

.1 Routine Quarterly Evaluations (71111.12Q)

a. Inspection Scope

The inspectors evaluated degraded performance issues involving the Technical Support Center (TSC) diesel generator (DG) voltage regulator and also reviewed the licensee's most recent 10 CFR 50.65(a)(3) Periodic Evaluation.

The inspectors verified the licensee's actions to address system performance or condition problems in terms of the following areas, as necessary:

- implementing appropriate work practices;
- identifying and addressing common cause failures;
- scoping of systems in accordance with 10 CFR 50.65(b) of the maintenance rule;
- characterizing system reliability issues for performance;
- charging unavailability for performance;
- trending key parameters for condition monitoring;
- ensuring 10 CFR 50.65(a)(1) or (a)(2) classification or re-classification; and,
- verifying appropriate performance criteria for structures, systems, and components (SSCs)/functions classified as (a)(2), or appropriate and adequate goals and corrective actions for systems classified as (a)(1).

The inspectors assessed performance issues with respect to the reliability, availability, and condition monitoring of the system. In addition, the inspectors verified maintenance effectiveness issues were entered into the CAP with the appropriate significance characterization. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two quarterly maintenance effectiveness samples as defined in IP 71111.12-05.

b. Findings

No findings were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13)

.1 Maintenance Risk Assessments and Emergent Work Control

a. Inspection Scope

The inspectors reviewed the licensee's evaluation and management of plant risk for the maintenance and emergent work activities affecting risk-significant and SR equipment listed below to verify that the appropriate risk assessments were performed prior to removing equipment for work:

- SW to turbine-driven auxiliary feedwater (TDAFW) pump bundled maintenance on January 26;
- emergent TSC DG work on February 7;
- turbine building fan coil unit (TBFCU) maintenance with the cross connect damper closed on February 13;
- emergent work on auxiliary building mezzanine fan coil unit (FCU) 1A on March 8;
- auxiliary feedwater (AFW) pump testing on March 16; and,
- EDG A tagged out with a mobile crane lift over the train B SW cables on March 19.

These activities were selected based on their potential risk significance relative to the Reactor Safety Cornerstones. As applicable for each activity, the inspectors verified that risk assessments were performed as required by 10 CFR 50.65(a)(4), and were accurate and complete. When emergent work was performed, the inspectors verified that the plant risk was promptly reassessed and managed. The inspectors reviewed the scope of maintenance work, discussed the results of the assessment with the licensee's

probabilistic risk analyst or shift technical advisor, and verified plant conditions were consistent with the risk assessment. The inspectors also reviewed TS requirements and walked down portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met. Documents reviewed are listed in the Attachment to this report.

These maintenance risk assessments and emergent work control activities constituted six samples as defined in IP 71111.13-05.

b. Findings

(1) Incorrectly Modeled Ventilation Damper Changes Daily Risk Color

Introduction: The inspectors identified an unresolved item (URI) concerning the incorrect modeling of an SR ventilation damper in the licensee's daily risk assessment tool.

Description: During the daily review of CRs, inspectors reviewed CR464332, which documented that cross connect damper TAV-82, which connected two trains of turbine building ventilation, was modeled in the licensee's probabilistic risk assessment (PRA) tool as open, when the actual position of the damper was closed. When the licensee's PRA tool was updated with the correct damper position, the daily risk calculated to comply with 10 CFR 50.65(a)(4) increased from green to orange on train B, and from green to red on train A. The licensee reevaluated the model taking credit for a nonsafety-related (NSR) general turbine building ventilation system that also provided air flow to the two rooms in question and the risk was reduced. The updated model for the removal of a TBFCU from service maintained green risk for train B and only increased train A to yellow risk.

At the conclusion of the inspection period the inspectors needed additional information to determine if an error in the original inputs to the base PRA tool, versus an error in the daily application of the PRA tool, was a violation of 10 CFR 50.65(a)(4). As a result, this item was considered unresolved (URI 05000305/2012002-01, Incorrectly Modeled Ventilation Damper Changes Daily Risk Color).

(2) Potential Mobile Crane Heavy Load Risk Modeling Error

Introduction: The inspectors identified a URI concerning the use of dropped load probabilities for mobile cranes in the licensee's daily risk assessment tool.

Description: During plant tours, the inspectors observed the licensee's preparations for a heavy lift of circulating water pump motor B from the SW screen house through the screen house roof hatch to a motor stand outside. The inspectors had previously identified during daily plant status activities that EDG train A was tagged out for maintenance; and during discussions with the maintenance personnel performing the motor lift, found that the load path for the 44,000 lb motor went over both buried cables for the SW pumps train B, which were a needed support system for EDG train B. The inspectors questioned the licensee about the load path and found that the licensee had not recognized the location of the underground cables during the planning phase of the load lift, and had not evaluated a load drop over the cables and what affect the drop would have on the cables. The licensee suspended the lift until the next day, when EDG train A was operable and the licensee had an opportunity to perform a risk assessment for the heavy load travelling over the SW cables. The inspectors reviewed

the risk assessment for the heavy lift and questioned whether the probability used for a load drop was conservative.

At the conclusion of the inspection period, the inspectors needed additional information to determine if a performance deficiency occurred. As a result, this item was considered unresolved (URI 05000305/2012002-02, Potential Mobile Crane Heavy Load Risk Modeling Error).

## 1R15 Operability Determinations and Functional Assessments (71111.15)

### .1 Operability Evaluations

#### a. Inspection Scope

The inspectors reviewed the following issues:

- OD 465, CIV CVC-7 function;
- OD 467, failure analysis report for engineered safety feature (ESF) relay PC483A/XB;
- CR460536, "Calc for Control Room Console Temperature Did Not Include Uncertainty";
- CR463265, "EDG A Damper Air Supply Leakage";
- OD 194, revision 3 and RAS 199 for spurious hot short; and,
- RAS 200, for spent fuel heat exchanger loads.

The inspectors selected these potential operability issues based on the risk significance of the associated components and systems. The inspectors evaluated the technical adequacy of the evaluations to ensure that TS operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred. The inspectors compared the operability and design criteria in the appropriate sections of the TSs and USAR to the licensee's evaluations to determine whether the components or systems were operable. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled. The inspectors determined, where appropriate, compliance with bounding limitations associated with the evaluations. Additionally, the inspectors reviewed a sampling of corrective action documents to verify that the licensee had identified and corrected any deficiencies associated with operability evaluations. Documents reviewed are listed in the Attachment to this report.

This operability inspection constituted six samples as defined in IP 71111.15-05.

#### b. Findings

The inspectors documented one licensee-identified violation in Section 4OA7.

1R18 Plant Modifications (71111.18)

.1 Plant Modifications

a. Inspection Scope

The inspectors reviewed the following modifications:

- DC-10-01101, EDG ventilation air supply modification (permanent); and,
- commercial grade dedication of TBFCU motors (permanent).

The inspectors reviewed the configuration changes and associated 10 CFR 50.59 safety evaluation screening against the design basis, the USAR, and the TSs, as applicable, to verify that the modification did not affect the operability or availability of the affected systems. The inspectors, as applicable, observed ongoing and completed work activities to ensure that the modifications were installed as directed and consistent with the design control documents; the modifications operated as expected; post-modification testing adequately demonstrated continued system operability, availability, and reliability; and that operation of the modifications did not impact the operability of any interfacing systems. As applicable, the inspectors verified that relevant procedure, design, and licensing documents were properly updated. For commercial grade dedications, the inspectors also reviewed the appropriateness of the critical characteristics selected for the dedication process and verified that the licensee's testing or acceptance method for the critical characteristics was appropriate. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two permanent plant modification samples as defined in IP 71111.18-05.

b. Findings

Potential Inadequate Commercial Grade Dedication

Introduction: The inspectors identified a URI concerning the adequacy of the commercial grade dedication for the SR TBFCU motors.

Description: On January 21, the licensee discovered elevated noise on TBFCU motor 1B. Subsequent vibration data indicated that the outboard bearing was in imminent failure. The licensee declared the FCU inoperable, replaced the motor, and returned the FCU to a functional status at 7:41 a.m. on January 22. A failure analysis of the motor and bearing determined that the apparent cause of the motor failure was incorrect assembly of the motor after installation of sealed bearings at a local vendor. The licensee also considered an undetected original manufacturing defect of the motor that resulted in excessive thrust load on the bearing was also a potential apparent cause because it could not be ruled out. The motor was procured as NSR; the original bearings were replaced at a local vendor for double shielded bearings; and then the motor was commercially dedicated. Since the opposite train motor was procured at the same time using the same process, the licensee replaced that the motor and also sent it off for analysis. The inspectors were concerned that the incorrect assembly error was not discovered during the commercial dedication process and inspected the commercial dedication package for the motor. The inspectors found that the critical characteristics for the dedication process may have been inadequate to identify the incorrect assembly

at the vendor; however, the licensee informed the inspectors near the end of the inspection period that the failure analysis for the second motor may have had different conclusions than the first.

The inspectors were unable to evaluate the second failure analysis prior to the end of the inspection period, and needed additional time to determine if a performance deficiency existed. As a result, this item was considered to be unresolved pending a review of the second failure analysis (URI 05000305/2012002-03, Potential Inadequate Commercial Grade Dedication).

1R19 Post-Maintenance Testing (71111.19)

.1 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed the following post-maintenance (PM) activities to verify that procedures and test activities were adequate to ensure system operability and functional capability:

- retest of the TSC DG following maintenance on January 11;
- TBFCU B work conducted on January 22;
- TSC DG troubleshooting and maintenance conducted on February 7;
- safeguard logic test following ESF relay replacement on February 10;
- retest of TBFCU A following motor replacement on February 13; and,
- retest of EDG ventilation damper air regulator following maintenance on February 21.

These activities were selected based upon the SSCs' ability to impact risk. The inspectors evaluated these activities for the following (as applicable): the effect of testing on the plant had been adequately addressed; testing was adequate for the maintenance performed; acceptance criteria were clear and demonstrated operational readiness; test instrumentation was appropriate; tests were performed as written in accordance with properly reviewed and approved procedures; equipment was returned to its operational status following testing (temporary modifications or jumpers required for test performance were properly removed after test completion); and, test documentation was properly evaluated. The inspectors evaluated the activities against documents such as TSs, USAR, 10 CFR Part 50 requirements, licensee procedures, and various NRC generic communications to ensure that the test results adequately ensured that the equipment met the licensing basis and design requirements. In addition, the inspectors reviewed corrective action documents associated with post-maintenance tests (PMTs) to determine whether the licensee identified problems and entered them into the CAP, and that the problems were corrected commensurate with their importance to safety. Documents reviewed are listed in the Attachment to this report.

This inspection constituted six post-maintenance testing samples as defined in IP 71111.19-05.

b. Findings

Inadequate Post-Maintenance Test of Motor Replacements

Introduction: The inspectors identified a finding of very low safety significance (Green) and an associated NCV of TS 5.4.1, "Procedures," which required, in part, that written procedures shall be implemented covering the applicable procedures recommended in RG 1.33, Revision 2, Appendix A. Specifically, GNP-08.02.12, "Post-Maintenance Testing/Operations Retest," stated, in part, that the PMTs were performed upon completion of maintenance activities and demonstrated that the identified deficiency was repaired and that no new deficiency was created. On July 4, 2011, the licensee replaced SFP pump motor B and failed to conduct an adequate PMT, which demonstrated no new deficiency was created. The PMT only tested the replaced motor, and failed to include testing of the pump to ensure that no new deficiency was created.

Description: The inspectors reviewed the PMT associated with the replacement of TBFCU motor 1B conducted on January 22, 2012, under work order (WO) KW100863379. The inspectors initially noted that the PMT for the motor only specified acceptable vibration readings of the motor and verification that the motor amperage readings were consistent with the name plate rating. Since the motor provided the power to rotate a fan, the inspectors questioned why the fan flow was not specified as a PMT to ensure that no new deficiency was created that affected FCU 1B overall, as required by procedure. The licensee initiated CR464645 to document this deficiency. The inspectors later determined that mechanics did verify fan speed, an indication of fan flow, as part of a procedure, even though it was not required by the PMT.

The inspectors noted that GNP-08.02.12, "Post-Maintenance Testing/Operations Retest," required that the PMT demonstrate the identified deficiency was repaired, and no new deficiency was created. The inspector also noted that the procedure did not provide adequate guidance for process flow testing of the equipment a motor was attached to, following a motor replacement. The inspectors identified that nuclear industry guidance available to the licensee in a PMT Guide, specified that in order to demonstrate a replaced motor was capable of performing its intended function, that verification of the correct process flow should be evaluated.

While researching the recent PMT of small motors onsite, the inspectors noted that in March 2012, SFP pump B performance flow exhibited a 13 percent drop in total flow since the pump's performance was last tested. While flow was still acceptable to perform the intended safety function, the licensee initiated CR466183 to document the measured decrease in flow. The inspectors reviewed WO KW100388379 for the replacement of SFP pump motor 1B, which occurred on July 4, 2011, because the existing motor had failed. The inspectors again noted that the PMT for this small motor replacement only specified acceptable vibration readings of the motor, and that verification that the motor amperage readings were consistent with the name plate rating. The inspectors concluded that verification of the replaced motor properties did demonstrate that the identified deficiency was repaired; however, it did not demonstrate that no new deficiency was created in the SFP train B system. The inspectors also noted that while the operations retest notes did specify verification of the pump discharge pressure, this was not performed or included as part of the PMT.

Analysis: The inspectors determined the failure to have adequate PMT of the SFP was a performance deficiency and a finding.

The inspectors determined that the finding was more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected, the failure to perform adequate PMT on motor replacements would have the potential to lead to a more significant safety concern. The inspectors determined that the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a, for the Barriers Integrity Cornerstone, dated January 10, 2008. The inspectors answered "No" to the "Reactor Coolant System or Fuel Barrier Questions" related to "Spent Fuel Pool Issues," and screened the finding as having very low safety significance (Green).

Therefore, the finding is considered to be of very low safety significance (Green). The inspectors also determined that this finding had a cross-cutting aspect in the area of human performance, resources, because the licensee did not ensure the PMT procedure guidance related to motor replacements were adequate and accurate to assure nuclear safety (H.2(c)).

Enforcement: The TS 5.4.1, "Procedures," requires, in part, that written procedures shall be implemented covering the applicable procedures recommended in RG 1.33, Revision 2, Appendix A, February 1978. The RG 1.33, Section 9.3.e, "Procedures for Performing Maintenance," states, in part, that general procedures for the control of maintenance, repair and replacement be prepared, as appropriate. Procedure GNP-08.02.12, "Post-Maintenance Testing/Operations Retest," stated, in part, that PMTs were performed upon completion of maintenance activities and demonstrated that the identified deficiency was repaired, and that no new deficiency was created.

Contrary to this, on July 4, 2011, the licensee implemented WO KW100388379 to replace SFP pump motor 1B, which specified PMT of satisfactory motor vibration readings and verification of motor amperage readings consistent with the motor name plate rating, and verification of pump discharge pressure. The PMT performed did not include verification of pump discharge pressure or pump flow, even though the motor for the pump was replaced. Therefore, the PMT performed only demonstrated that the identified motor deficiency was repaired; but the test failed to demonstrate that no new deficiency was created as part of the maintenance for the SFP train B pump and motor system. Because this violation was of very low safety significance, and because it was entered into the licensee's CAP, as CRs 464645, 466183, and 466215, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy. (NCV 05000305/2012002-04, Inadequate Post-Maintenance Test of Motor Replacements)

At the end of the inspection period, the licensee was performing an ACE to determine the causes of the event, and developing corrective actions.

## 1R22 Surveillance Testing (71111.22)

### .1 Surveillance Testing

#### a. Inspection Scope

The inspectors reviewed the test results for the following activities to determine whether risk-significant systems and equipment were capable of performing their intended safety function, and to verify testing was conducted in accordance with applicable procedural and TS requirements:

- OSP-54-063, turbine trip mechanism test on February 13 (routine);
- OSP-CCI-004, CIV on February 5 (CIV);
- SP-47-62B, reactor protection system train B on March 27 (routine);
- OSP-AFW-003B, motor driven AFW pump B testing on March 16 (inservice testing (IST));
- OSP-CC-002A, component cooling pump and valve test train A on March 8 (IST); and,
- OSP-RCS-001, reactor coolant system (RCS) leakrate surveillances on February 8 and February 9 (RCS).

The inspectors considered the following test attributes, if applicable, while they observed in-plant activities and reviewed procedures and associated records:

- did preconditioning occur;
- were the effects of the testing adequately addressed by control room personnel or engineers prior to the commencement of the testing;
- were acceptance criteria clearly stated, demonstrated operational readiness, and consistent with the system design basis;
- plant equipment calibration was correct, accurate, and properly documented;
- as-left setpoints were within required ranges; and the calibration frequency was in accordance with TSs, the USAR, procedures, and applicable commitments;
- measuring and test equipment calibration was current;
- test equipment was used within the required range and accuracy; applicable prerequisites described in the test procedures were satisfied;
- test frequencies met TS requirements to demonstrate operability and reliability; tests were performed in accordance with the test procedures and other applicable procedures; jumpers and lifted leads were controlled and restored where used;
- test data and results were accurate, complete, within limits, and valid;
- test equipment was removed after testing;
- where applicable for IST activities, testing was performed in accordance with the applicable version of Section XI, American Society of Mechanical Engineers (ASME) code, and reference values were consistent with the system design basis;
- where applicable, test results not meeting acceptance criteria were addressed with an adequate operability evaluation or the system or component was declared inoperable;
- where applicable for SR instrument control surveillance tests, reference setting data were accurately incorporated in the test procedure;

- where applicable, actual conditions encountering high resistance electrical contacts were such that the intended safety function could still be accomplished;
- prior procedure changes had not provided an opportunity to identify problems encountered during the performance of the surveillance or calibration test;
- equipment was returned to a position or status required to support the performance of its safety functions; and,
- all problems identified during the testing were appropriately documented and dispositioned in the CAP.

Documents reviewed are listed in the Attachment to this report.

This inspection constituted two routine surveillance testing samples, two IST samples, one CIV sample, and one RCS leak detection inspection sample, as defined in IP 71111.22, Sections -02 and -05.

b. Findings

Inadequate Procedure For Technical Specification Surveillance

Introduction: A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the failure to have adequate procedures to complete TS-required surveillances. Specifically, OSP-CCI-004, "Containment Isolation Valve Verification," did not contain adequate steps to complete a TS-required airlock door check and the procedure did not include six manual CIVs that should have been included in the procedure for position verification.

Description: During the inspection for the closure of URI 05000305/2011004-02, "Failure to Perform Maintenance Rule Evaluations for Risk Significant Fire Door Failures," the inspectors identified that the licensee may not have been properly controlling airlock doors that were credited for maintaining the integrity of the shield building. The SBV system filters potential radioactive leakage coming from the containment liner into the shield building during a design basis accident. While collecting information to answer the inspectors' question related to the control of the shield building airlock doors, the licensee found that OSP-CCI-004 was not worded adequately, and operators were checking the wrong air lock doors during completion of the surveillance requirement. The TS SR 3.6.8.1 stated, "Verify one shield building access door in each access opening is closed." Procedure OSP-CCI-004, Step 5.2.2, which accomplished TS SR 3.6.8.1, stated, "ENSURE one door for each of the following openings is closed: [- Personnel Air Lock, -Emergency Air Lock]." Because the procedure did not clarify which air lock to check, the operators were checking the containment air locks closed instead of the shield building air locks. The inspectors performed a review of OSP-CCI-004, and also identified six additional manual valves that appeared in the CIV table in the USAR, but were not included in the procedure. The inspectors gave their observation to the licensee, and the licensee concluded that the six manual valves missing from the procedure should have been included.

Analysis: The inspectors determined that the failure to have appropriate procedures was contrary to 10 CFR Part 50, Appendix B, Criterion V, and was a performance deficiency. The finding was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because the

finding was associated with the Barrier Integrity Cornerstone attribute of procedure quality, and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, inspectors found seven examples in OSP-CCI-004 where either the procedure steps were not adequate or CIVs were missing that should have been included in the procedure for position verification. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a for the Barrier Integrity Cornerstone, dated January 10, 2008. The inspectors answered "No" to the Containment Barrier questions and screened the finding as having very low safety significance (Green).

This finding has a cross-cutting aspect in the area of human performance, resources, because the licensee did not ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety was supported. Specifically, OSP-CCI-004 did not get an approval review during the procedure review process and the supervisory review that was conducted did not identify the procedural errors (H.4(c)).

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings.

Contrary to the above, from February 12, 2011, through March 23, 2012, the licensee failed to prescribe procedures appropriate to the circumstances for activities affecting quality. Specifically, OSP-CCI-004 did not contain appropriate steps to complete a TS-required airlock door check, and the procedure did not include six manual CIVs that should have been included in the procedure for position verification. Because this violation was of very low safety significance and it was entered into the licensee's CAP as CRs 464355, 464494, and 467560, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy (NCV 05000305/2012002-5, Inadequate Procedure For Technical Specification Surveillance).

The licensee corrected the procedure and planned to perform an ACE at the end of the inspection period.

#### 4. OTHER ACTIVITIES

##### **Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness**

#### 4OA2 Identification and Resolution of Problems (71152)

##### **Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness, Public Radiation Safety, Occupational Radiation Safety, and Physical Protection**

#### .1 Routine Review of Items Entered into the Corrective Action Program

##### a. Inspection Scope

As part of the various baseline inspection procedures discussed in previous sections of this report, the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to verify that they were being entered into the licensee's CAP at an appropriate threshold, that adequate attention was being given to timely corrective actions, and that adverse trends were identified and addressed. Attributes reviewed included: identification of the problem was complete and accurate; timeliness was commensurate with the safety significance; evaluation and disposition of performance issues, generic implications, common causes, contributing factors, root causes, extent-of-condition reviews, and previous occurrences reviews were proper and adequate; and that the classification, prioritization, focus, and timeliness of corrective actions were commensurate with safety and sufficient to prevent recurrence of the issue. Minor issues entered into the licensee's CAP as a result of the inspectors' observations are included in the Attachment to this report.

These routine reviews for the identification and resolution of problems did not constitute any additional inspection samples. Instead, by procedure they were considered an integral part of the inspections performed during the quarter and documented in Section 1 of this report.

##### b. Findings

No findings were identified.

#### .2 Daily Corrective Action Program Reviews

##### a. Inspection Scope

In order to assist with the identification of repetitive equipment failures and specific human performance issues for follow-up, the inspectors performed a screening of items entered into the licensee's CAP. This review was accomplished through inspection of the station's daily condition report packages.

These daily reviews were performed by procedure as part of the inspectors' daily plant status monitoring activities and, as such, did not constitute any separate inspection samples.

b. Findings

No findings were identified.

.3 Selected Issue Follow-Up Inspection: ACE 18964: Engineered Safety Feature Relay Failure During Testing

a. Inspection Scope

During a review of items entered in the licensee's CAP, the inspectors recognized a corrective action item documenting the failure of an ESF relay during routine testing. The inspectors reviewed the licensee's ACE, previous occurrences, and the licensee's planned remedial corrective actions, as well as long term corrective actions to address the issue. Documents reviewed are listed in the Attachment to this report.

This review constituted one in-depth problem identification and resolution sample as defined in IP 71152-05.

b. Findings

No findings were identified.

4OA3 Follow-up of Events and Notices of Enforcement Discretion (71153)

.1 Retraction of Event Notification (EN) 47476: 4160-Volt Alternating Current Busses Declared Inoperable

a. Inspection Scope

The inspectors reviewed the plant's January 18 retraction of a November 24, 2011, event in which the licensed operators declared both 4160-Volt AC busses inoperable due to voltages being high outside of the procedurally directed band. While the control board indications for SR busses 5 and 6 indicated less than 4400 Volts, a laptop installed as part of temporary modification (TMOD) TMOD-2011-05 that more accurately measured voltage at the back of the meter indicated values that were out of the specified range prescribed in OSP-MISC-002, Attachment D. As a result, at 3:15 a.m., the operators declared busses 5 and 6 inoperable per TS 3.8.9; declared offsite power sources as inoperable per TS 3.8.1; and entered the requirements of TS 3.0.3, which required action to commence a unit shutdown within one hour if operability could not be restored. At 4:10 a.m., the load tap changers for the supply transformers to busses 5 and 6 were adjusted to reduce the emergency bus voltages to within their procedurally required operating bands, and the aforementioned TSs were exited.

The licensee reviewed the events and determined that the ranges prescribed in OSP-MISC-002, Attachment D, contained unnecessary conservatism in the development of voltage values for the laptop installed as part of TMOD-2011-05. A review of the actual voltages present on November 24, 2011, with the correct procedure values revealed that voltages did not exceed the required values to support bus operability.

As part of the review, the inspectors reviewed control room logs and available indications; interviewed engineering and operations staff; and reviewed operations procedures and engineering technical evaluations. Documents reviewed are listed in the Attachment to this report.

The inspectors concluded that with the new values, the busses remained operable on November 24, 2011, and this condition did not meet the reportability criteria.

This event follow-up review constituted one sample as defined in IP 71153-05.

b. Findings

No findings were identified.

.2 (Closed) Licensee Event Report (LER) 05000305/2011-005-00: Shield Building Ventilation Train Inoperable for Longer Period Than Allowed by Technical Specifications

a. Inspection Scope

On January 26, 2011, the licensee found a control card, for train A of the SBV system, hanging down partially by its control cables. The licensee determined the cause to be insufficient quality and design of the standoff material resulting in improper adhesion between the metal stud and the neoprene. The standoffs were used to support the control cards at four points and were needed to maintain the seismic qualification of the card. The licensee's initial assessment of this event failed to recognize the past operability implications, as well as, how the unqualified standoffs were installed in the system to begin with. The inspectors documented two violations related to this event in NRC Integrated Inspection Report (IR) 05000305/2011003. One additional violation of 10 CFR 50.73 was identified during the review of this LER for the failure to report any event where a single cause or condition caused two independent trains to become inoperable in a single system designed to control the release of radioactive material. Specifically, the licensees failed to report or update their previous LER after the vendor communicated that the standoffs were the wrong design if they needed to support the control cards during a seismic event. Documents reviewed are listed in the Attachment to this report. This LER is closed.

This event follow-up review constituted one sample as defined in IP 71153-05.

b. Findings

Failure to Submit Licensee Event Report per 10 CFR 50.73

Introduction: The inspectors identified an SL IV NCV of 10 CFR 50.73(a)(2)(vii) for the failure of the licensee to report an event where a single cause or condition caused two independent trains to become inoperable in a single system designed to control the release of radioactive material. Specifically, the licensee failed to report that both trains of SBV were inoperable due to a single cause, because both trains contained unqualified control card standoffs that were needed to maintain the seismic qualification and operability of the system.

Description: As part of the inspection for LER 05000305/2011-005, the inspectors reviewed information related to the vendor's failure analysis of the SBV circuit card standoffs that were found failed in train A on January 26, 2011. The inspectors found that the licensee received communications from the vendor that the standoffs failed because they were embrittled, most likely from over-processing during the freezing and tumbling portion of the manufacturing process. While none of the train B standoffs failed until the licensee was removing them from the system, the licensee was not able to determine the extent of the embrittlement of the standoffs in train B, and whether they would have been able to survive a seismic event. Additionally, the licensee found out on November 17, 2011, during further communications with the vendor, that the standoff design specifications were not appropriate for the application and would not survive a seismic event. The licensee installed the standoffs on train A on December 3, 2010, and removed them on January 26, 2011. The licensee installed the train B standoffs on January 6, 2011, and removed them on February 3, 2011. The inspectors concluded that since the inadequate standoffs were installed on both trains from January 6 to January 26, 2011, and they were needed to maintain the seismic qualification of the independent trains, the licensee should have reported this issue as a single cause or condition that caused two independent trains to become inoperable in a single system designed to control the release of radioactive material.

Analysis: The inspectors determined that the failure to report the condition in accordance with 10 CFR 50.73 was a performance deficiency. Because violations of 10 CFR 50.73 are considered to be violations that potentially impact the regulatory process, they are dispositioned using the traditional enforcement process instead of the ROP SDP. Because the performance deficiency, a failure to report, was not an ROP finding per IMC 0612, Appendix B, "Issue Screening," a cross-cutting aspect was not assigned to this violation. Per the NRC Enforcement Policy, Section 6.0, "Violation Examples," a failure to submit a required LER is categorized as an SL IV violation.

Enforcement: Title 10 CFR 50.73(a)(2)(vii) requires, in part, that licensees report any event where a single cause or condition caused two independent trains to become inoperable in a single system designed to control the release of radioactive material. Contrary to these requirements, on February 7, 2012, the licensee failed to report that both SBV trains A and B were inoperable from January 6, 2011, through January 26, 2011, from a single cause of unqualified parts. Because this violation was not repetitive or willful, and was entered into the licensee's CAP as CR429469, this violation is being treated as an SL IV NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy (NCV 05000305/2012002-06, Failure to Submit LER Per 10 CFR 50.73).

The licensee entered this into their CAP, planned to perform an ACE, and is drafting an update to Licensee Event Report (LER) 05000305/2011-005.

#### 40A5 Other Activities

##### .1 Temporary Instructions (TI) -2515/182 - Review of the Industry Initiative to Control Degradation of Underground Piping and Tanks

###### a. Inspection Scope

Leakage from buried and underground pipes has resulted in ground water contamination incidents with associated heightened NRC and public interest. The industry issued a

guidance document, Nuclear Energy Institute (NEI) 09-14, "Guideline for the Management of Buried Piping Integrity," (ADAMS Accession No. ML1030901420) to describe the goals and required actions (commitments made by the licensee) resulting from this underground piping and tank initiative. On December 31, 2010, the NEI issued Revision 1 to NEI 09-14, "Guidance for the Management of Underground Piping and Tank Integrity," (ADAMS Accession No. ML110700122), with an expanded scope of components which included underground piping that was not in direct contact with the soil and underground tanks. On November 17, 2011, the NRC issued TI-2515/182, "Review of the Industry Initiative to Control Degradation of Underground Piping and Tanks," to gather information related to the industry's implementation of this initiative.

The inspectors reviewed the licensee's programs for buried pipe, underground piping and tanks in accordance with TI-2515/182 to determine if the program attributes and completion dates identified in Sections 3.3 A and 3.3 B of NEI 09-14, Revision 1 were contained in the licensee's program and implementing procedures. For the buried pipe and underground piping program attributes with completion dates that had passed, the inspectors reviewed records to determine if the attribute was in fact complete and to determine if the attribute was accomplished in a manner which reflected good or poor practices in program management.

Based upon the scope of the review described above, Phase I of TI-2515/182 was completed.

b. Observations

The licensee's buried piping and underground piping and tanks program was inspected in accordance with Paragraphs 03.01.a through 03.01.c of TI-2515/182, and was found to meet all applicable aspects of NEI 09-14, Revision 1, as set forth in Table 1 of the TI.

c. Findings

No findings were identified.

.2 (Closed) URI 05000305/2011004-02: Failure to Perform Maintenance Rule Evaluations for Risk Significant Fire Door Failures

a. Inspection Scope

During a 2011 FP inspection sample, the inspectors identified that the licensee was not performing maintenance rule evaluations for risk significant fire doors as required by its maintenance rule program. The licensee entered this into their CAP and at the conclusion of the inspection period, was performing a historical review of door failures to determine if the maintenance rule doors system should be monitored in accordance with 10 CFR 50.65a(1). The inspectors reviewed the additional door failures identified in the licensee's review and did not identify a violation of 10 CFR 50.65a(1). This URI is closed.

b. Findings

During the closure of this URI, the inspectors identified a violation 10 CFR Part 50, Appendix B, Criterion V, "Procedures," which is documented in Section 1R22. Additionally, the inspectors documented a licensee-identified violation in Section 4OA7.

#### 4OA6 Management Meetings

##### Exit Meeting Summary

On April 4, 2012, the inspectors presented the inspection results to Mr. A. Jordan, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

##### Interim Exit Meetings

- The Review of TI-2515/182, "Industry Initiative to Control Degradation of Underground Piping and Tanks," with Site Vice-President, Mr. A. Jordan, and other members of the licensee staff on February 1, 2012. The licensee confirmed that none of the potential report input discussed was considered proprietary.
- Notification to the station of the licensee-identified violation with Mr. A. Fahrenkrug, Supervisor, Licensed Operator Requalification Training, via telephone on March 27, 2012.

#### 4OA7 Licensee-Identified Violations

The following violations of very low safety significance (Green) were identified by the licensee, and are violations of NRC requirements, which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as NCVs.

##### .1 Calculation Error Leads to Inadequate Post-Maintenance Test Procedure

Title 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," states, in part, that activities affecting quality shall be prescribed by documented procedures of a type appropriate to the circumstances.

Contrary to this, on November 28, 2011 and December 5, 2011, procedure ER-KW-STP-DGM-002A and -002B, "Post-Tie-in Testing for DC KW-10-01101, Train A" and "Post-Tie-in Testing for DC KW-10-01101, Train B" which were one time use special test procedures, were not appropriate to the circumstances. Specifically, the procedures determined the leak rate for the SR backup air supply for the EDG ventilation dampers and because of a calculation error, the procedure only required a test duration of 2 hours instead of a test duration of 24 hours. The licensee corrected the operations version of the procedure and, during the quarterly test of train A on February 19, 2012, found the leakage to be greater than expected, and determined the installed bottles would not have enough air to support operation of the dampers for 7 days without manual operator action. The licensee repaired the leaking components and entered this into the CAP as CRs 460168 and 463265. The air bottles contained enough air to operate the dampers for approximately 3.5 days, which exceeded the 24-hour PRA mission time of the EDG, and therefore, the inspectors screened this finding as having very low safety significance (Green).

##### .2 Appendix R Fire Door Pinned Open and Unattended

License condition 2.C(3) required the licensee to implement and maintain, in effect, all provisions of the approved FP program as described in the licensee's fire plan, and as

referenced in the USAR, and as approved through Safety Evaluation Reports dated November 25, 1977, and December 12, 1978, and supplement dated February 13, 1981. Appendix B of the KPS Fire Protection Program Plan lists the 1975 edition of NFPA-80, "Fire Doors and Windows," as an applicable NFPA code. NFPA-80 states, in part, that a fire door shall be closed and latched at the time of fire.

Contrary to the above, on May 15, 2010, the licensee failed to implement and maintain, in effect, all provisions of the approved FP program as described in the licensee's Fire Plan. Specifically, the licensee found fire door 265 unattended and propped open with the door's bottom bolt engaged in the floor. The licensee closed fire door 265 and entered this into their CAP as CR381342. The inspectors walked down both sides of the fire door using guidance from IMC 0609, Appendix F, "Fire Protection Significance Determination Process," and concluded that no creditable fire scenario existed that would allow fire to pass from either the alternate fire area to the dedicated fire area or from the dedicated fire area to the alternate fire area. The inspectors screened this finding as having very low safety significance (Green).

### .3 Failure of Licensed Operator to Report a Medical Condition

On December 21, 2005, a KPS employee was diagnosed with sleep apnea and was prescribed a CPAP [Continuous Positive Airway Pressure] device to aid in correcting sleep patterns. The employee was subsequently enrolled in the KPS initial operator license training to obtain an NRC operator's license. The employee did not report the use of the CPAP device to the site nurse when she was preparing the applicant's medical certification in conjunction with his application to the NRC to become a licensed operator. This prescribed device was used to treat sleep apnea and was a condition requiring notification of the NRC. The employee was unaware of the requirement to report the use of CPAP devices.

The employee was issued an NRC operating license on March 2, 2011, without a requirement to use therapeutic devices as directed. The NRC issued the operator's license without knowledge of the operator's medical condition. If the NRC had been informed of this medical condition, the NRC would have required a medical restriction be included in the operator's license. This was a potential violation of 10 CFR 50.9, "Completeness and Accuracy of Information."

On July 6, 2011, the operator notified the site nurse of his prescription for a CPAP device. On August 1, 2011, the licensee notified the NRC of the need to add this condition to the operator's license. On October 24, 2011, the NRC amended the operator's license to include the license condition, "must use therapeutic devices as prescribed to maintain medical qualifications." Since the license had previously been submitted without the license condition, and the NRC doctor determined that the license needed to be revised; the original license submittal was incomplete/inaccurate. As such, this was a violation of 10 CFR 50.9.

Because this issue impacted the ability of the NRC to perform its regulatory oversight function, the regulatory significance was determined using the traditional enforcement process. The inspectors determined that the operator's medical condition did not adversely affect the operator's ability to safely operate the facility even though the operator's license was incorrect. The operator's performance was monitored and evaluated as satisfactory during periodic testing and requalification testing. As such,

the NRC determined this to be an SL IV violation, which may be dispositioned as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy.

Corrective actions included a resubmitted NRC Form 396 for the operator, documenting the issue in CR435966, and performing an ACE. Additionally, the licensee conducts annual training regarding operator license restrictions, including the use of prescribed medication, therapeutic devices, and reporting of medical conditions.

The inspectors' review of this issue was considered to be a part of the original inspection effort, and as such did not constitute any additional inspection samples.

ATTACHMENT: SUPPLEMENTAL INFORMATION

## **SUPPLEMENTAL INFORMATION**

### **KEY POINTS OF CONTACT**

#### Licensee

S. Jordan, Site Vice President  
S. Yuen, Director of Engineering  
V. Armentrout, Dominion Fleet Buried Pipe Program Owner  
J. Rusch, Site Buried Piping Program Owner  
T. Breene, Licensing Manager  
M. J. Haese, Licensing  
J. Gadzala, Licensing  
R. Repshas, Licensing  
J. Kudick, Engineering  
J. Stafford, Director, Safety & Licensing  
R. Simmons, Plant Manager  
J. Grau, Maintenance Manager  
D. Lawrence, Operations Manager  
D. Asbel, Planning & Scheduling Manager  
J. Madden, System Engineering Manager  
R. Schaefer, Supply Chain  
R. Adams, Radiation Protection  
M. Aulik, Design Engineering Manager  
A. Fahrenkrug, Licensed Operator Requalification Training Program Supervisor

#### Nuclear Regulatory Commission

K. Riemer, Chief, Division of Reactor Projects, Branch 2

**LIST OF ITEMS OPENED, CLOSED AND DISCUSSED**

Opened

05000305/2012002-01	URI	Incorrectly Modeled Ventilation Damper Changes Daily Risk Color (Section 1R13.1(1))
05000305/2012002-02	URI	Potential Mobile Crane Heavy Load Risk Modeling Error (Section 1R13.1 (2))
05000305/2012002-03	URI	Potential Inadequate Commercial Grade Dedication (Section 1R18.1)
05000305/2012002-04	NCV	Inadequate Post-Maintenance Test of Motor Replacements (Section 1R19.1)
05000305/2012002-05	NCV	Inadequate Procedure For Technical Specification Surveillance (Section 1R22.1)
05000305/2012002-06	NCV	Failure to Submit LER Per 10 CFR 50.73 (Section 4OA3.2)

Closed

05000305/2012002-04	NCV	Inadequate Post-Maintenance Test of Motor Replacements (Section 1R19.1)
05000305/2012002-05	NCV	Inadequate Procedure For Technical Specification Surveillance (Section 1R22.1)
05000305/2011-005-00	LER	Shield Building Ventilation Train Inoperable for Longer Period Than Allowed by Technical Specifications (Section 4OA3.2)
05000305/2012002-06	NCV	Failure to Submit LER Per 10 CFR 50.73 (Section 4OA3.2)
05000305/2011004-02	URI	Failure to Perform Maintenance Rule Evaluations for Risk Significant Fire Door Failures (Section 4OA5.2)

## LIST OF DOCUMENTS REVIEWED

The following is a partial list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspector reviewed the documents in their entirety, but rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

### 1R01 Adverse Weather Protection

- Historical Operations Department Instruction Book; June 22, 2010
- NERC Standard NUC-001; Nuclear Plant Interface Coordination Agreement Between Dominion Energy Kewaunee, Inc. And American Transmission Company LLC; April 1, 2010
- NP 2.1.5; Electrical Communications, Switchyard Access And Work Planning; Revision 21
- NRC Information Notice No. 90-42; Failure Of Electrical Power Equipment Due To Solar Magnetic Disturbances; June 19, 1990
- OP-KW-AOP-GEN-002; Rapid Power Reduction; Revision 11
- OP-KW-NOP-SUB-003; RST And TST Load Tap Changer Operation, System 59; Revision 1
- RTO-OP-053-r5; Geo-Magnetic Disturbance Procedure; December 20, 2011
- Standard EOP-004-1; Disturbance Reporting; January 1, 2007
- System Operating Guide From JA Maenner, To System Operators, Kewaunee Operators, Weston Operators; Subject: Transformer Saturation Caused By Solar Magnetic Disturbances; May 4, 1998

### 1R04 Equipment Alignment

- CA215404; Det, Doc And Resolve Question By NRC Resident Related To Line Voltage
- CA225813; Evaluate Operability In MODE 3 & 4 Concerning SW-1300A/B And Initiate Actions
- CR416341; Valves Found Capped
- CR456353; EO Took Aux Bldg A/C Unit Fan Switch To Incorrect Position
- CR461062; Tagging Error On CR A/C Train B Duplex Strainer
- CR461206; Waste Evaporator Feed Pump And RCDT Pump A Control Switches In Wrong Position
- CR465339; Discrepancy in Heat Transfer Rate Of SFP Hx
- CR465480; SFP HX Performance Monitoring Test Did Not Meet Acceptance Criteria
- CR467517; Chain Tightener Sprocket On The 1A2 TWS, Has 4 Broken Gear Teeth
- Drawing M-202-1; Flow Diagram Service Water System; Revision CP
- Drawing M-202-2; Flow Diagram Service Water System; Revision CU
- Drawing OPERM-202-2; Flow Diagram Service Water System; Revision CY
- Drawing OPERXK-100-18; Flow Diagram Residual Heat Removal System; Revision BH
- Drawing OPERXK-100-19; Flow Diagram Component Cooling System; Revision AQ
- Drawing OPERXK-100-20; Flow Diagram Component Cooling System; Revision AE
- Exelon PowerLabs Certificate Of Calibration No. 0010647166; Asset No. KEW 91585, Temperature System; June 13, 2011
- GNP-01.32.01; Heat Exchanger Performance Monitoring Program Evaluation Procedure; Revision 13
- Kewaunee Power Station Asset Report For: 158-011; March 27, 2012
- MA-KW-PMP-MAE-005; Measuring & Test Equipment (M&TE) Calibration By Vendors; Completed July 15, 2011
- N-CC-31-CL; Component Cooling System Prestartup Checklist; Revision 32

- OP-KW-AOP-SW-001; Abnormal Service Water System Operation, System No. SW-02; Revision 7
- OP-KW-NCL-SW-001; Service Water System Prestartup Checklist, System No. 2; Revision 3
- OP-KW-NOP-CC-001; Component Cooling System Operation, System No. 31; Revision 0
- OP-KW-NOP-SW-001; Service Water System, System No. 2; Revision 8
- PGT Data Acquisition System; SFP HX Test Results Summary; March 13, 2012
- PROTO-HX 4.10; SN#PHX-1016; Calculation Report For SFPhx – Spent Fuel Pool Heat Exchanger; March 13, 2012
- PROTO-HX; Software Application – Air Cooling Coil; Version 3.00
- RAS 000200; Spent Fuel Pool HX Performance Monitoring Test
- SFP Heat Transfer & Fouling Trends; January 28, 2000 To March 8, 2012
- System Health Report; System No. 02-SW; Q1-2012
- Vendor Tech Manual SPKIN-0001 (162-13-1); Automatic Self-Cleaning Strainer (Models A & AM); Revision 3
- WO KW07-010763; PM21-527: Performance Monitoring
- WO KW100330144; PM21-527: Performance Monitoring
- WO KW100388379; PM21-538: Contingency WO For SSA-Replacement Of SFP Pump B Motor (1-248) W/ SP

#### 1R05 Fire Protection

- CA21221; Det. Doc. & Initiate Actions For Maintenance Rule Program Requirements
- CR381342; Fire Door 265 Found Propped Open
- CR442071; NRC Question Regarding Door 1 And Door 2
- CR447019; Penetration 443 Damaged
- CR427843; Door 1 Handle On Tunnel Side Falls Off
- CR446966; Open Limit Switch Appears To Be Not Making Up On ACC-15
- CR465445; KPS Licensee Event Report And NRC Inspection Report Conclusions Questioned
- Fire Drill Project Plan; January 17 To March 30, 2012
- FP Impairment No. 07-81; Appendix R Lighting; November 24, 2007
- FPP-08-08; FP – Control Of Transient Combustible Materials; Revision 10
- FPP-08-17; Impairments To Active Fire Protection Systems; Revision 9
- GNP-01.31.01; Plant Cleanliness And Storage; Revision 27
- KPS Fire Protection Program Analysis; AX-23A Refueling Water Storage Tank Area; Revision 9
- OP-KW-AOP-FP-002; Fire In Alternate Fire Zone, System No. FP-08; Revision 12
- PFP-29; Auxiliary building And Turbine Building Fan Rooms; Revision C
- PMP-08-14; FP – Safeguards Common Zones Fire Detection Functional Test' Revision 14
- SA-KW-FPP-010; Fire Drills, System No. 08; Revision 0
- WO KW100274694; PM08-114: Operability Test Fire Dampers
- WO KW100601164; Visual Inspection Of Fire Dampers (During Plant Shutdown Only)

#### 1R11 Licensed Operator Requalification Program

- LRC-12-DY201; 12-01 Cycle Dynamic; Revision A
- OP-AA-100; Conduct Of Operations; Revision 18
- SP-47-62B; Reactor Protection System Train B Logic Test; Completed March 27, 2012
- WO KW100594759; Repair Loose Wire
- WO KW100594761; Repair Loose Wire Lug

## 1R12 Maintenance Effectiveness

- Basler Electric Instruction Manual For Voltage Regulator; Revised December 13, 1976
- CA141091; Track ER Issue For Erratic KVAR Control During TSC DG Operation
- CR319867; Control Room Deficiency. Erratic Voltage Control Observed For The TSC Diesel Generator
- CR339770; Erratic KVAR Control During TSC DG Operation Per OP-KW-ORT-DGM-002
- CR461778; Erratic TSC D/G KVAR Indications During ORT-DGM-002
- CR461812; TSC Diesel Generator KVAR Response Was Not Correct During ORT-DGM-002
- Maintenance Rule Scoping Questions For EDG Emergency Diesel Generator; Revision 3
- MRE014103; For Erratic KVAR Control During TSC D/G Operation Per OP-KW-ORT-DGM-002 (Inactive)
- MRE014789; Erratic TSC D/G KVAR Indications During ORT-DGM-002
- SAR001141; Kewaunee Power Station maintenance Rule (a)(3) Formal Self-Assessment; Completed August 19, 2010
- SSC Performance Criteria Sheet For 40 480 VAC; Revision 4
- SSC Performance Criteria Sheet For EDG Emergency Diesel Generator; Revision 7

## 1R13 Maintenance Risk

- CR368298; Battery Room Exhaust Flow Rates Below Design
- CR432037; Train B Screenhouse Dampers Not Modeled In PRA
- CR451711; Pending Changes To CAFTA/EOOS Models Are Not Reviewed For Cumulative Impact
- CR466807; NRC Resident Questioned Activities Related To Heavy Lifts For CW Pump B Work
- Documentation Of Information Sharing; PRA And Safety Monitor Briefing; March 19, 2012
- Drawing E-2016; Integrated Logic Diagram Turbine Building & Screenhouse Vent System; Revision AJ
- Drawing OPERM-601; Flow Diagram Turbine & Aux. Bldg. Ventilation; Revision DG
- Drawing S-750; Screenhouse Appendix R Hatch Cover & Elect. Manholes; Revision A
- EPRI; Nuclear Maintenance Application Center (NMAC) Memo November 2009
- GNP-08.12.02; Controls For Use Of Cranes Within The Protected Area; Revision 27
- High Risk Contingency Plan for SFP Cooling Outage In Work Week 1206 For February 7
- Letters From W. Ruland, Director, Division Of Safety Systems, ONR, NRC; To T. Houghton, Director, Strategic Regulatory Programs, Nuclear Generation Division, NEI; Subject: Industry Initiative On Control Of Heavy Loads; May 16, 2008 And May 27, 2008
- Log Entries Report; February 13, 2012, July 22, 2010, December 16, 2008, And December 10, 2008
- Major Activities Scheduled For Work Weeks 1211 And 1212; March 11 To March 24, 2012
- MA-KW-MPM-TAV-001B; Annual Preventive Maintenance Of Turbine Building Supply Fan 1A, 1B, And 1C; Revision 1
- NF-AA-PRA-101-3081; Probabilistic Risk Assessment Procedures And Methods: Configuration Risk Assessment Of Load Lifts; Revision 1
- NF-AA-PRA-370; Probabilistic Risk Assessment Procedures And Methods: PRA Guidance For MRule (a)(4); Revision 12
- NRC RIS 2008-28; Endorsement Of Nuclear Energy Institute Guidance For Reactor Vessel Head Heavy Load Lifts; December 1, 2008
- NUREG-0612; Control Of Heavy Loads At Nuclear Power Plants
- Planned Activities For March 19, 2012

- Planning and Scheduling, Work Week/Daily Risk and Work Schedule Documentation for the Days of January 25, February 7, And March 8, 2012
- Rigging Lift Plant; B Circ Pump Motor; Completed March 20, 2012
- Scheduler's Evaluation For Kewaunee On-Line Schedule; February 13, 2012, And March 19, 2012
- Scheduler's Evaluation For Kewaunee On-Line Schedule; March 15 To March 17, 2012, And March 19 To March 21, 2012
- Volume RA.027; KPS PRA Notebook; Heavy Load Lift Over Screenhouse; March 2012
- WM-AA-20; Risk Assessment Of Maintenance Activities; Revision 1
- WO KW100647507; 1A Auxiliary Building Mezzanine Fan Coil Unit Adjustment

#### 1R15 Operability Evaluations

- CA155813; RAS 102-CA To Revise Calculation NAI-1200-001 Based On The Eval In CA145251
- CA178188; Det, Doc, And Resolve Issue Of How Carbon Steel Hilti Anchors Were Accepted
- CA228142; Review Control Room Console Temperature For Past Operability
- Calculation NAI-1200-001; GOTHIC Model For CREZ Heat Up At The Kewaunee Nuclear Power Plant; February 28, 2011
- CR393235; Hilti Anchor Material Issue
- CR428736; RFT – Operability Assessment
- CR433180; Isolated Charging Pump A Due To The Seal Leak Off Exceeding The Drain
- CR440439; Review Operability/Functionality Call On Previous Corrective Action
- CR457393; CVC-7 Containment Isolation Function
- CR458531; Failure analysis Report For ESF Relay PC483A/XB
- CR459164; CVC-101B Increased Leakage
- CR460536 Functionality Review
- CR460536; Calculation For Control Room Console Temperature Did Not Include Uncertainty
- CR460835; Electrical Surveillance PM Templates Require Clarification
- CR462239; Increase In Charging Pump B Seal Leak Off
- CR463265; EDG A Vent Damper Air Supply Leakage
- CR463968; Unexpected Procedural Latent Issues Found During Management Observation
- CR464121; Review Control Room Console Temperature For Past Operability
- Drawing OPERXK-100-35; Chemical And Volume Control System; Revision AG
- Drawing OPERXK-100-36; Chemical And Volume Control System; Revision BH
- End Of Month Status; Maintenance Rule (a)(1) Systems With Open Corrective Actions – 3 Systems; January 2012
- KPS Bases B 3.6.3; Containment Isolation Valves; LC000407, February 12, 2011
- KPS LER 2008-001-00; Pressurizer PORV And Reactor Coolant System Vent Valves Appendix R Spurious Operation Concern; November 7, 2008
- KPS USAR 5.3; Reactor Containment Vessel Isolation Systems; Revision 23
- KPS USAR 9.6-10; Revision 23
- OD 000393; Provide Supporting Documentation For Hilti Anchor Material Issue
- OD 000465; Perform OD For CVC-7 Containment Isolation Function
- OD 000467; Perform OD For Failure Analysis Report Of ESF Relays
- OP-AA-102; Operability Determination; Revision 7
- RAS Documentation For CRs 463949 And 464393 And RAS000199; Completed March 5, 2012
- Request For FSRC For: RAS 102 Control Room Consoles; August 18, 2009
- WO KW100581854; Gather Temperature Data Inside And Outside Control Room Mechanical Counsel A & C

## 1R18 Modifications

- 2006 Pricing Guide For Severe Duty – TEFC Motors
- ACE 19016; Turbine Building FCU 1B Motor Failure
- Calculation No. C11965; Method For Determining EDG Ventilation Damper Operating Time After Loss Of Instrument Air; Completed February 25, 2011
- CM-KW-MEL-101; Safety Classification Of Structures, Systems, And Components; Revision 0
- CTG Order No. 51-601-983-006; Bearing, Ball, Annular; March 15, 2012
- DC KW-10-01101; EDG Ventilation Air Supply Modification (Capital); June 29, 2011
- Drawing OPERM-213-13; Station And Instrument Air System Diesel Generator A And B Ventilation Damper; Revision A
- ITTCO-0004 (77312-1); Instruction And Maintenance Manual For IEEE Qualified Airpak; June 2007; Revision 4
- Letter From S.E. Schulz, Supervisor Nuclear Quality, Dominion Resources Services, Inc., To M. Szymczuk, Laboratory Manager, Airgas East; Subject: Airgas East Commercial Grade Survey, DS 2011-02; November 23, 2010
- MA-AA-PTE-401; Procurement Technical Evaluation Determination; Revision 5
- MS-AA-PTE-401-1002; Sampling Methodology For Material Acceptance; Revision 0
- MS-AA-PTE-401-1004; Commercial Grade Dedication; Revision 0
- MS-AA-SCE-301; Subcomponent Classification Evaluation; Revision 1
- NLI Test Data Sheet For VP-1LA91844YK60; Completed December 1, 2005
- OP-KW-ARP-DR101-13; Damper Bottle Low Pressure, System No. 16; Revision 0
- OP-KW-ORT-DGM-001A; Emergency Diesel Generator 1A Operation Log; Revision 11
- OP-KW-ORT-MISC-009; Equipment Operator Daily Miscellaneous Repetitive Tasks; Revision 10
- PTE 10000016291; Switch, Pressure, ASHCROFT, 42169048; Version 00
- PTE 10000016533; EDG Ventilation Gas Cylinders; Version 01; April 21, 2011
- PTE No. 05-0010; Procurement Technical Evaluation For: Spent Fuel Pool Pump Motors; Completed April 13, 2005
- RAS000198; Performance Of OSP-TAV-002A Resulted In EDG A HVAC Damper Air System Leakage Exceeding Procedure Acceptance Criteria; February 23, 2012
- Report From Badger Electric Motor; Re: Badger Job Number 126690M, Inspection Of Quantity One, Siemens Electric Motor; January 10, 2012
- SAP PO 0045833615-00001-000000170422; Industrial Controls Distributors; July 19, 2011
- SAP PO 0045839950-00001-000000171425; Airgas North Central; June 1, 2011
- TE No. CGIBE01; EPRI CGI Utility Task Group Commercial Grade Item Evaluation For Bearings - Rolling; Revision 3A
- TE No. CGIMO01; EPRI CGI Utility Task Group Commercial Grade Item Evaluation For Three Phase Squirrel-Cage Induction Motors; Revision 2B
- Verification Plan No. VP-1LA91844YK60; Motor, Electric, 5 HP, 230/460 VAC, 60 Hz, 3 Phase, 1800 RPM, Frame 184T Mfg./Model: Siemens / 1LA91844YK60; Revision 0

## 1R19 Post-Maintenance Testing

- CR454258; STP-DGM-002A Acceptance Criteria Exceeded
- CR454725; High Resistance Found On Aux Contact
- CR460168; Place OP-KW-OSP-TAV-002A&B On Admin Hold
- CR461778; Erratic TSC D/G KVAR Indications During ORT-DGM-002
- CR461812; TSC Diesel Generator KVAR Response Was Not Correct During ORT-DGM-002
- CR464645; Potential To Affect Turbine Building FCU Performance When Replacing The Motors

- CR465230; Procedure MA-KW-EPM-RLY-049 Rev. 1 PMT 5.5 Could Not Be Performed As Written
- CR467771; Closed/Vaulted Work Order# 863379, For B TBFCU Motor Change Incomplete
- Drawing E-2702; Engineered Safeguards System, Logic Trip Relays; Revision D
- Drawing E-2708; Engineered Safeguards System, Logic Trip Relays; Revision E
- Drawing E-2710; Engineered Safeguards System, Safety Injection Scheme; Revision AC
- Drawing E-2711; Engineered Safeguards System, Safety Injection And Steam Line Isolation; Revision Z
- EP-AA-303; Equipment Important To Emergency Response; Revision 2
- EPRI Post-Maintenance Testing Guide; Revision 1
- ER-KW-STP-DGM-002A; Post-Tie-In Testing For DC KW-10-01101, Train A; Completed November 28, 2011
- GMP-131; Operational Use For SKF Microlog Analyzers; Revision 11
- GNP-03.01.01; Directive, Implementing Document And Procedure Administrative Controls; Review Completed August 29, 2008
- GNP-03.01.01; Directive, Implementing Document, And Procedure Administrative Controls; Revision 46
- GNP-08.02.12; Post-Maintenance Testing/Operations Retest; Revision 14
- GNP-10.01.01; Instructions For Control Of Measuring And Test Equipment; Revision 24
- ITTCO-0004 (77312-1); Vendor Tech Manual: Instruction And Maintenance Manual For IEEE Qualified Airpack; Revision 4
- Log Entries Report; February 10, 2012
- M&TE Usage Report For Work Order OSP-TAV-002A; March 21, 2012
- MA-AA-103 Conduct Of Troubleshooting, Attachment A: TSC Diesel Generator KVAR/Voltage Unstable Troubleshooting; February 7, 2012
- MA-KW-EPM-DGE-002; TSC Diesel Generator Component Retest; Review Completed January 11, 2012
- MA-KW-ICP-SW-018A; Train A Service Water Pumps Bearing Seal Water Flow Switches Three Year Calibration; Review Completed July 19, 2010
- MA-KW-ICP-TAV-008; Diesel Generator Room 1A Damper Control Functional Test; Review Completed November 23, 2011
- MA-KW-ICP-TAV-008; Diesel Generator Room 1A Damper Control Functional Test; Revision 0
- MP-20-WP-GDL40; Millstone Station Pre And Post Maintenance Testing; Revision 013-02
- OP-AA-106; Infrequently Conducted Or Complex Evolutions; Revision 6
- OP-KW-ORT-DGM-002; TSC Diesel Generator Monthly Availability Test, System No. 10; Completed February 7, 2012
- OP-KW-OSP-TAV-002A, Revision 3; Diesel Generator A Back Up Air Supply Leak Rate Test; Review Completed February 19, 2012
- OP-KW-OSP-TAV-002A, Revision 4; Diesel Generator A Back Up Air Supply Leak Rate Test; Review Completed February 21, 2012
- PI-AA-300-3000; Emergent Issue Response; Revision 3
- PMP-05B-03; AFW – Motor Operated Valve Electrical Maintenance (QA-1); Review Completed December 7, 2010
- PMP-05B-03; AFW – Motor Operated Valve Electrical Maintenance (QA-1); Review Completed July 7, 2011
- PMP-05B-03; AFW – Motor Operated Valve Electrical Maintenance (QA-1); Revisions 18, 19, And 20
- PMP-05B-08; AFW – Auxiliary Feedwater Pump Motor Electrical Maintenance; Review Completed September 7, 2011

- PMP-05B-08; AFW – Auxiliary Feedwater Pump Motor Electrical Maintenance (QA-1); Revisions 7 And 8
- Post-Tie-In Testing For DC KW-10-01101, Train A; Performed November 28, 2011
- SP-55-155A; Engineered Safeguards Train A Logic Channel Test; Completed February 10, 2012
- SP-55-155A; Engineered Safeguards Train A Logic Channel Test; Revision 26
- SP-55-155A; Engineered Safeguards Train A Logic Channel Test; Review Completed May 20, 2010
- VPAP-2003; Post-Maintenance Testing Program; Revision 14
- Weekly Schedule Of Major Activities; February 5 – 11, 2012
- WM-AA-101; Post-Maintenance Test Requirements; Revision 0
- WO KW100388379; PM21-538: Contingency WO For SSA-Replacement Of SFP Pump B Motor (1-248) W/ SP
- WO KW100440375; PM10-605, 36 Mo Calib Check
- WO KW100458898; Contingency Work Order To Replace Motor
- WO KW100494464; Replace Turbine Building Basement FCU A, 1-201
- WO KW100494464; Replace Turbine Building Basement FCU A, 1-201
- WO KW100704948; PM 10-675: TSC Diesel Generator Component Retest
- WO KW100822794; Contingency-Replace MOP For TSC Generator
- WO KW100825601; Take As-Found Readings On TSC Diesel MOP/ Test New MOP
- WO KW100860629; Replace PS-16192
- WO KW100861656; Replace Relay PC483A/XA
- WO KW100861660; Replace Relay PC946A/XA
- WO KW100863379; Replace The Turbine Building FCU 1B Motor
- WO KW100869630; Regulator 36073 Repair Or Replace

### 1R22 Surveillance Testing

- ACE002859; Doors 138 & 123 Both Open When Above Cold Shutdown
- CR097711; Door #123 CTMT Handle Is Free Spinning & Door Does Not Lock, PERSONNEL AIRLOCK
- CR353501; Door 123 Sticks
- CR393133; Fire Door 123 Door Closure Needs Adjustment
- CR449523; Door 123 (Personnel Airlock Door To Containment) Degraded And Fails Inspection
- Dominion Troubleshooting Sheet; RCS Leakrate/RCDT Inleakage
- Drawing A-586-2-3; Door Schedule Doors 121-143; Revision F
- Drawing A-586-7; Door Notes; Revision K
- OP-K2-OSP-CCI-004; Containment Isolation Valve Verification, System No. 56; Completed February 5, 2012
- OP-KW-OSP-AFW-003B; Motor Driven AFW Pump B Full Flow Test – IST, System No. 05B; Completed March 16, 2012
- OP-KW-OSP-CC-002A, Train A Component Cooling Pump And Valve Test – IST, System No. 31; Completed March 9, 2012
- OP-KW-OSP-CC-002B; Train B Component Cooling Pump And Valve Test – IST, System No. 31; Completed January 18, 2012
- OP-KW-OSP-RCS-001; Reactor Coolant System Leak Rate Check, System No. 36; Completed February 9, February 10, February 11, February 12, February 13, February 15, And February 17, 2012
- Pre-Job Briefing No. 1149; OP-KW-OSP-CC-002A, Train A Component Cooling Pump And Valve Test – IST

- Seal Leak Off Vs. Cont Temp; February 1 To February 17, 2012
- SP-47-62B; Reactor Protection System Train B Logic Test; Completed March 27, 2012
- SP-54-063; Turbine Trip Mechanism Tests; Completed February 13, 2012
- SP-55-177; Inservice Testing Of Pumps Vibration Measurements – Components 145-411, 145-412, And 145-413; Completed March 16, 2012
- WM-AA-301; Activity: KW100808915, OP-KW-OSP-CC-002A Train A CC Pump And Valve Test – IST (Task 2); Completed January 12, 2012
- WO KW1005947561; Lug Replacement On Relay 1/N35A/TB, Contact 1, Wire T10

#### 4OA2 Identification and Resolution of Problems

- 50.59/72.48 Applicability Review; OD407, Revision 0; January 10, 2012
- ACE 018964; ESF Relay Failure Discovered During Testing
- Report From Exelon PowerLabs; DOM-78257, Revision 1; Failure Analysis Of A Relay; January 11, 2012
- Request For FSRC; OD000467 Failure Analysis Report For ESF Relay PC483A/XB; January 11, 2012

#### 4OA3 Follow-Up of Events and Notices of Enforcement Discretion

- Bases; AC Source – Operating, B 3.8.1; Amendment No. 207, February 2, 2011
- CA204892; Determine, Document And Initiate Actions As Appropriate IAW PI-AA-200
- CA219029; CA To Document Effects Of Analysis In CA204892 On Train B Of SBV
- CA220573; TS 3.8.1 Be Reviewed By The Technical Specifications Review Committee
- CR453926; TLA-21 Safeguards Bus Voltage Abnormal Did Not Provide Early Warning
- CR454022; Offsite Voltage Requirements For Operability Of RST/RAT And TST/TAT Per TS 3.8.1
- CR454859; AOP-EG-001 Not Implemented On 11/24/11
- CR454950; Grid Voltage High
- CR456261; TLA-21 Was Received For Bus 6 Low Voltage/Possible PPCS Voltage Inaccuracies
- CR468965; Failure Analysis Report For SBV System Standoffs From Lord Corp.
- EN 47476; Emergency 4160 Volt AC Busses Declared Inoperable; Event Date November 24, 2011
- ETE-KW-2010-0005; Voltage Specifications For The Safeguard AC And DC Buses At Kewaunee Power Station; October 21, 2010
- ETE-KW-2011-0065; Evaluation Of Bus 1-5 And 1-6 Voltages Resulting In NRC Event 47476; December 13, 2011
- ETE-KW-2011-0065; Evaluation Of Bus 1-5 And 1-6 Voltages Resulting In NRC Event 47476; December 20, 2011
- ETE-NAF-2011-0025; Evaluation Of Kewaunee Power Station (KPS) Emergency Core Cooling System (ECCS) Operability Requirements For Improved Technical Specification (ITS) Mode 4 Operating Conditions; February 9, 2011
- LCO 3.8.1; LCO 3.8.9 AND TRM 8.8.2; Rev. Original December 8, 2011
- LER 2011-005-00; Shield Building Ventilation Train Inoperable For Longer Period Than Allowed By Technical Specifications; August 4, 2011
- LER 2011-006-00; Misapplication of Testing Allowance Results in Condition Prohibited by Technical Specifications; October 31, 2011
- Letter From NRC To D. Heacock, Dominion Energy Kewaunee, Inc.; Subject: Kewaunee Power Station – Issuance Of Amendment Re: License Amendment Request To Change The

- Current Licensing Basis For Automatic Operation Of Transformer Load Tap Changers (TAC No. ME4011); July 29, 2011
- NERC Standard NUC-001; Nuclear Plant Interface Coordination Agreement Between Dominion Energy Kewaunee, Inc. (Kewaunee Power Station) And American Transmission Company LLC; Effective April 1, 2010
  - Nuclear Plant Operating Agreement Between The Midwest Independent Transmission System Operator, Inc. And Dominion Energy Kewaunee, Inc. For Kewaunee Power Station; Executed March 26, 2010
  - OD407; CR414092; Reserve Auxiliary Transformer (RAT) And RAT Supply Transformer (RST); October 12, 2011
  - OP-KW-AOP-EG-001; Abnormal Grid Conditions, System No. EG-43; Revisions 9 And 10
  - OP-KW-ARP-47034-11; TLA-21 Safeguards Bus Voltage Abnormal; Revision 8
  - OP-KW-OSP-MISC-002; Electrical Power System Weekly Surveillance Test; Revision 7
  - Serial No. 09-491; Dominion Energy Kewaunee, Inc., Kewaunee Power Station, License Amendment Request 249: Kewaunee Power Station Conversion To Improved Technical Specifications (TAC No. ME02467); August 24, 2009
  - Serial No. 10-063A; Dominion Energy Kewaunee, Inc., Kewaunee Power Station, Supplement And Response To Request For Additional Information: License Amendment Request 236, Automatic Operation Of Transformer Load Tap Changers (TAC No. ME4011); January 18, 2011
  - Serial No. 10-649; Dominion Energy Kewaunee, Inc., Kewaunee Power Station, License Amendment Request 249: Kewaunee Power Station Conversion To Improved Technical Specifications (TAC No. ME3460) – Submittal Of Revised Technical Report; November 10, 2010
  - Serial No. 10-693; Dominion Energy Kewaunee, Inc., Kewaunee Power Station, License Amendment Request 249: Kewaunee Power Station Conversion To Improved Technical Specifications (TAC No. ME2139) – Reiteration Of Position And Revised Submittal Pages; December 2, 2010
  - Standing Order # 11-27; RST And TST Load Tap Changer Operation; April 1, 2011
  - Standing Order # 11-83; Bus Voltage And Load Tap Changers; November 26, 2011
  - Station Narrative Logs; November 23 To November 25, 2011
  - Tracking And Processing Record For ARP-47034-11; TLA-21 Safeguards Bus Voltage Abnormal; November 26, 2011
  - WO KW100471262; Inspect Circuit Board For Damage
  - WO KW100755927; Remove The Circuit Board Stand-Offs From Train B Shield Bldg Vent

#### 4OA5 Temporary Instruction (TI) 2515/182

- CA21221; Det. Doc. & Initiate Actions For Maintenance Rule Program Requirements
- CA228814; Review Door 123 And Door 138 Containment/Shield Building Door Interlock Issue
- CR381342; Fire Door 265 Found Propped Open
- CR442071; NRC Question Regarding Door 1 And Door 2
- CR447019; Penetration 443 Damaged
- Document ER-AA-BPM-10; Dominion Underground Piping And Tank Integrity Program Description ; Revisions 2 and 3
- EPRI Report 1016456; Recommendation For An Effective Program To Control The Degradation Of Buried Pipe; Final Report Dated December 2008
- Kewaunee Power Station Life Cycle Management Plan, Buried Pipe Program; January 9, 2012
- LA 001754; NEI Buried Piping Initiative – Establish Procedures; January 6, 2010
- LA 001755; NEI Buried Piping Initiative – Complete Risk-Ranking; January 6, 2010

- LA 001756; NEI Buried Piping Initiative – Complete Asset Management Program; January 6, 2010
- LA 001756; NEI Buried Piping Initiative – Develop an Inspection Plan; January 6, 2011
- LA 001757; NEI Buried Piping Initiative – Begin Inspection Plan; January 6, 2010
- LA 001758; NEI Buried Piping Initiative – Condition Assessment Of Piping Containing Radioactive Material; January 6, 2010
- Procedure MA-KW-EPM-CAP-001; Kewaunee Cathodic Protection Rectifier Inspection And ½ Cell Test; Revision 0
- SAR 001156; Buried Piping Risk-Ranking Self-Assessment; November 15, 2010
- WO KW100756491; Inspect A 10' Section Of The 2" Circ. Water Recalculating Vent Line Near The Discharge Basin; November 8, 2011
- WO KW100756610 Is A Work Order To Inspect The Buried FP Line West Of Hydrant No. 10; November 2011
- WO KW100756611 Is A Work Order To Inspect The Buried FP Line Between Hydrants No. 3 & 4; November 2011
- WO KW100784500; Inspect 1B UFOST Vault; November 2011
- WO KW100801884; Inspect 10-Foot Of The Non-Cathodically Protected 1A Diesel FO Supply Line; November 28, 2011

#### 40A7 Licensee-Identified Violations

- CR381342; Fire Door 265 Found Propped Open
- CR435966; Failure To Report Medical Condition At Time of NRC License Application
- CR463265; EDG A Vent Damper Air Supply Leakage
- NRC Form 396 For One License Operator; January 18, 2011 And September 8, 2011

#### NRC-Identified Condition Reports

- CR457972; BUS 1 And 2 FME Concern
- CR458150; Contaminated Area Identified Around Spent Fuel Pool Pump B
- CR458774; NRC Questions AC Setting On Thermostat 26291 For Non-Safeguards Battery Room
- CR458906; Door 264 Lower Cane Bolt Was Found Not Engaged
- CR459840; Door 83 Latch Slider Is Sticking
- CR460536; Calculation For Control Room Console Temperature Did Not Include Uncertainty
- CR461030; Benchmark Industry For Guidance On Incorporating Instrument Uncertainties
- CR461230; USAR Description Does Not Match Current Calc For Max Control Room Temperature
- CR462073; NRC Resident Question On Primary To Secondary Leakage
- CR462298; NRC Identified Editorial Error In Work Order For ESF Relay Replacement
- CR462584 NRC Questioned Why Procedure Revisions Did Not Have A QC Review
- CR462602; OP-KW-601 Does Not Address Safeguards Fan Coil Units
- CR463146; NRC Requests ECCS Evaluation Information Per 10 CFR 50.54(f)
- CR463777; Seismic Impact Of CR Panel Doors Being Open
- CR463979; Scaffold Not Evaluated – NRC Identified
- CR463986; NRC Question Regarding Aux Building Rood Leakage
- CR464121; Review Control Room Console Temperature For Past Operability
- CR464315; Door 123 And Door 138 Containment/Shield Building Door Interlock May Not Work
- CR464355; Procedure Issue – OP-KW-OSP-CCI-004, Containment Isolation Valve Verification
- CR464645; Potential To Affect Turbine Building FCU Performance When Replacing The Motors

- CR464664; OSP-TAV-002A Rev 4 Does Not Record M&TE
- CR464774; Scaffold Installed Within 10 Feet Of Safety Related Equipment – TDAFW Steam Piping
- CR464776; Unattended Material Found By Resident NRC Inspector In Aux. Bldg.
- CR464779; Transient Combustibles Found In Cable Trays In Zone SV Area
- CR465631; NRC Raised Concern About Solar Magnetic Disturbances
- CR465754; Door 130 Handle Is Need Of Repair
- CR465842; NRC Question On Storage Of Gas Bottle
- CR465946; NRC Question Regarding Assessing Leakage From Charging System
- CR466025; NRC Question On Gas Bottle Storage Procedures
- CR466183; SPF HX Performance Monitoring Shows Decrease In SFP Flow From The Last Test
- CR466215; NRC Expressed A Concern On The PMT For SFP Pump B Motor Replacement
- CR466555; Discharge Gauge AFW Pump B
- CR466807; NRC Resident Questioned Activities Related To Heavy Lifts For CW Pump B Work
- CR466877; Scissors Lift Found In Seismic Storage Area
- CR467288; NRC Concern With M&TE Tracking From CR464664
- CR467560; NRC Question On SR 3.6.3.3

## LIST OF ACRONYMS USED

AC	Alternating Current
ACE	Apparent Cause Evaluation
ADAMS	Agencywide Document Access Management System
AFW	Auxiliary Feedwater
ASME	American Society of Mechanical Engineers
CAP	Corrective Action Program
CCW	Component Cooling Water
CFR	Code of Federal Regulations
CIV	Containment Isolation Valve
CPAP	Continuous Positive Airway Pressure
CR	Condition Report
DG	Diesel Generator
DRP	Division of Reactor Projects
EDG	Emergency Diesel Generator
EP	Emergency Plan
ESF	Engineered Safety Feature
FCU	Fan Coil Unit
FP	Fire Protection
IMC	Inspection Manual Chapter
IP	Inspection Procedure
IR	Inspection Report
IST	Inservice Testing
IV	Independent Verification
KPS	Kewaunee Power Station
LER	Licensee Event Report
LLC	Limited Liability Corporation
NCV	Non-Cited Violation
NEI	Nuclear Energy Institute
NFPA	National Fire Protection Association
NRC	U.S. Nuclear Regulatory Commission
NSR	Nonsafety-Related
PARS	Publicly Available Records System
PM	Post-Maintenance
PMT	Post-Maintenance Testing
PRA	Probabilistic Risk Assessment
RCS	Reactor Coolant System
RG	Regulatory Guide
ROP	Reactor Oversight Process
SBV	Shield Building Ventilation
SFP	Spent Fuel Pool
SL	Severity Level
SR	Safety-Related
SSC	Structure, System, and Component
SW	Service Water
TBFCU	Turbine Building Fan Coil Unit
TDAFW	Turbine-Driven Auxiliary Feedwater
TI	Temporary Instruction
TMOD	Temporary Modification
TS	Technical Specification

TSC	Technical Support Center
TSO	Transmission System Operator
URI	Unresolved Item
USAR	Updated Safety Analysis Report
WO	Work Order

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Sincerely,

**/RA/ By N. Shah Acting For/**

Kenneth Riemer, Branch Chief  
Branch 2  
Division of Reactor Projects

Docket No. 50-305  
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