LER and NRC finding search data related to painting/ cleaning activity events 1991-2008

Note: This document (ML091600446) is referenced from Information Notice 2009-14, "PAINTING ACTIVITIES AND CLEANING AGENTS RENDER EMERGENCY DIESEL GENERATORS AND OTHER PLANT EQUIPMENT INOPERABLE," that is available at ML091980474 .

NRC review of other painting related events - (based on LER and NRC findings review)

The NRC Operating Experience Branch performed a review of LERs and Reactor Oversight Process (ROP) NRC inspection findings related to painting events.

An LER review for Painting / Cleaning fluid related issues identified the following:

Other "paint related" LERs impacting Emergency Diesel Generators (EDGs) were also noted.

1) Turkey Point-4 Foreign Material Exclusion Cover Causes Inoperability of One Emergency Diesel Generator (this event occurred during or just prior to painting activities), event date: 11/29/2005, (LER in ADAMS ML060410102). Corrective actions included painting a highly visible notice on the floor next to the grating in each air receiver room for the 4A and 4B EDGs stating that Engineering is to be contacted before covering the floor.

2) River Bend, Emergency Diesel Generator Failed Surveillance Test due to Paint on Fuel Injector Control Linkage, event date: 8/15/2007, (LER in ADAMS ML072890356). This LER documented an event that was caused by inadequate planning and controls of the work. The work order for the painting was found to lack the rigor required to perform the task. Due to the sensitive nature of the equipment being painted, more stringent controls should have been specified. Steps requiring documented involvement of the system engineer or mechanical maintenance technicians in pre-job and daily walk downs with documentation would have been appropriate. A retest of the fast start capability of the DG should have been performed upon completion of the painting activity.

3) The subject of this IFR - LER for Comanche Peak-1, Emergency Diesel Generator Inoperable for Longer Than Allowed by TS due to Paint on Metering Rod, event date: 11/21/2007, (LER in ADAMS ML ML080240252) and discussed in NRC Special Inspection Report (ADAMS ML080600164)/ This event was the subject of Information Notice (ML091980474) and was a White Finding.

LERs involving "Paint" issues / painting affecting the plant or equipment, 1991-2008

LER ML#	Event Date	Plant/Unit	LER Description (paint related info)
ML091520398	01/07/1993	Haddam Neck	Fire Door Opened Without Entering LCO and Establishing Fire Watch (during painting)
ML091530183	02/08/1995	Indian Point 2	Paint Peeling on the 46 foot elevation floor inside containment (paint condition)
ML091520413	03/24/1993	Turkey Point 3	FAILURE TO MAINTAIN AN HOURLY FIRE WATCH PATROL; TECHNICAL SPECIFICATION VIOLATION (control of door painting issue)
ML060410102	11/29/2005	Turkey Point 4	Foreign Material Exclusion Cover Causes Inoperability of One **Emergency Diesel Generator** (FME cover installed during painting activities)
ML012710311	07/27/2001	Browns Ferry 2 , Browns Ferry 3	Inoperable Control Room Emergency Ventilation System Due to a Door Being Blocked Open During Maintenance Activities (during painting)
ML091530197	02/27/1997	Diablo Canyon 1	Technical Specification 3.7.1.2, Not Met Due to Paint Applied to **Auxiliary Feedwater Pump** Turbine Governor Linkage Due to Personnel Error
ML091520470	08/11/1993	Surry 1 , Surry 2	Mechanical Equipment Room #4 Fire Door Left Blocked Open Due to Personnel Error (during painting)
ML091520484	08/30/1993	Cooper Station	HPCI System Inoperability Resulting From A Dislodged Motor Operated Valve Pinion Gear Key And Motor Starter Contaminants (paint chips)
ML091520539	06/20/1994	Brunswick 1 , Brunswick 2	Inadvertent Loss of Power To The Main Stack Radiation Monitor Results In Dual Unit Unplanned ESF Actuations (due to painters)
ML091520556	06/09/1995	Brunswick 1	DURING HIGH PRESSURE COOLANT INJECTION SYSTEM SURVEILLANCE A GROUND WAS NOTED AFFECTING SYSTEM INSTRUMENTATION. (due to paint chips)
ML091420300	09/17/1991	Fitzpatrick	HIGH COOLANT INJECTION INSTRUMENT LINE FAILURE (poor weld due to painting on the pipe)
ML091530210	01/23/1998	Beaver Valley 1 , Beaver Valley 2	Failure to Perform Required Ventilation Filter Bank Testing as Required by Technical Specifications (following painting)
ML091520547	12/30/1994	Millstone 2	Charcoal Filter Iodine Removal Efficiency Failure Associated With Enclosure Building Filtration and Control Room Air Conditioning (due to exposure to paint fumes)
ML003731274	06/01/2000	Millstone 2	Entry into an Operational Mode While in the LCO 3.6.5.2 Action Statement is a Violation of Technical Specification 3.0.4 (blocked open doors during painting activities)

LER ML#	Event Date	Plant/Unit	LER Description (paint related info)
ML091520207	01/16/1992	Trojan	Failure to Recognize a Fire Suppression System Deluge Nozzle led to Erection of Scaffold Which Obstructed the Nozzle Spray Pattern (piping was not painted proper color - red)
ML091520306	09/21/1993	San Onofre 2 , San Onofre 3	CALCULATED PEAK FUEL CLAD TEMPERATURE (incorrect paint thickness used in calculations)
ML091530267	01/13/1998	San Onofre 2	Turbine Driven Auxiliary Feedwater Pump Speed Circuit Collar Loose (during painting activities)
ML091530234	09/01/1995	Arkansas 2	**Automatic Reactor Trip** on `B' Steam Generator High Level as a Result of Human Error Involving Use of an Improper Work Surface by a Contract Painter
ML091530292	04/12/1996	LaSalle 1, LaSalle 2	Unit 1 "B" RPS MG SET EPMA Breaker Inadvertently Tripped due to Personnel Error (by a painter)
ML091520326	06/11/1993	Susquehanna 1 , Susquehanna 2	Potential Plugging Of ECCS Suction Strainers By Containment Debris (unqualified paint)
ML091520507	01/21/1993	Columbia	**REACTOR SCRAM** DUE TO LOW RPV LEVEL AS A RESULT OF LOSS OF REACTOR FEEDWATER PUMP CAUSED BY AN INADVERTENT ACTUATION OF THE DELUGE SYSTEM (by a painter)
ML091530363	10/15/1996	Beaver Valley 2 , Beaver Valley 1	Control Room Ventilation System Purge Mode Operation (due to paint fumes)
ML091520171	04/14/1992	Grand Gulf	Misidentified Valve Causes Violation of Tech spec 3.0.3 (paint labeling issues)
ML091520261	04/01/1992	Millstone 3	Improper Filter Retests After Painting or Welding Due to Failure to Properly Identify Situational Surveillance
ML091530407	09/22/1999	Vogtle 1	CONTROL ROOM DOOR PAINTING RESULTS IN LOSS OF POSITIVE PRESSURE BOUNDARY
ML091520293	09/08/1993	Vogtle 2	**REACTOR TRIP** DUE TO TRIP OF REACTOR COOLANT PUMP (cabinet door housing the circuit breaker for the loop 4 reactor coolant pump (RCP) was jarred, door was stuck along the bottom edge due to paint buildup on the floor)
ML080240252	11/21/2007	Comanche Peak 1	**Emergency Diesel Generator** Inoperable for Longer Than Allowed by TS due to Paint on Metering Rod
ML091530463	09/07/1994	River Bend	VIOLATION OF TECHNICAL SPECIFICATIONS DUE TO INADEQUATE FIRE WATCH (during painting activities)
ML072890356	08/15/2007	River Bend	**Emergency Diesel Generator** Failed Surveillance Test due to Paint on Fuel Injector Control Linkage
ML091520514	01/20/1993	South Texas 1	Standby Diesel Generator 13 Failure to Start (due to paint)

NRC ROP FINDINGS REVIEW (for paint issues)

ROP PIM Reports - Event Dates: 01/01/1998 - 03/03/2009 - Generated on 03/3/09
By Types, Cornerstones, Event Dates, Sites
Key Word Search on "paint"
Significance: All
14 *Open/Closed Final* items selected - All Regions

Finding - **Green**	3
NonCited Violation - **Green**	10
Violation - **White**	1

Cross Cutting Areas:

- SCWE - *Safety Conscious Work Environment*
- HP - *Human Performance*
- PIR - *Problem Identification and Resolution*

Finding						
Mitigating Systems	06/29/2007	D.C. Cook	**Green**	*SCWE: N	*HP: N	*PIR: N
Docket/Status: , 05000316 (C)						
ADAMS ML072040388						
(PIM) Inadequate Foreign Material Exclusion Controls During Painting Surface Preparations Affected Operability of the Unit 2 AB EDG						
A finding of very low safety significance was identified through a self-revealing event. During painting surface preparation activities in the Unit 2 AB emergency diesel generator (EDG) room, the licensee failed to establish appropriate foreign material exclusion controls by allowing foreign material to collect on the EDG fuel injector pumps' metering rods. This resulted in an inoperable EDG when foreign material on one of the fuel injector pump metering rods became lodged in the pump and prevented the metering rod from further movement. No violation of regulatory requirements was identified. Corrective actions included verifying that the affected fuel injector pump metering rod was free to move, cleaning and lubricating the engine governor linkage, and cleaning other light dust from the engine and the room. The licensee also ran the other three EDGs to verify no common cause failure existed and then cleaned and lubricated the engine governor linkage after each of the runs. This finding was of more than minor significance because it is related to the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the Unit 2 AB EDG was rendered inoperable by foreign material present on the engine. The finding was of very low safety significance because it did not represent a design or qualification deficiency, loss of safety function for a single train for greater than its Technical Specification (TS) allowed outage time, and was not risk-significant due to						

external event initiators. The primary cause of this finding was not related to any of the cross-cutting areas because none of the cross-cutting aspects was determined to be a significant contributor to the finding.						
Mitigating Systems	03/31/2002	Quad Cities	**Green**	*SCWE: N	*HP: Y	*PIR: N
Docket/Status: , 05000265 (C)						
ADAMS ML021070149						
(PIM) CATASTROPHIC FAILURE OF 2B CONTROL ROD DRIVE PUMP						
On January 24, 2002, a catastrophic failure of the 2B control rod drive pump occurred approximately 4 days after conducting maintenance. The pump failure was caused by the inadequate lubrication of the inboard pump bearing due to the inappropriate setting of a constant level oiler. The root cause was that the constant level oiler was set approximately 15/64 of an inch lower than the specified setting due to maintenance personnel using a previously painted oil level reference line on the pump casing rather than a more exact installation method. No violations of NRC requirements were identified as a result of this event due to the control rod drive system being non-safety related. The finding was of very low safety significance. Although the finding represented an actual loss of safety function of one train of non-Technical Specification equipment designated as risk significant by the maintenance rule for greater than 24 hours, all remaining mitigating equipment remained available to respond to potential transients.						
Mitigating Systems	08/10/2000	Dresden	**Green**	*SCWE: N	*HP: N	*PIR: N
Docket/Status: , 05000249 (C)						
ADAMS ML003748060						
(PIM) Area temperature sensors used in Dresden Emergency Operating Procedure (EOP) 0300-01, "Secondary Containment Control" Revision 6, were inadvertently painted						
The inspectors noted that the area temperature sensors used in Dresden Emergency Operating Procedure (EOP) 0300-01, "Secondary Containment Control" Revision 6, were inadvertently painted. The paint could delay entry into the EOP by preventing the sensors from properly sensing area temperature. Through a Significance Determination Process Phase 1 screening, the inspectors concluded that the painted sensors did not result in the actual loss of any mitigating systems, and therefore the issue was of very low safety significance. (Section 1R04)						
NonCited Violation						
Initiating Events	12/31/2008	Point Beach	**Green**	*SCWE: N	*HP: Y	*PIR: N
Docket/Status: 05000266 (C) , 05000301 (C)						
ADAMS ML090370679						

(PIM) Inadequate Inspection Procedure for Containment Polar Crane Structures						
A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was self revealed for the failure to have inspection procedures appropriate to the circumstances for the Unit 1 and Unit 2 containment polar cranes and their integral support structures. Specifically, station routine maintenance procedure 1(2) RMP 9118 1(2), “Containment Building Crane OSHA Operability Inspections,” did not require that the polar crane lateral restraint bolts be inspected to ensure that they do not show signs of degradation or movement, e.g., flaking paint or being backed out of position. As a result, improperly installed bolts went undiscovered by the licensee until a failed bolt was found on October 16, 2008, lying on the containment floor. The discovery prompted further inspection of the entire crane support structure and led to the de rating of the polar crane’s lifting capacity from 100 tons to 40 tons. In addition to conducting an extent-of-condition inspection, the licensee entered the issue into its corrective action program (CAP), replaced all degraded bolts, and performed an apparent cause evaluation. The finding was determined to be more than minor because the finding was associated with the Initiating Events Cornerstone attribute of equipment performance and affected the cornerstone objective of limiting the likelihood of those events that challenge critical safety functions during shutdown. Specifically, failing to visually inspect critical bolting locations on crane supports could have allowed the use of the polar crane for heavy load lifts while in a degraded condition, increasing the likelihood of a load drop. The inspectors determined that the finding could be evaluated in accordance with IMC 0609, Appendix G, “Shutdown Operations SDP,” dated February 28, 2005. The issue did not need a quantitative assessment and screened as Green using Figure 1. This finding has a cross cutting aspect in the area of human performance, resources, for the failure to have complete and accurate procedures in place. Specifically, the vague and insufficient detail in the crane inspection procedures contributed to the licensee’s failure to perform an adequate inspection to identify degraded components prior to their failure [H.2(c)].						
Mitigating Systems	12/31/2005	Three Mile Island	**Green**	*SCWE: N	*HP: Y	*PIR: N
Docket/Status: 05000289 (C)						
ADAMS ML060310339						
(PIM) Deficient Procedural Compliance Resulted in Inadequate Control of Materials Brought into the Reactor Building Containment (Section 1R20)						
The inspectors identified a non-cited violation (NCV) of Technical Specification (TS) 6.8.1.a for multiple failures to properly implement procedural requirements and engineering instructions to ensure control of materials brought into the reactor building containment while the plant was at power. The procedural violation resulted in multiple deficient conditions that challenged plant safety, including; the potential for hydrogen generation beyond design due to significant amounts of stored scaffolding, aluminum toe plates, unqualified materials (lead insulation blankets, painted scaffolding, plastic bags) with potential for reactor building sump clogging, and unrestrained stored materials inside containment. The licensee entered these issues into the corrective action program (issue reports 387939, 388006, 388791, 388916, 388407, and 395100), performed a prompt investigation, an extent of condition review, and an operability						

determination for each of the issues identified. This finding is more than minor because it affected the reliability objective of the equipment performance attribute under the mitigating systems cornerstone. The finding is also associated with the barrier integrity cornerstone and the respective containment configuration control attribute. The finding is of very low safety significance because no equipment was rendered inoperable, and no actual open pathway in the physical integrity of the reactor containment occurred. The cause of the finding is related to the cross-cutting area of human performance, because station personnel did not comply with engineering instructions and established procedures for control of materials inside containment.						
Mitigating Systems	09/30/2005	Beaver Valley	**Green**	*SCWE: N	*HP: N	*PIR: Y
Docket/Status: , 05000412 (C)						
ADAMS ML053140051						
(PIM) DEGRADED SERVICE WATER SYSTEM PIPE SUPPORT						
The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," for inadequate and untimely corrective actions regarding a degraded (corroded) service water piping support that existed for approximately nine years. This finding is more than minor because if the corroded pipe support was left uncorrected, it would become a more significant safety concern in that the service water piping would not maintain structural integrity during a seismic event due to the corroded and inoperable pipe support, and result in a large service water leak that could impact safety-related equipment that require service water for cooling. This finding was considered to be of low safety significance because the pipe support was determined to be degraded by approximately 20 percent, but capable of performing its intended function. The licensee will update the design basis calculation to address the wall loss from corrosion, and has cleaned and painted the affected area to ensure further degradation does not occur. Additionally, system walkdown effectiveness was being evaluated due to the longstanding nature of this degradation. A contributing cause to this finding is related to the corrective action subcategory of the problem identification and resolution cross-cutting area, because the licensee failed to correct a long-standing degradation that existed in a pipe support for the safety-related service water system.						
Mitigating Systems	03/31/2005	Fort Calhoun	**Green**	*SCWE: N	*HP: N	*PIR: Y
Docket/Status: 05000285 (C)						
ADAMS ML051330248						
(PIM) Failure to include quantitative acceptance criteria for containment protective coatings inspection						
A noncited violation of 10 CFR Part 50, Appendix B, Criterion V, was identified based on the licensee's procedures not including appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished. Specifically, the containment protective coatings procedure did not contain appropriate criteria to inspect the						

condition of safety-related coatings. This finding affected the Mitigating Systems cornerstone and was considered more than minor because it affected the Procedure Quality attribute of the cornerstone. Specifically appropriate quantitative acceptance criteria was not provided to ensure that representative areas were selected for review within the coatings program. The finding was characterized under the significance determination process as having very low safety significance because the as-found reactor vessel head paint condition did not challenge the debris loading assumptions of the containment sumps and no actual loss of safety function occurred. Based on previous opportunities to recognize and correct this condition, a problem identification and resolution aspect was identified for this finding. This condition has been entered into the licensee's corrective action program.						
Mitigating Systems	09/30/2002	LaSalle	**Green**	*SCWE: N	*HP: N	*PIR: N
Docket/Status: 05000373 (C) , 05000374 (C)						
ADAMS ML023020679						
(PIM) Essential Switchgear Room Degraded Fire Barriers						
The inspectors identified dried paint on the side of a safety-related switchgear bus duct which led to the identification of openings between the Unit 1 and Unit 2 Division 1 and Division 2 Essential Switchgear Rooms. These openings compromised the 3-hour fire protection barrier separating the two fire zones. The issue was of very low safety significance since it was not likely that redundant safe shutdown equipment would be significantly impacted. A Non-Cited Violation of License Condition 25 concerning the LaSalle Unit 1 and Unit 2 Fire Protection Program was identified.						
Mitigating Systems	09/30/2000	Oconee	**Green**	*SCWE: N	*HP: N	*PIR: N
Docket/Status: , 05000270 (C)						
ADAMS ML003765107						
(PIM) Failure to Evaluate Flammable Material Use in the Unit 2 East Penetration Room						
The inspectors identified a non-cited violation of Paragraph 3.E of the Oconee Operating License for failure to follow the approved fire protection plan procedures when cleaning the floor in the Unit 2 east penetration room on September 15, 2000, with a flammable paint thinner. The licensee failed to evaluate and control the use of the flammable paint thinner before cleaning the floor with it, which constituted a degradation in the fire protection defense-in-depth strategy to prevent fires. This issue was determined to have very low safety significance because a fire in this area would not affect redundant safe shutdown functions (Section 1R05.2).						

Barrier Integrity	09/08/2005	Diablo Canyon	**Green**	*SCWE: N	*HP: Y	*PIR: N

Docket/Status: 05000275 (C) , 05000323 (C)

ADAMS ML053190124

(PIM) Failure to Implement Adequate Work Control for Activities That Can Affect The Control Room Boundary

A self-revealing noncited violation of Technical Specifications 5.4.1.a was identified for the failure to implement adequate work controls for painting activities in the area of control room ventilation equipment. Subsequently, the conduct of painting in the supply duct for Control Room Supply Fan S-38 resulted in operating fans drawing in the paint fumes into the control room. The work planning did not identify that the established ventilation path would result in the paint fumes entering the control room. The finding has crosscutting aspects associated with human performance in the planning of the work activity. This finding impacted the Barrier Integrity Cornerstone and was determined to be more than minor because if left uncorrected the finding could result in a more significant safety concern involving control of work activities that could affect the control room atmosphere. Using the Significance Determination Process Phase 1 Screening Worksheet in Appendix A of Inspection Manual Chapter 0609, the inspector considered that the issue represented an administrative control function for preventing paint fumes from entering the control room and the protection of the control room ventilation system charcoal filters. This issue was discussed with a senior reactor analyst and determined that the appropriate safety significance evaluation was through management review. The management review considered Pacific Gas and Electric Company's control of painting materials in and around the control room envelope, any potential impact on the charcoal filters used to maintain the radiological barrier in the event of an accident, and any potential impact on licensee personnel. Based on the introduction of paint fumes into the control room did not adversely affect the control room operators' ability to operate the plant, there was not an actual degradation of the control room boundary and the charcoal filters remained operable, the finding was determined to be of very low safety significance.

Barrier Integrity	12/31/2003	PALISADES	**Green**	*SCWE: N	*HP: N	*PIR: N

Docket/Status: 05000255 (C)

ADAMS ML040230196

(PIM) Failure of Containment Spray Pump P-54C Inboard Motor Bearing

A finding of very low safety significance was self-revealed when the Containment Spray Pump P-54C inboard motor bearing failed on August 21, 2003. Following a scheduled oil change on the motor bearing, the bearing housing drain plug was also replaced and enough oil was lost during this drain plug replacement to uncover the bearing; however, the vent on the oiler had been plugged when the pump was painted in June 2002 which resulted in an erroneous level indication in the oiler for the bearing housing. Consequently, the operator did not add sufficient oil through the oiler to the bearing housing after the drain plug was replaced. As a result, the

inboard motor bearing was inadequately lubricated which caused the bearing to fail when Containment Spray Pump P-54C was started. This finding was more than minor because if left uncorrected, it would become a more significant safety concern. Specifically, the painted vent hole on the motor bearing oiler resulted in erroneous oil level indication and prevented the oiler from adding oil to the bearing housing when the level decreased. Consequently, an inadequately lubricated bearing would not be detected until the bearing failed. The finding was of very low safety significance because it did not represent an actual reduction of the atmospheric pressure control function of the reactor containment. Corrective actions to address this issue included clearing the vent hole on the bearing oiler, verifying that the oiler vent holes on other safety-related pump motors were not painted over and replacing the inboard motor bearing on Containment Spray Pump P-54C. One Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," was identified.						
Barrier Integrity	09/30/2003	Prairie Island	**Green**	*SCWE: N	*HP: N	*PIR: N
Docket/Status: 05000282 (C) , 05000306 (C)						
ADAMS ML033040227						
(PIM) FAILURE TO ESTABLISH APPROPRIATE QUANTITATIVE/QUALITATIVE ACCEPTANCE CRITERIA						
Green. A finding of very low safety significance was identified by inspectors during a plant status review of scheduled surveillance testing and daily work. The licensee concurrently scheduled the performance auxiliary building special ventilation system surveillance tests while conducting painting in areas of the auxiliary building that communicated with the ventilation system. The primary cause for the finding was inadequate procedural guidance in the licensee's procedure for the protection of pre-, absolute, and charcoal ventilation filters from contamination. The finding was determined to be more than minor since if left uncorrected the condition would become a more significant safety concern as additional operation of the auxiliary building special ventilation system occurred concurrently with painting activities and would eventually have resulted in the inoperability of the auxiliary building special ventilation system filter units. The finding only represents a degradation of the radiological barrier function provided for the auxiliary building and has been determined to be a finding of very low safety significance. The finding was determined to be a violation 10 CFR Part 50, Appendix B, Criterion V, for a failure to include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished.						
Public Radiation Safety	01/30/2004	San Onofre	**Green**	*SCWE: N	*HP: N	*PIR: N
Docket/Status: , 05000362 (C)						
ADAMS ML040720322						
(PIM) The licensee failed to follow radiation protection procedures related to the release of radioactive material from the protected area-magenta- painted hose with total fixed activity of 40 nanocuries.						

The licensee failed to follow radiation protection procedures related to the release of radioactive material from the protected area - magenta-painted hose with total fixed activity of 40 nanocuries. A self-revealing, non-cited violation of Technical Specification 5.5.1 was reviewed by the team because the licensee failed to follow radiation protection procedures related to the release of radiative material from the protected area. Specifically, on November 6, 2003, the licensee discovered one magenta-painted hose in a 55 gallon drum which had been stored in the Mesa rea (outside the protected area) since January 1998. The licensee surveyed the hose and determined that it contained a total fixed activity of 40 nanocuries. The finding was greater than minor because it is associated with the cornerstone attribute (material release) and it affected the associated cornerstone objective (to ensure adequate protection of public health and safety from exposure to radioactive material released into the public domain). The finding involved an occurrence in the licensee's radioactive material control program that was contrary to licensee procedures. This finding was evaluated as having very low safety significance using the Public Radiation Safety Significance Determination Process because the finding was a radioactive material control issues, was not a transportation issue, public exposure was not greater than 5 millimrem, and there were less than 5 occurrences over the past rolling 8 quarters. The finding was greater than minor because it is associated with the cornerstone attribute (material release) and it affected the associated cornerstone objective (to ensure adequate protection of public health and safety from exposure to radioactive material released into the public domain). The finding involved an occurrence in the licensee's radioactive material control program that was contrary to licensee procedures. This finding was evaluated as having very low safety significance using the Public Radiation Safety Significance Determination Process because the finding was a radioactive material control issues, was not a transportation issue, public exposure was not greater than 5 millirem, and there were less than 5 occurrences over the past rolling 8 quarters.						
Violation						
Mitigating Systems	06/06/2008	Comanche Peak	**White**	*SCWE: N	*HP: Y	*PIR: N
Docket/Status: 05000445 (C)						
ADAMS ML081930568						
(PIM) Painting Activities Result in Inoperability of Emergency Diesel Generator						
The U.S. Nuclear Regulatory Commission performed this supplemental inspection to assess the licensee's evaluation associated with a White finding (failure of Unit 1 Train B Emergency Diesel Generator 1-02) in the first quarter of 2008. The primary reason for this finding being characterized as White was based on the results of a Phase 3 analysis performed by a region-based senior reactor analyst. The failure of Emergency Diesel Generator 1-02 was attributed to paint being deposited in a location that caused the EDG to fail to start on demand.						