UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D.C. 20555-0001

August 31, 2026

Michael Schultheis
Site Vice President
Palisades Energy, LLC
Palisades Nuclear Plant
27780 Blue Star Memorial Hwy
Covert MI 49043-9530

SUBJECT: PALISADES NUCLEAR PLANT - NRC INSPECTION REPORT 05000255/2026090

Dear Michael Schultheis:

On March 20, 2026, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at Palisades Nuclear Plant. On August 12, 2026, the NRC inspectors discussed the results of this inspection with you and other members of your staff. The results of this inspection are documented in the enclosed report.

Two findings of very low safety significance (Green) are documented in this report. Two of these findings involved violations of NRC requirements. We are treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violations or the significance or severity of the violations documented in this inspection report, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555 0001; with copies to the Regional Administrator, Region III; 2056 Westings Avenue, Suite 400, Naperville, IL 60563; the Director, Division of Reactor Projects; and NRC Resident Inspector at Palisades Nuclear Plant.

If you disagree with a cross-cutting area assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555 0001; with copies to the Regional Administrator, Region III; 2056 Westings Avenue, Suite 400, Naperville, IL 60563; the Director, Division of Reactor Projects; and the NRC Resident Inspector at Palisades Nuclear Plant.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at http://www.nrc.gov/reading-rm/adams.html and at the NRC Public Document Room in accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

 Signed by April Nguyen Signing on behalf of Michael Ziolkowski on 08/31/26

Michael E. Ziolkowski, Chief
Division of Reactor Safety
Plant Support Branch
Region III

Docket No. 05000255

License No. DPR-20

Enclosure:
As stated

cc: w/ encl: distribution via digital
communications platform

Letter to Michael Schultheis from Michael E. Ziolkowski dated August 31, 2026.

SUBJECT: PALISADES NUCLEAR PLANT - NRC INSPECTION REPORT 05000255/2026090

DISTRIBUTION:
Eric Stamm
RidsNrrPMPalisades Resource
RidsNrrDlp1Orlb3
RidsNrrDroIrib Resource
Mohammed Shuaibi
Diana Betancourt-Roldan
Deborah Piskura
All-CNRI-R3DRS-Staff
All-CNRI-R3DRP-Staff

ADAMS Accession Number: ML26245A104
PKG: ML26243A262
e-Concurrence case: 20260831-02186

U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Number:	05000255
License Number:	DPR-20
Report Number:	05000255/2026090
Enterprise Identifier:	I-2026-090-0007
Licensee:	Palisades Energy, LLC
Facility:	Palisades Nuclear Plant
Location:	Covert, MI
Inspection Dates:	February 23, 2026 to March 20, 2026
Inspectors:	J. Cassidy, Senior Health Physicist V. Myers, Senior Health Physicist S. Orth, Senior Health Physicist
Approved By:	Michael E. Ziolkowski, Chief Division of Reactor Safety Plant Support Branch Region III

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting an inspection at Palisades Nuclear Plant, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to https://www.nrc.gov/reactors/operating/oversight.html for more information.

List of Findings and Violations

Failure to implement the radiation protection program for work activities with high alpha contamination levels			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Occupational Radiation Safety	Green NCV 05000255/2026090-01 Open/Closed	Problem Identification and Resolution	71124.01
The inspectors identified a Green Finding and associated Non-Cited Violations (NCVs) of T.S 5.4.1, 10 CFR 20.1501, 10 CFR 20.1702, 10 CFR 20.1902 and 10 CFR 20.1101 when the licensee failed to implement its radiation protection program for work activities with high alpha contamination levels.			

Failure to Monitor Internal Dose			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Occupational Radiation Safety	Green NCV 05000255/2026090-02 Open/Closed	Human Performance	71124.04
The NRC identified a Green finding and associated Non-Cited Violation (NCV) of 10 CFR 20.1502 when the licensee failed to assess internal dose for various individuals in elevated airborne areas.			

Additional Tracking Items

None.

PLANT STATUS

On August 25, 2025, Palisades notified the NRC that they rescinded their Title 10 of the *Code of Federal Regulations* (10 CFR) 50.82(a)(1) certification, which removed the prohibition on operation and emplacement of fuel in the reactor. Palisades also implemented the set of licensing actions to support reimplementation of their operational licensing basis. On August 25, 2025, the NRC transitioned oversight of Palisades to the Reactor Oversight Process (ROP).

The NRC is conducting inspections to evaluate and assess the licensee's activities for restoration to an operating status. The resident inspectors, as well as supplemental inspectors, continue to provide daily oversight of the restart activities occurring at the site.

The unit ended the inspection period in a defueled status.

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

RADIATION SAFETY

71124.01 - Radiological Hazard Assessment and Exposure Controls

Radiological Hazard Assessment (IP Section 03.01) (1 Sample)

(1) The inspectors evaluated how the licensee identifies the magnitude and extent of radiation levels, identifies the concentrations and quantities of radioactive materials, and assesses radiological hazards.

Instructions to Workers (IP Section 03.02) (1 Sample)

(1) The inspectors evaluated how the licensee instructs workers on plant-related radiological hazards and the radiation protection requirements intended to protect workers from those hazards.

Contamination and Radioactive Material Control (IP Section 03.03) (2 Samples)

The inspectors observed/evaluated the following licensee processes for monitoring and controlling contamination and radioactive material:

(1) licensee surveys of potentially contaminated material leaving the radiologically controlled area

(2) workers exiting the radiologically controlled area

Radiological Hazards Control and Work Coverage (IP Section 03.04) (3 Samples)

The inspectors evaluated the licensee's control of radiological hazards for the following radiological work:

(1) tilt pit work activities: During review of tilt pit work activities, the inspectors identified elevated airborne radioactivity levels. Per IMC 0309, “Reactive Inspection Decision Basis for Power Reactors,” the NRC considered whether this inspection sample should be the subject of a reactive inspection and determined that a reactive inspection was not necessary, as documented in ADAMS Nos. ML26063A512 and ML26110A280.
(2) shutdown cooling heat exchanger work activities: During review of shutdown cooling heat exchanger work activities, the inspectors identified elevated airborne radioactivity levels. Per IMC 0309, “Reactive Inspection Decision Basis for Power Reactors,” the NRC considered whether this inspection sample should be the subject of a reactive inspection and determined that a reactive inspection was not necessary, as documented in ADAMS Nos. ML26063A512 and ML26110A280.
(3) preparation for primary system passivation

High Radiation Area and Very High Radiation Area Controls (IP Section 03.05) (3 Samples)

The inspectors evaluated licensee controls of the following high radiation areas (HRAs) and very high radiation areas (VHRAs):

(1) Locked High Radiation Area (LHRA) for the reactor head laydown area
(2) LHRA controls for the old boronometer room
(3) Walkdowns of HRA posting and controls for passivation

Radiation Worker Performance and Radiation Protection Technician Proficiency (IP Section 03.06) (1 Sample)

(1) The inspectors evaluated radiation worker and radiation protection technician performance as it pertains to radiation protection requirements.

71124.03 - In-Plant Airborne Radioactivity Control and Mitigation

Temporary Ventilation Systems (IP Section 03.02) (1 Sample)

The inspectors evaluated the configuration of the following temporary ventilation systems:

(1) South tilt pit

Use of Respiratory Protection Devices (IP Section 03.03) (1 Sample)

(1) The inspectors evaluated the licensee’s use of respiratory protection devices.

Self-Contained Breathing Apparatus for Emergency Use (IP Section 03.04) (1 Sample)

(1) The inspectors evaluated the licensee’s use and maintenance of self-contained breathing apparatuses.

71124.04 - Occupational Dose Assessment

Source Term Characterization (IP Section 03.01) (1 Sample)

(1) The inspectors evaluated licensee performance as it pertains to radioactive source term characterization.

Internal Dosimetry (IP Section 03.03) (3 Samples)

The inspectors evaluated the following internal dose assessments:

(1) Internal dose assessment for PCE 2025-0008
(2) Internal dose assessment performed for condition report 25015324
(3) Lapel air sample results for numerous individuals

INSPECTION RESULTS

<table>
<tr><td colspan="4">Failure to implement the radiation protection program for work activities with high alpha contamination levels</td></tr>
<tr><td>Cornerstone</td><td>Significance</td><td>Cross-Cutting Area</td><td>Report Section</td></tr>
<tr><td>Occupational Radiation Safety</td><td>Green
NCV 05000255/2026090-01
Open/Closed</td><td>Problem Identification and Resolution</td><td>71124.01</td></tr>
<tr><td colspan="4">The inspectors identified a Green Finding and associated Non-Cited Violations (NCVs) of T.S 5.4.1, 10 CFR 20.1501, 10 CFR 20.1702, 10 CFR 20.1902 and 10 CFR 20.1101 when the licensee failed to implement its radiation protection program for work activities with high alpha contamination levels.</td></tr>
<tr><td colspan="4">Description:

During discussions with site personnel and observing fuel handling system work in the tilt pit, the inspectors became aware of recent elevated airborne radioactivity samples, and that additional High Efficiency Particulate Air (HEPA) ventilation was recently installed for the on-going work activities. A review of requested air sample records indicated that on 2/11/26 and 2/13/26, the airborne radioactivity in the tilt pit reached levels of 173 Derived Air Concentration (DAC) and 469 DAC respectively. The tilt pit was posted as an Airborne Radioactivity Area (ARA) and individuals inside the tilt pit were wearing respirators and personal air samplers for internal dosimetry (lapels) in accordance with the Radiation Work Permit (RWP). Support activities were performed by individuals on the floor above and surrounding the tilt pit. Airborne radioactivity levels for this area on 2/11 and 2/13 reached 2.21 DAC and 3.82 DAC respectively. This area was not posted as an ARA and the stop work criteria in this location was 0.3 DAC. Individuals performing support functions in this location were not wearing respirators but were wearing lapel air samplers. Based on this information, the inspectors reviewed aspects of the site’s planning and work control for this work activity.

This work was controlled under RWP 20250633, Reactor Cavity Fuel Handling Equipment Upgrade. On 9/15/25, after drain down of the tilt pit, a survey was performed to establish radiological conditions. This survey included contamination surveys on the framework and upender, and identified up to 25,510 dpm/100cm2 alpha. This survey was used as the basis for establishing controls in the RWP. This included a calculation to establish expected</td></tr>
</table>

airborne radioactivity levels of 3.95 DAC, an assessment of respiratory protection based on the expected levels, and stop work criteria of 500K dpm/100cm2 alpha contamination, and 30 DAC for airborne radioactivity.

Procedure EN-RP-141, Job Coverage, requires that surveys be sufficient to identify the radiological hazards associated with the job being covered. On 2/11/26 maintenance personnel entered the tilt pit to work on the tilt pit floor. However, the survey performed on 9/15/25, which was used to establish the RWP controls, did not include contamination surveys of the floor. On 2/13/26 another entry was made into the tilt pit for a radiation protection technician to perform a contamination survey and to apply an adhesive fixative to tilt pit floor. The contamination survey on the floor taken at this time indicated alpha contamination of 6.5 million dpm/100cm2, which is well above the contamination levels from the 9/15/25 survey and the stop work criteria of the RWP. This demonstrates that the survey performed on 9/15/25 was insufficient to identify the radiological hazard associated with the work activities conducted on 2/11/26, and a contamination survey of the floor should have been performed prior to allowing worker entry on 2/11/26.

A continuous air monitor (CAM) was in the same room as the work being conducted; however, it was not near the work, and the CAM did not detect alpha radiation. As the airborne radioactivity was heavily driven by alpha (172 out of 173 DAC and 468 out of 469 DAC respectively), this monitor did not provide real time airborne radioactivity monitoring for this work. In addition, the air samples collected inside the tilt pit and just above the tilt pit were taken for the duration of the work each shift and analyzed after work was completed and workers had already exited the area. Therefore, there was no real time, or near real time, monitoring for airborne radioactivity.

Procedure EN-RP-105, Radiological Work Permits (RWPs), requires documentation of planned engineering controls, such as the use of HEPA ventilation. Specifics on engineering controls for this work were not identified in the RWP or other planning documents and no revisions were made when the existing engineering controls were demonstrated to be insufficient, as evidenced by the repeated exceedance of the stop work criteria established in the RWP. Initially, a single 125 cfm HEPA unit was installed for the tilt pit. On 2/12/26, a second 125 cfm HEPA was installed, and a third 2,500 cfm HEPA unit was installed on or around 2/17/26. However, air samples collected during multiple shifts identified that the stop work criteria for airborne radioactivity was exceeded. Additional actions, such as wetting the tilt pit walls were performed after each exceedance. This continued, unsuccessfully, until the conditions were evaluated as an engineering issue and resulted in the construction of a full tent erected over the tilt pit. This engineered action increased effectiveness by increasing the number of air changeouts in the smaller defined space, while reducing the resuspension of particles by reducing the number HEPA units in the tilt pit.

Procedure EN-RP-141, Job Coverage, requires certain actions when initiating stop work authority. Specifically, that the Radiation Protection Supervisor, Radiation Protection Manager, and outage management must be notified of the stop work and a condition report must be initiated. On multiple occasions these communications were not made, and condition reports were not generated for instances in which stop work criteria were met. Additionally, although the tilt pit was posted as an ARA, the floor above the tilt pit was not. The inspectors reviewed records for 2/11 and 2/13 when the air samples taken next to the tilt pit indicated 2.21 DAC and 3.82 DAC respectively in this location. Due to the containment equipment hatch being near the tilt pit, the area around the tilt pit was frequently occupied by individuals performing other work activities. RP-131, Air Sampling, requires certain actions when an air sample

exceeds 0.3 DAC in an area not already posted and controlled as an ARA. This includes 1) stop work, 2) evacuate workers from the area, 3) collect grab samples to determine if airborne concentrations are sustained and to identify the source if unknown, 4) inform workers without respirators that airborne activity was measured and potential exposures will be evaluated, 5) if conditions may still exist or are unknown, post the area as an ARA, 6) notify RP supervision, and 7) document the occurrence in the corrective action program. For the elevated levels seen on 2/11/26, a grab sample was not taken until approximately eight hours later. For the elevated levels seen on 2/13/26, a grab sample was not taken until approximately sixteen hours later. Workers were not evacuated from the area or informed of the ARA conditions, the area was not posted or controlled as an ARA, and these occurrences were not documented in the corrective action program.

The inspectors reviewed another work activity with similar radiological hazards, which was the opening and inspection of the shutdown cooling heat exchanger. This activity was covered under RWP 20250574, Eddy Current Inspections on E-60B Shutdown Cooling Heat Exchanger. This area was posted as an ARA, alpha III, and required respiratory protection and lapels for entry. The stop work criteria for these work activities included 200,000 dpm/100 cm2 alpha contamination and 40 DAC airborne radioactivity inside the enclosure. Initial surveys taken upon opening of the heat exchanger on 12/23/25 showed alpha contamination in a range of 700 dpm/100cm2 to 9.6 million dpm/100cm2. An air sample taken during this evolution showed airborne radioactivity of 56.1 DAC (55.9 DAC from alpha). For this work activity, this was the first opportunity RP had to perform surveys to assess radiological conditions against those assumed in the RWP. No further entries were made until 12/26/25, when RP entered the area to perform decontamination efforts. Post decontamination surveys indicated contamination levels below the stop work criteria.

The inspectors reviewed contamination surveys taken in the area during subsequent heat exchanger inspections and identified one smear above the stop work criteria for alpha contamination, at 680,000 dpm/100 cm2. In addition, the inspectors reviewed air sampling records and identified two instances in which the stop work criteria of 40 DAC was exceeded. One air sample record was taken on 1/6/26 for the duration of the work activity and indicated 890 DAC (888 DAC alpha) when analyzed after individuals had left the area. The next air sample taken in this location was performed on 1/7/26, during the next work evolution in the area, and indicated 6.7 DAC at that time. On 1/9/26, another air sample result indicated airborne radioactivity of 61.5 DAC. The next air sample taken in this location was performed on 1/10/26, during the next work evolution in the area, and indicated 0.97 DAC at that time. The air sample records exceeding the stop work criteria of 40 DAC contained no remarks, condition reports were not initiated for exceeding the stop work criteria, and the inspectors did not identify any communications and/or actions taken in response to these results. In addition to air sample records in the work area, the inspectors reviewed air sample records for the area adjacent to the work area, which was not controlled as an ARA or alpha III area, therefore no respiratory protection or lapels were required. This area was a staging/support area for the heat exchanger work and was frequently occupied. These records showed levels that would have required posting and controlling the area as an ARA on several occasions; including on 12/29/25 with 5.8 DAC, on 1/6/26 with 1.7 DAC, and on 1/9/26 with 3.8 DAC. The inspectors did not identify any condition reports related to these elevated readings and could not identify any actions taken by the site in response to the results. The inspectors reviewed various other air sample records in nearby locations and individual lapel records around the times of these elevated readings and did not identify any instances in which occupational dose limits were challenged.

Corrective Actions:

The licensee established a review process for upcoming high radiological risk activities to validate appropriate controls were planned and executed. In addition, the licensee initiated a root cause evaluation to further review the issues and identify appropriate corrective actions.

Corrective Action References: CR 26012884

Performance Assessment:

Performance Deficiency: The licensee failed to implement and maintain its radiation protection program for work activities with high alpha contamination levels. This was reasonably within the licensee's ability to foresee and correct and could have been prevented.

Screening and Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix C, “Occupational Radiation Safety SDP” The Performance Deficiency (PD) was determined to be more than minor because it resulted in 100 mrem or more of unplanned, unintended effective dose to a single individual. Specifically, several lapel air sample results from work on the tilt pit indicated internal doses greater than 100 mrem when no internal exposure was planned. The PD was determined to be Green because it did not involve an overexposure (i.e., no regulatory dose limit was exceeded).

Cross-Cutting Area: Problem Identification and Resolution

The organization did not implement a corrective action program with a low threshold for identifying issues. Specifically, the issues with high alpha contamination levels and airborne radioactivity were not promptly raised to sufficient levels to initiate timely corrective actions to prevent repeated occurrences.

Enforcement:
Violations:

Technical Specification (TS) 5.4.1 requires that procedures be established, implemented, and maintained covering activities in Regulatory Guide 1.33, Revision 2, Appendix A. RG 1.33, Revision 2, Appendix A includes radiation protection procedures for radiation permits, radiation surveys, airborne radioactivity monitoring, and contamination control. Contrary to the above, from December 2025 through February 2026, the licensee failed to implement procedures established in accordance with TS 5.4.1. Specifically, the licensee failed to implement portions of EN-RP-141, EN-RP-105, and RP-131 for work activities associated with the tilt pit and shutdown cooling heat exchanger.

Title 10 CFR 20.1501 requires that the licensee make or cause to be made surveys of areas that may be necessary to comply with the regulations in 10 CFR Part 20 and are reasonable under the circumstances to evaluate the potential radiological hazards of radiation levels and residual radioactivity detected. 20.1701 requires the licensees use, to the extent practical, process or other engineering controls to control the concentration of radioactive material in air. Contrary to the above, from December 2025 through February 2026, the licensee failed to perform adequate surveys to comply with the regulations in 20.1701. Specifically, over different radiological work activities, the licensee failed to assess contamination and airborne radioactivity measurements to ensure that the established process and engineering controls would be/were sufficient.

Title 10 CFR 20.1702 requires, in part, that when it is not practical to apply process or other engineering controls to control the concentrations of radioactive material in the air to values below those that define an ARA, the licensee shall increase monitoring and limit intakes by use of controls. Contrary to the above, From December 2025 through February 2026, the licensee failed to control areas not maintained below the levels of an ARA. Specifically, the areas around the tilt pit and shutdown cooling heat exchanger indicated airborne radioactivity above the ARA threshold and no action were taken by the licensee to control these areas.

Title 10 CFR 20.1902 requires that licensees post each ARA with a conspicuous sign or signs bearing the radiation symbol and the words “CAUTION (or DANGER), AIRBORNE RADIOCTIVITY AREA”. Contrary to the above, on multiple occasions between December 2025 and February 2026, the licensee failed to post ARAs around the tilt pit and shutdown cooling heat exchanger.

Title 10 CFR 20.1101 requires that each licensee develop, document, and implement a radiation protection program commensurate with the scope and extent of licensed activities and sufficient to ensure compliance with the provisions of this part. Contrary to the above, from December 2025 to February 2026, the licensee did not develop, document, and implement a radiation program commensurate with the scope and extent of licensed activities and sufficient to ensure compliance with the provisions of 10 CFR Part 20. Specifically, the licensee’s radiological source term has changed significantly enough that the established protocols did not adequately address managing the alpha contamination levels or establishing adequate administrative and engineering controls.

Enforcement Action: These violations are being treated as non-cited violations, consistent with Section 2.3.2 of the Enforcement Policy.

Failure to Monitor Internal Dose			
Cornerstone	Significance	Cross-Cutting Area	Report Section
Occupational Radiation Safety	Green NCV 05000255/2026090-02 Open/Closed	Human Performance	71124.04
The NRC identified a Green finding and associated Non-Cited Violation (NCV) of 10 CFR 20.1502 when the licensee failed to assess internal dose for various individuals in elevated airborne areas.			

Description:

The inspectors reviewed all lapel results for individuals performing work activities in and around the tilt pit on February 11 and 13, 2026, when general area air samples identified elevated airborne radioactivity. Lapels are personal air samplers that monitor the breathing zone of workers and are a dosimeter used to assess the internal dose, Committed Effective Dose Equivalent (CEDE), received by intake of radioactive material.
The licensee’s procedures for internal monitoring include the following:

1. EN-RP-122, Alpha monitoring, requires that lapels be used by each individual involved in work activities in alpha level 3 areas.

2. RP-131, Air Sampling, requires 1) that if the final activity of a lapel is equal to or greater than the activity corresponding to 10 mrem CEDE, perform a lapel CEDE Calculation per RP-203, Dose Assessment, and to contact the RP supervisor to evaluate the CEDE and 2) that an assessment of potential doses be performed for workers in an ARA without respiratory protection.
3. RP-203, Dose Assessments, requires various actions related to internal dose assessment, including: 1) a worker's dosimetry record be updated if the calculated dose is 10 mrem or more, 2) for calculations greater than or equal to 100 mrem CEDE, bioassays must be initiated and a condition report must be written and 3) the results of the CEDE calculation must be forwarded to the dosimetry supervisor for review.

Three lapel results reviewed by the inspectors indicated a CEDE greater than the site's investigation threshold of 10 mrem CEDE (20 mrem, 48 mrem, and 311 mrem CEDE). The licensee annotated these results with handwritten notes indicating the samples were cross contaminated and referenced a worksheet. The worksheet showed the relative amount of activity on each half and/or quarter of a lapel to try to identify if it was cross contamination or a true measurement of the amount of airborne radioactive material within the breathing zone of the worker. The worksheet included gross activity, but there was no evaluation of the data, and the process is not described in site procedures. The worksheet provided to the inspectors included a total of 29 lapel results, since January 1, 2026, all of which had exceeded the 10 mrem CEDE investigation threshold.

Using the data provided in the worksheet, the inspectors requested the results of an additional four lapels for review. One of the lapels was from work removing the reactor vessel head gasket on 1/9/26 with a result of 257 mrem CEDE. Two of the lapels were from work on 1/10/26 for installing the reactor vessel head o-ring with doses of 150 mrem and 223 mrem CEDE. The fourth lapel was from housekeeping activities in the West Engineering Safeguards room on 2/10/26 with a dose of 690 mrem CEDE. Based on a review of the information provided to the inspectors and discussion with site staff in February and March 2026, none of the requirements in RP-203, for performing dose estimates, were completed for any of the lapel results greater than 10 mrem CEDE that were referenced on the worksheet.
In addition, the inspectors identified air sample results in the area around the tilt pit, meeting the definition of an ARA on February 11 & 13 of 2026. In addition to the individuals directly supporting the work in the tilt pit, individuals would have been present in the area without lapels or respiratory protection. For example, the containment equipment hatch, which was the routine entry/exit point for containment, was near the tilt pit and routinely had individuals in this area. An assessment of potential doses for these individuals was not performed in accordance with RP-131, Air Sampling.

The licensee's prospective evaluation for determining if individuals are likely to receive internal dose to such a degree that internal monitoring is required has determined that internal monitoring is generally not required. However, the inspectors determined that this evaluation was based on historical radiological conditions and work activities that did not reflect the radiological conditions for the work activities reviewed. In addition, the prospective evaluation states that dose evaluations for unusual/unanticipated exposure events would constitute required monitoring, consistent with Regulatory Guide 8.34, Monitoring Criteria and Methods to Calculate Occupational Radiation Doses. Therefore, the inspectors determined that for the instances reviewed, monitoring was required. 10 CFR Part 20 defines monitoring as the measurement of radiation levels, concentrations, surface area concentrations or quantities of radioactive material and the use of the results of these measurements to

evaluate potential exposure and doses. Although the licensee had provided internal dosimetry in the form of lapels, they failed to use the results of those measurements; and therefore, did not provide monitoring.

Corrective Actions:
The licensee performed an extent of condition from November 2025 forward to identify what lapel air sample results needed evaluations and has started these evaluations. In addition, the licensee conducted a root cause evaluation to identify appropriate corrective actions to address procedural and programmatic issues.

Corrective Action References: CR 26012884

Performance Assessment:

Performance Deficiency: The licensee failed to monitor internal dose for individuals impacted by elevated airborne radioactivity in accordance with established procedures. Specifically, on numerous occasions from January 2026 to March 2026, the licensee failed to 1) assess the potential doses to workers in unposted ARAs in accordance with EN-RP-131, Air Sampling, and 2) perform internal dose evaluations on individuals for whom their internal dosimetry results exceeded the activity level that would equate to 10 mrem CEDE, in accordance with RP-131, Air Sampling, and EN-RP-203, Dose Assessment. This was reasonably within the licensee's ability to foresee and correct and could have been prevented.

Screening and Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix C, “Occupational Radiation Safety SDP” The Performance Deficiency (PD) was determined to be more than minor because there was a failure of the personnel monitoring radiation protection program barrier. Specifically, there were program deficiencies that resulted in a failure to account for exposures that exceeded, or could have exceeded, an acute intake of radionuclides greater than 0.02 annual limit on intake (ALI) per individual (which equates to 100 mrem CEDE), meeting the definition of a compromised ability to assess dose. The PD was determined to be Green because it did not involve an overexposure (i.e., no regulatory dose limit was exceeded).

Cross-Cutting Area: Human Performance

The licensee failed to follow processes and procedures for assessing internal dose.

Enforcement:

Violation:
10 CFR 20.1502 requires, in part, that licensees monitor exposure to radiation and radioactive material at levels sufficient to demonstrate compliance with occupational dose limits of 10 CFR Part 20. At a minimum, each licensee shall monitor the occupational intake of radioactive material by and assess the CEDE to adults likely to receive an intake in excess of 10 percent of the Annual Limit of Intake. Contrary to the above, from January 1, 2026 to February 23, 2026, the licensee failed to monitor the occupational intake of radioactive material by and assess the CEDE to multiple individuals for whom monitoring was required.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On March 20, 2026, the inspectors presented the preliminary results to Michael Schultheis, Site Vice President, and other members of the licensee staff.
- On August 12, 2026, the inspectors presented the final inspection results to Michael Schultheis, Site Vice President, and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71124.01	Corrective Action Documents	25015255	Individual Received Dose Alarm	12/16/2025
		25015324	Working Through Fault Alarm	12/18/2025
		25015327	Worker in LHRA with No SRD	12/18/2025
		26010125	LHRA Discovered Unlocked	01/06/2026
	Corrective Action Documents Resulting from Inspection	26012832	RWP 2025-0633 revision 3 documentation is missing from RWP package	03/19/2026
		26012847	Contamination Survey Not Found	03/19/2026
		26012848	Posting Discrepancy Identified during NRC Inspection	03/19/2026
		26012851	Guidance on Stop Work Authority In EN-RP-141, Job Coverage	03/19/2026
		26012853	Condition Report Not Generated When RWP Stop Work Criteria Met	03/19/2026
		26012884	Radiation Protection Program Not Effectively Maintained to Account for Changes for Alpha Contamination	03/20/2026
	Miscellaneous	EN-RP-503, Attachment 9.11	Methodology For Estimating Airborne Radioactivity for RWP 20250633	0
		EN-RP-503, Attachment 9.11	Methodology for Estimating Airborne Radioactivity for RWP 20250574	0
		EN-RP-503, Attachment 9.12	TEDE-ALARA Evaluation Screening Worksheet for RWP 20250633	0
		EN-RP-503, Attachment 9.12	TEDE-ALARA Evaluation Screening Worksheet for RWP 20250574	0
	Procedures	EN-RP-122	Alpha Monitoring	10
		EN-RP-141	Job Coverage	10
		EN-RP-304	Operation of Counting Equipment	6
		RP-105	Radiological Work Permits	0

		RP-108	Radiation Protection Posting	0
		RP-131	Air Sampling	0
	Radiation Surveys	2025-1784	South Tilt Pit	09/15/2025
		2025-2405	West Engineered Safeguards Heat Exchanger Bolt Removal	12/23/2025
		2025-2410	West Engineered Safeguards Heat Exchanger Breach	12/23/2025
		2025-2421	E-60B Pre/Post Decon	12/26/2025
		2025-2425	E-60B Eddy Current Set Up	12/27/2025
		2025-2436	E-60B Eddy Current	12/30/2025
		2025-2442	E-60B Tube Plugging	01/6/2026
		2026-0006	E-60B Eddy Current Activities	01/02/2026
		2026-0060	E-60B Downpost	01/10/2026
		AS-010726-020773	Air Sample for West Engineered Safeguards	01/06/2026
		AS-010726-020774	Air Sample for East Engineered Safeguards	01/06/2026
		AS-010926-021123	Air Sample for East Engineered Safeguards	01/09/2026
		AS-011026-021213	Air Sample for West Engineered Safeguards	01/100/26
		AS-021126-024278	Air Sample Inside Tilt Pit	02/11/2026
		AS-021126-024280	Air Sample Top Side of Tilt Pit	02/11/2026
		AS-021226-024350	Air Sample Top Side of Tilt Pit	02/12/2026
		AS-021326-024446	Air Sample Inside Tilt Pit	02/13/2026
		AS-021326-024447	Air Sample Top Side of Tilt Pit	02/13/2026
		AS-021426-024501	Air Sample Top Side of Tilt Pit	02/14/2026
		AS-122325-022905	Air Sample for West Engineered Safeguards for end bell removal	12/23/2025
		AS-122325-022913	Air Sample for West Engineered Safeguards for End Bell Removal Entrance	12/23/2025
		AS-122325-022914	Air Sample for East Engineered Safeguards for End Bell Removal	12/23/2025

		AS-122925-023112	Air Sample in East Engineered Safeguards	12/29/2025
	Radiation Work Permits (RWPs)	20250431	Spent Fuel Side South Tilt Pit and Transfer Tube Decon, Entries for Carriage Removal	0-3
		20250574	Eddy Current Inspections on E-60B Shutdown Cooling Heat Exchanger	0-1
		20250633	Reactor Cavity Fuel Handling Equipment Upgrade	0-6
71124.03	Miscellaneous	N/A	Respiratory Protection Training, Medical Physical, and Fit Testing Qualifications	02/10/2026
		RA-001, Attachment 1	SCBA Flow Checks	06/25/2025
		WI-RSD-T-008, Attachment 1	SCBA Inspection Log for January 2026	01/29/2026
	Procedures	EN-RP-505	PortaCount Respirator Fit Testing	9
		RP-502	Inspection and Maintenance of Respiratory Protection Equipment	0
	Work Orders	00600142	Analysis of Scott Liberty One Breathing Air System	01/05/2026
71124.04	Miscellaneous	AS-011026-021199	Lapel Air Sample Result	01/10/2026
		AS-011126-021278	Lapel Air Sample Result	01/11/2026
		AS-011126-021286	Lapel Air Sample Result	01/11/2026
		AS-021126-024232	Lapel Air Sample Result	02/11/2026
		AS-021126-024269	Lapel Sample Report	02/11/2026
		AS-021126-024273	Lapel Sample Report	02/11/2026
		AS-021126-024277	Lapel Sample Report	02/11/2026
		AS-021126-024287	Lapel Sample Report	02/11/2026
		AS-021126+024276	Lapel Sample Report	02/11/2026
		AS-021326-024448	Lapel Sample Report	02/13/2026
		AS-021326-024449	Lapel Sample Report	02/13/2026
		AS-021326-024449	Lapel Sample Report	02/13/2026
		AS-021326-024460	Lapel Sample Report	02/13/2026
		AS-121725-022233	Lapel Air Sample Result	12/17/2025

		N/A	PCE 2025-0008 Internal Dose Assessment Package	0
		N/A	Whole Body Count Records for CR 25015324	12/17-18/2026
	Procedures	RP-201	Dosimetry Administration	0
		RP-203	Dose Assessments	0