

# Perry 1

## 3Q/2010 Plant Inspection Findings

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### Initiating Events

**Significance:**  Dec 31, 2009

Identified By: Self-Revealing

Item Type: FIN Finding

#### **FAILURE TO ADHERE TO MAINTENANCE INSTRUCTIONS RESULTED IN LOSS OF RECIRCULATION PUMP 'A'**

A finding of very low significance was self-revealed on October 15, 2009, when one of two reactor recirculation pumps failed to transfer to slow speed while operators were attempting to downshift both pumps. The finding involved the licensee's failure to adhere to maintenance instructions when personnel incorrectly assembled a relay contactor during maintenance activities on an 'A' recirculation pump low frequency motor generator relay panel. The improperly assembled contactor led to the failure of the 2A breaker to close and re-energize recirculation pump 'A' in slow speed, which caused the loss of the pump and a subsequent unplanned drop in power. No violation of regulatory requirements occurred, and the issue was entered into the licensee's corrective action program.

The failure to adhere to the maintenance instructions resulted in the loss of recirculation pump 'A,' which caused an actual upset in plant stability, and directly affected the objective for the Initiating Events cornerstone. The finding was more than minor because the reactor recirculation pump failure to downshift affected the equipment performance attributes of availability and reliability of the Initiating Events Cornerstone of Reactor Safety. The issue was of very low safety significance because the finding did not result in exceeding the Technical Specification limit for identified reactor coolant system leakage and did not affect other mitigation systems; the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available; and the finding did not increase the likelihood of a fire or internal/external flood. The primary cause of this finding was related to the cross-cutting area of human performance, per IMC 0305 H.4.a., work practices, human error prevention techniques, because the licensee did not ensure that appropriate human error prevention techniques were used.

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

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### Mitigating Systems

**Significance:**  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **UNACCEPTABLE PRECONDITION OF RHR VALVE PRIOR TO ASME IN-SERVICE TESTING**

The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR 50, Appendix B, Criterion XI, Test Control, for the unacceptable preconditioning of the 'A' residual heat removal (RHR) pump minimum flow valve prior to quarterly in-service testing. Specifically, the licensee performed a surveillance that cycled the valve prior to performing stroke time testing, and had not previously performed an evaluation assessing the sequence for preconditioning. The licensee entered the issue into their corrective action program.

The inspectors determined that unacceptably preconditioning the RHR minimum flow valve was a performance deficiency that affected the Mitigating Systems Cornerstone because it can mask the true as-found condition of a component designed to mitigate accidents. The performance deficiency was determined to be more than minor because, if left uncorrected, it could lead to a more significant safety concern. The finding was of very low safety significance because it was not a design/qualification deficiency, did not represent a loss of system safety function, did not result in a loss of function of a single train for greater than its Technical Specification (TS)-allowable outage

time, did not result in a loss of function of nonsafety-related risk-significant equipment and was not risk significant due to external events. This finding has a cross-cutting aspect in the work control planning component of the Human Performance area (per IMC 0310 H.3(a)), because the licensee did not appropriately plan work activities for plant structures, systems, and components. Specifically, the licensee did not schedule the surveillance tests in the proper sequence to prevent unacceptable preconditioning of the valve.

Inspection Report# : [2010004](#) (pdf)

**Significance:**  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO COMPLY WITH TECHNICAL SPECIFICATION LCOS WHEN REACTOR VESSEL LEVEL INSTRUMENTS WERE DECLARED INOPERABLE**

The inspectors identified a finding of very low safety significance and associated NCV for a failure to comply with TS 3.0.2 by not entering TS Limiting Condition for Operation (LCO) 3.3.5.1 Condition A and TS LCO 3.3.6.1 Condition A when required. The inspectors determined that the licensee incorrectly utilized a TS Surveillance Requirement Note that allows a delay in entering the Conditions and Required Actions for the given TS LCO. As a result, the licensee failed to correctly enter the Conditions and Required Actions when reactor level instruments were declared inoperable to perform testing in support of planned maintenance. The licensee entered the issue associated with the failure to comply with TS into their corrective action program.

This performance deficiency was determined to be more than minor because it impacted the Equipment Performance attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage); and if left uncorrected it could lead to a more significant safety concern. This finding is of very low safety significance because it was not a design/qualification deficiency, did not represent a loss of system safety function, did not result in a loss of function of a single train for greater than its TS-allowable outage time, did not result in a loss of function of nonsafety-related risk-significant equipment and was not risk significant due to external events. This finding has a cross cutting aspect in the decision making component of Human Performance cross cutting area (per IMC 0310 H.1(b)), because the licensee did not use conservative assumptions to ensure the proposed action was safe. Specifically, the licensee incorrectly used the TS Surveillance Requirement Note to satisfy maintenance requirements.

Inspection Report# : [2010004](#) (pdf)

**Significance:**  Aug 03, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Effectively Manage, Prioritize and Disposition Numerous Operations Procedures Document Change Requests (DCRs) Notifications**

The inspectors identified a finding of very low safety significance and associated NCV of Technical Specification 5.4.1.a for the licensee's failure to maintain written procedures covering "General Plant Operating Procedures," "Procedures for Startup, Operation and Shutdown of Safety-Related BWR Systems," and "Procedures for Combating Emergencies and Other Significant Events," as required by the Technical Specifications. Specifically, the licensee failed to effectively manage, prioritize and disposition numerous long-standing design change requests (DCRs). The DCRs documented operations procedure issues/discrepancies identified by plant operators during plant operation activities under normal, abnormal, emergency and shutdown conditions. The licensee entered this finding into their corrective action program (CR10 79187) and performed a cause analysis evaluation to identify the causes and determine potential impact on plant operations.

The finding was more than minor in accordance with IMC 0612, Appendix B because the finding was associated with the procedure quality attribute of the mitigating systems cornerstone and affected the cornerstone's objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the licensee's failure to maintain the operations procedures up to date could have complicated and prolonged operator response during plant operation activities under normal, abnormal, and emergency conditions. The finding was of very low safety significance based on a Phase 1 screening in

accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening and Characterization of Findings," Table 4a.

This finding had a cross cutting aspect in the area of human performance, resources because the licensee did not provide complete, accurate, and up-to-date operations procedures to plant personnel. Specifically, the licensee failed to effectively manage, prioritize and disposition numerous long-standing DCRs. The DCRs documented procedure changes to be incorporated into plant procedures that were used during plant operation activities under normal, abnormal, emergency and shutdown conditions. [H.2(c)] (Section 1R17.1b.(1))

Inspection Report# : [2010006](#) (pdf)

**Significance:**  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

#### **FAILURE TO CORRECTLY ASSESS RISK DURING POST-MAINTENANCE ACTIVITIES**

. A finding of very low safety significance and associated NCV of 10 CFR 50.65(a)(4) was identified by the inspectors for the licensee's failure to accurately assess plant risk during maintenance activities. The inspectors determined that the licensee failed to correctly identify the plant risk condition when the Unit 1 Division 1 Emergency Diesel Generator (EDG) was out of service for maintenance. Specifically, there was a 5 hour period of time that the licensee restored plant risk to GREEN status while the EDG remained unavailable and plant risk was actually YELLOW. The licensee entered the issue associated with their failure to correctly assess the plant risk condition into their corrective action program (CAP).

The performance deficiency was determined to be more than minor because the finding was similar to IMC 0612, Appendix E, Example 7.e, and resulted in actual plant risk being in a higher licensee-established risk category than declared. The finding was of very low safety significance because the risk deficit, or incremental core damage probability deficit (ICDPD) was  $< 1E-6$ . This finding had a cross-cutting aspect in the area of Human Performance, Decision-Making per IMC 0310 (H.1(b)) because the licensee did not use conservative assumptions in decision making nor adopt a requirement to demonstrate that the proposed action is safe in order to proceed rather than a requirement to demonstrate that it is unsafe in order to disapprove the action. Specifically, the licensee chose to minimize system unavailability time and as a result did not perform a complete post-maintenance test which would have verified the EDG system was fully functional and available to perform its mission at the end of the maintenance period.

Inspection Report# : [2010002](#) (pdf)

**Significance:**  Mar 31, 2010

Identified By: NRC

Item Type: FIN Finding

#### **FAILURE TO MAKE AN ACCURATE IMMEDIATE OPERABILITY DETERMINATION**

A finding of very low safety significance was identified by the inspectors for the licensee's failure to make an accurate immediate operability determination (IOD) based on the actual plant conditions and the available information to provide reasonable assurance of operability. Specifically, on February 15, 2010, through wall leakage was identified coming from a welded elbow connection of an instrument line associated with the 'B' Emergency Closed Cooling (ECC) system supply to the 'B' control complex chiller heat exchanger. This instrument line is an American Society of Mechanical Engineers (ASME) Section III, Class 3 piping system, and the licensee's IOD declared the 'B' ECC system operable without the degradation mechanism being discernable from visual examination (such as external corrosion or wear) or having substantial operating experience (site specific) with the identified degradation mechanism in the affected system. No violation of regulatory requirements occurred, and the issue was entered into the licensee's CAP.

The performance deficiency was determined to be more than minor because it is associated with the Mitigating Systems cornerstone attribute of "Equipment Performance-Availability, Reliability," and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding was of very low safety significance because a loss

of system safety function, or the actual loss of safety function of a single train for greater than its TS-allowed outage time did not occur, and the finding does not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a safety culture cross-cutting aspect in the area of Problem Identification and Resolution, related to the Operating Experience component for not implementing and institutionalizing operating experience through changes to station processes, procedures, equipment, and training programs per IMC 0310 (P.2 (b)). Specifically, the requirement for the degradation mechanism of through wall leakage on ASME Section III, Class 2 and 3 piping, to be readily apparent from visual examination in order to support an operable IOD, was not completely understood by operations personnel. This finding did not involve a violation of regulatory requirements.

Inspection Report# : [2010002](#) (*pdf*)

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Failure to Adequately Establish the Radiological Conditions In A Locked High Radiation Area to Allow Workers to Be Properly Briefed Prior to Entry.**

A finding of very low safety significance and an associated Non-Cited Violation (NCV) of Technical Specification 5.7.1 was self-revealed following worker entry into the fuel pool cooling and cleanup (FPCC) heat exchanger room. At the time, the FPCC heat exchanger room was being controlled as a locked high radiation area (HRA). The licensee failed to adequately determine radiological dose rates in the room to ensure workers were briefed accurately on the radiological conditions prior to entry. On March 12, 2010, workers involved in tag-out activities in the room, encountered greater than expected dose rates. After completion of a tag-out activity in the FPCC heat exchanger room, the licensee identified that the electronic dosimeter (ED) worn by one of the workers had a dose rate of 550 mrem/hour and had alarmed. The workers were briefed to expect dose rates no greater than 150 mrem/hour based on the radiation survey used to support the briefing. The radiological information conveyed to the workers through a briefing by the radiation protection (RP) staff was inadequate because it was based on an incomplete survey. As part of the licensee's corrective actions, lessons learned were shared with the RP staff to address survey adequacy and for enhanced communications with workers during pre-job briefings.

The inspectors identified Example 6(h) of IMC 0612, Appendix E, as similar to the performance issue. The workers were not made aware of the radiological conditions before entry into the room. Therefore, as provided in Example 6 (h), the inspectors determined that the performance deficiency was more than minor. Additionally, the performance deficiency impacted the program and process attribute of the Occupational Radiation Safety Cornerstone and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation, in that, worker entry into areas without knowledge of the radiological conditions placed them at increased risk for unnecessary radiation exposure. The finding was determined to be of very low safety significance because the problem was not an as-low-as-reasonably-achievable (ALARA) planning issue, there was no overexposure, nor substantial potential for an overexposure, and the licensee's ability to assess dose was not compromised. The inspectors determined that the cause of this incident involved a cross cutting component in the human performance area for inadequate work control (H.3.(a)) in that, work activities were not adequately planned by incorporating job site radiological conditions. Specifically, the licensee job briefing did not utilize complete and accurate survey maps for the areas being entered into by the workers assigned to conduct tasks in the FPCC heat exchanger room. (Section 2RS1.2)

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure To Work In High Radiation Areas Within The Bounds Of The Radiological Briefing Resulting In Entry Into Areas Without Knowledge Of The Radiological Conditions. (Section 2RS1.3)**

A finding of very low safety significance and an associated NCV of Technical Specification 5.7.1 was self-revealed after workers entered into high radiation areas (HRAs) on March 28, 2010. On two occasions, workers entered HRAs without knowledge of the radiological (dose rate) conditions of the areas entered. As a result, the electronic dosimeters (EDs) worn by the workers alarmed on high dose rate. The involved individuals were authorized to work in specified locations within the HRAs and were informed of the radiological conditions by the radiation protection (RP) staff for those specific areas. However, the workers took actions inconsistent with the briefings because they moved to other locations without authorization from RP and without knowledge of the radiological conditions of the area they entered. The individuals were briefed to expect dose rates of approximately 100 mrem/hour but traversed into other locations within the HRA with dose rates three to six times greater than those briefed. As corrective actions, the licensee is developing means to improve its pre-job briefings and contemplating other approaches to ensure workers do not work beyond the scope of the pre-job brief.

The inspectors identified Example 6(h) of IMC 0612, Appendix E, as similar to the performance issue. In both instances the workers took unauthorized actions and entered into other HRAs unaware of the elevated radiological conditions in those areas. Therefore, as provided in Example 6(h), the inspectors determined that the performance deficiency was more than minor. Additionally, the performance deficiency impacted the program and process attribute of the Occupational Radiation Safety Cornerstone and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation, in that, worker entry into areas without knowledge of the radiological conditions placed them at increased risk for unnecessary radiation exposure. The finding was determined to be of very low safety significance because the problem was not an ALARA planning issue, there were no overexposures, nor substantial potential for overexposures, and the licensee's ability to assess dose was not compromised. The inspectors determined that the cause of the incidents each involved cross-cutting components in the human performance area for inadequate work practices (H.4.(b)). Specifically, personnel work practices did not support human performance because the licensee did not effectively communicate expectations regarding procedural compliance and personnel failed to follow procedures. (Section 2RS1.3)

Inspection Report# : [2010003](#) (pdf)

**Significance:**  Jun 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate ALARA Planning And Radiological Controls That Did Not Prevent Unplanned, Unintended Dose For Several Work Activities In Refuel Outage 12.**

3The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR 20.1101.b for inadequate ALARA planning and radiological controls. The inspectors determined that as a result of these inadequacies, the licensee's ALARA program did not prevent unplanned, unintended dose for several work activities during refuel outage 12 (RFO-12). As a result, the licensee failed to achieve occupational radiation exposures that were ALARA. The issue was entered into the licensee's CAP as CR 09-59216, and corrective actions were implemented to address the outage planning and work execution issues.

The inspectors identified Example 6(i) of IMC 0612, Appendix E, as similar to the performance issue. Therefore, as provided in Example 6(i), the inspectors determined that the performance deficiency was more than minor. Additionally, the performance deficiency impacted the program and process attribute of the Occupational Radiation Safety Cornerstone and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation, in that, worker exposures were not maintained ALARA. The inspectors concluded that the finding did not result in overexposures, a substantial potential for overexposures, or a compromised ability to assess dose. The inspectors determined that the finding involved ALARA planning and work controls. Since the licensee's 3-year rolling collective dose average was less than 240 person-rem per unit, at the time the performance deficiency occurred, the inspectors determined that the SDP assessment for this finding was of very low

safety significance. The inspectors also concluded that the finding was associated with a cross-cutting aspect in the area of human performance in the area of work controls (H.3.(a)), in that, the licensee did not appropriately plan work activities by incorporating radiological safety. (Section 2RS2.2)

Inspection Report# : [2010003](#) (pdf)

**Significance:** **G** Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure To Evaluate The Need For Radiological Engineering Measures To Control Contamination During Installation Of A Cover Over The Drywell Head.**

4A finding of very low safety significance and an associated NCV of 10 CFR 20.1501 was self-revealed during an activity associated with the installation of a contamination control cover element (i.e., the parachute) over the drywell head. The inspectors concluded that the licensee failed to perform an evaluation to determine the need for process or other engineering controls as required by 10 CFR 20.1701 and 20.1702. On February 24, 2009, 15 individuals working on the refuel floor were contaminated and several received small intakes of radioactive material during installation of the cover. Low levels of airborne radioactivity were created and contamination was spread over large areas of the refuel floor. The individuals involved in the work activity were not provided with instruction for the installation and were unfamiliar with the task. Also, neither an ALARA Plan nor radiation work permit (RWP) specified if or how the drywell head was to be covered because the work package lacked sufficient detail. As corrective actions, the licensee removed the parachute cover and applied a fixative to the drywell head to minimize further spread of contamination. An experienced supervisor was assigned to the refuel floor to better oversee work activities.

The inspectors did not identify any examples in IMC 0612, Appendix E, similar to the performance issue. However, the inspectors determined that the finding was more than minor because it impacted the program and process attribute of the Occupational Radiation Safety Cornerstone and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation. Specifically, the failure to evaluate the methods used to install the parachute cover and use engineering controls resulted in personal contaminations and intakes to several workers. The finding was determined to be of very low safety significance because it was not an ALARA planning issue, there was no overexposure nor substantial potential for an overexposure, and the licensee's ability to assess dose was not compromised. The work package was incomplete and failed to prescribe if and how the cover was to be installed over the drywell head to ensure a successful outcome. Consequently, the cause of the problem involved a cross-cutting component in the human performance area for resources (H.2.(c)), in that, the licensee did not ensure that personnel, equipment and procedures including the work package were available and adequate. (Section 2RS3.1).

Inspection Report# : [2010003](#) (pdf)

**Significance:** **G** Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Failure To Effectively Use The Intended Radiological Engineering Controls During Cavity Drain-Down In Preparation For Its Decontamination.**

5A finding of very low safety significance and an associated NCV of Technical Specification 5.4.1 was self-revealed during reactor cavity drain down. On March 14, 2009, an airborne radioactivity condition (about 3.3 DAC (derived air concentration)) was generated on the refuel floor when the cavity water level was lowered to support decontamination activities. The inspectors concluded that the licensee failed to effectively implement intended radiological engineering controls in accordance with the ALARA Plan, which caused the event. Due to a communication problem, cavity drain-down commenced before the decontamination crew already positioned on the refuel floor was ready to support the activity. Moreover, the drain down proceeded at a rate faster than expected by the work crew. The work plan called for the cavity walls to be misted with water as the drain-down took place. Five workers had small (low dose) unplanned intakes. Corrective actions focused on the communications problem and better controlling the rate of drain-down through a procedural modification.

The inspectors did not identify any examples in IMC 0612, Appendix E, similar to the performance issue. However, the inspectors determined that the finding was more than minor because it impacted the program and process attribute

of the Occupational Radiation Safety Cornerstone and adversely affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation. Specifically, the failure to effectively implement intended engineering controls during cavity drain-down caused several unplanned worker intakes and placed workers at increased radiological risk. The finding was determined to be of very low safety significance because it was not an ALARA planning issue, there was no overexposure nor substantial potential for an overexposure, and the licensee's ability to assess dose was not compromised. The cause of the problem involved a cross-cutting component in the human performance area for inadequate work control (H.3.(b)), in that, the licensee did not appropriately coordinate work activities by incorporating actions to address the need for work groups to communicate and coordinate with each other during activities in which interdepartmental coordination was necessary to assure human performance. (Section 2RS3.1).

Inspection Report# : [2010003](#) (*pdf*)

**Significance:**  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

### **UNPOSTED HIGH RADIATION AREA AT THE TIP MACHINES**

The inspectors identified a finding of very low safety significance and an associated non-cited violation of Technical Specification 5.7.1 for the failure to conspicuously post a high radiation area on the 599' elevation of the containment building. Corrective actions included instituting high radiation area controls when the traverse in-core probe system is operated. The licensee entered the issue into its corrective action program as Condition Reports 09-59344 and 09-67987.

The finding was more than minor because it impacted the Occupational Radiation Safety Cornerstone objective for ensuring adequate protection of worker health and safety from exposure to radiation in the attribute of program and process for as-low-as-is-reasonably-achievable (ALARA) planning, in that, not conspicuously posting high radiation areas may result in unnecessary and unplanned radiation exposures to workers. The finding was determined to be of very low safety significance because it was not an ALARA planning issue, there was no overexposure nor potential for overexposure, and the licensee's ability to assess dose was not compromised. The primary cause of this finding was related to the cross-cutting area of human performance in work practices, per IMC 0305 H.4.a., in that, personnel work practices and human performance error reduction techniques were not used commensurate with the risk of the assigned task.

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

**Significance:**  Dec 31, 2009

Identified By: NRC

Item Type: FIN Finding

### **EXCESS DOSE INCURRED FOR THE ALTERNATE DECAY HEAT REMOVAL PROJECT**

The inspectors identified a finding of very low safety significance for inadequate job planning and ineffective work controls which adversely impacted the licensee's ability to minimize dose for the alternate decay heat removal (ADHR) project during Refuel Outage 12. Specifically, controls were not effectively implemented to reduce ambient radiation levels, and minimize in-field work hours for craft personnel. The issue resulted in an actual dose outcome that was not consistent with the planned, intended dose for work associated with modifications to the ADHR. Corrective actions were implemented to address the organization and programmatic deficiencies in managing the installation of major plant modifications.

The finding was more than minor because it impacted the Occupational Radiation Safety Cornerstone objective for ensuring adequate protection of worker health and safety from exposure to radiation in the attribute of program and process for ALARA planning, in that, ineffective ALARA planning and work control deficiencies contributed to an actual increase in worker doses in excess of five person-rem and exceeded the licensee's initial intended dose estimates by more than 50 percent. The finding did not involve: (1) an overexposure; (2) a substantial potential for an overexposure; or (3) an impaired ability to assess dose. While the finding involved ALARA planning and controls, the 3 year rolling average dose for the Perry Plant was less than the SDP threshold of 240-person-rem for boiling water reactors at the time the performance deficiency occurred. Consequently, the inspectors concluded through the SDP assessment that this is a finding of very low safety-significance. The finding was determined to be associated with a cross-cutting aspect in the area of human performance in work controls, per IMC 0305 H.3.a., in that, the licensee did not appropriately plan work activities by incorporating radiological safety.

## Public Radiation Safety

**Significance:** SL-IV Jul 16, 2010

Identified By: NRC

Item Type: VIO Violation

**Deliberate Failure to Follow Portal Monitor Use Procedure - traditional enforcement portion - traditional enforcement portion.**

A willful violation was identified through an OI Investigation for the failure to comply with the procedure that governed portal radiation monitor usage. Specifically, a contract radiation protection technician deliberately violated a radiation protection procedure when the technician exited the Perry site without authorization from radiation protection supervision following three consecutive portal monitor alarms at the personal access facility.

The significance of the violation was assessed using Traditional Enforcement because it was determined to be willful. A Severity Level IV violation was determined to be appropriate because the incident had more than minor safety significance given that the technician was radioactively contaminated and departed the site. The violation was cited since it was willful and because the licensee failed to: (1) timely and appropriately respond to the incident; (2) adequately assess the potential for offsite contamination; and (3) take corrective action to ensure against recurrence.

The associated Performance Deficiency is item 2010-008-02.

Inspection Report# : [2010008](#) (pdf)

**Significance:**  Jul 01, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Deliberate Failure to Follow Portal Monitor Use Procedure - Performance Deficiency portion.**

A willful violation was identified through an OI Investigation for the failure to comply with the procedure that governed portal radiation monitor usage. Specifically, a contract radiation protection technician deliberately violated a radiation protection procedure when the technician exited the Perry site without authorization from radiation protection supervision following three consecutive portal monitor alarms at the personal access facility.

Failure to follow this procedure represents a performance deficiency. The issue had more than minor safety significance because the RPT was radioactively contaminated and departed the site. The inspectors determined that no cross-cutting components applied to this issue, because the underlying performance issue was the same as the performance deficiency (Failure to follow procedure).

The Traditional Enforcement portion of this issue is tracked as item 2010-008-01.

Inspection Report# : [2010008](#) (pdf)

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

Last modified : November 29, 2010