

Susquehanna 1

2Q/2012 Plant Inspection Findings

Initiating Events

Significance: **G** Mar 21, 2012

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Gain Settings Result in Reactor Scram

A self-revealing finding of very low safety significance was identified when Unit 1 automatically scrammed from 32 percent power on April 22, 2010, due to low reactor water level. PPL entered inadequate gain settings in the feedwater digital ICS for reactor feed pump turbine (RFPT) speed control as part of the ICS design modification, and the test procedure, which was in progress at the time, did not specify exit criteria that would have ended the test prior to an automatic scram. PPL completed corrective actions related to the direct cause by updating the RFPT speed control characterizer block gain settings. This issue was entered in PPL's CAP as condition report (CR) 1257781 (April 2010) and CR 1348940 (January 2011).

The inspectors determined that inadequate procedures to perform post-modification testing on the digital ICS was a performance deficiency because the testing performed did not detect incorrect gain settings prior to a reactor scram. The inspectors screened the performance deficiency in accordance with IMC 0612, Appendix B, "Issue Screening." The performance deficiency was determined to be more than minor because the finding was associated with the Initiating Events cornerstone attribute of Design Control, and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operation. The inspectors evaluated the finding using IMC 0609, Attachment 4, "Initial Screening and Characterization of Findings," and determined the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment would not be available. Consequently, the finding is of very low safety significance (Green).

This finding has a cross-cutting aspect in the area of Human Performance, Work Control, because PPL did not plan and coordinate work activities consistent with nuclear safety. Specifically, PPL did not appropriately consider risk during the design modification and did not have adequate planned contingencies for the testing of the new digital ICS. (H.3(a)) (Section 4OA3.1)

Inspection Report# : [2012008](#) (*pdf*)

Significance: **W** Sep 30, 2010

Identified By: Self-Revealing

Item Type: FIN Finding

Procedural Inadequacies Result in Reactor Scram and Loss of Normal Heat Sink

A self-revealing preliminary White finding regarding procedure NDAP-QA-0008, "Procedure Writer's Guide," Revision 8, was identified following a July 16, 2010, flooding event in the Unit 1 condenser bay which resulted in a manual reactor scram and loss of the normal heat sink. There were three instances of inadequate procedures identified. The first instance involved maintenance procedure MT-043-001 which provided inadequate instructions regarding installation of the condenser waterbox gaskets and led to the event. In addition, two other off-normal procedures were inadequate in that they complicated operator response to the event. Specifically, operators used a diagram in off-normal procedure ON-100-003, "Chemistry Anomaly," to identify and isolate the leak which was incorrect, delayed leak isolation, and resulted in a manual reactor scram in anticipation of a loss of the normal heat sink. Finally, ON-142-001, "Circulating Water (CW) Leak," did not contain specific instructions to isolate a condenser waterbox leak which contributed to operators using ON-100-003 which was not intended to be used to isolate the condenser box during flooding conditions. PPL corrected the diagram error, dewatered and repaired affected equipment, and entered this issue into their CAP (1282128).

This finding was determined to be more than minor as it affected the Initiating Events cornerstone attribute of Procedure Quality and its objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operation. The finding was evaluated using Phases 1, 2, and 3 of the

Significance Determination Process. The conclusion of the Phase 3 analysis was an estimated change in core damage frequency (CDF) of 1.1E-6/yr (White) and an estimated change in large early release frequency (LERF) of 2.6E-7/yr (White). The finding is related to the cross-cutting area of Problem Identification and Resolution, Corrective Action Program, in that PPL did not thoroughly evaluate problems such that the resolutions address the causes and extent of condition, as necessary. Specifically, PPL did not appropriately evaluate and correct a known issue in an off-normal procedure or adequately evaluate previous CW system waterbox manway gasket leaks to ensure that future occurrences could be prevented.

Final SDP issued 12/16/2010. IR 2010-008

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

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

Mitigating Systems

Significance:  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate MOV Program Implementation

The inspectors identified a Green NCV of 10 CFR Part 50 Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” regarding PPL’s safety-related motor operated valve (MOV) program. Specifically, the program lacked a procedure, qualification, and prescribed acceptance criteria for actuator grease analysis and PPL improperly implemented maintenance instructions for lubricating valve stems. PPL’s QA organization conducted a separate investigation and entered this issue in their CAP via CRs 1545581 and 1544737.

This finding was considered more than minor because it was similar to IMC 0612, Appendix E, examples 3.j and 3.k, in that significant programmatic deficiencies existed that could lead to worse errors if uncorrected. The lack of a procedure, repeatable acceptance criteria, qualification, and multiple cycles without stem lubrication could result in untimely actuator overhauls and ultimately MOV degraded performance. Further, the performance deficiency affected the equipment performance attribute of the Mitigating Systems cornerstone and its objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

Specifically, inadequate MOV program implementation affects MOV reliability. The issue screened to Green via IMC 0609 Attachment 4 since it was not a design or qualification deficiency or loss of safety function and did not screen as potentially risk significant due to external events. The issue was determined to have a cross-cutting aspect in the area of Problem Identification and Resolution. In this case, PPL was aware of the lack of procedural guidance and qualification for MOV grease analysis as well as non-compliance with stem lubrication instructions but had not entered the concerns in its CAP. [P.1(a)] (Section 1R12)

Inspection Report# : [2012002](#) (pdf)

Significance:  Dec 31, 2011

Identified By: NRC

Item Type: FIN Finding

Failure to Properly Implement Work Instructions Results in C EDG Inoperability

An NRC-identified Green finding of TS 5.4.1, “Procedures,” due to PPL’s failure to properly plan and implement work instructions and Quality Control (QC) hold point inspections associated with a modification to the ‘C’ Emergency Diesel Generator (EDG) fuel pump assemblies was identified. The error resulted in the failure of the ‘C’ EDG to continue running during surveillance testing on December 6, 2011. This resulted in PPL failing to meet the requirements of TS 3.8.1, “AC Sources- Operating,” when it was determined that the ‘C’ EDG was inoperable from September 19, 2011, following restoration from its maintenance outage, until December 6, 2011, when the operable ‘E’ EDG was substituted for the ‘C’ EDG. Additionally, the failure to implement work instructions resulted in PPL failing to meet the requirements of 10 CFR Part 50, Appendix B, Criterion X, “Inspection,” which requires, in part, that licensees execute a program for inspection of activities affecting quality to verify conformance with the

documented instructions, procedures, and drawings for accomplishing the activity. The deficiency was entered into PPL's corrective action program (CAP) as condition Report (CR) 1506105 and a root cause analysis (RCA) was performed.

The performance deficiency was determined to be more than minor because the finding was associated with the Mitigating Systems cornerstone attribute of Human Performance, and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding was evaluated using Phase 1 and inspectors determined the finding was potentially greater than very low safety significance because the finding represented an actual loss of safety function of a single train for greater than its TS Allowed Outage Time. The Phase 2 analysis determined the finding was potentially greater than very low safety significance given an exposure time of 75 days. A Phase 3 analysis was conducted by an NRC Senior Reactor Analyst (SRA). This analysis indicated an increase in core damage frequency (? CDF) for internal initiating events in the range of 1 core damage accident in 40,000,000 years of reactor operation, in the low E-8 range per year for each unit. The dominant core damage sequences included losses of offsite power with the failure of all EDGs, due to common cause, resulting in a station blackout, followed by operator failure to extend RCIC operation with loss of DC power, failure to depressurize the reactor and failure to recover offsite power within 4 hours. The finding is related to the CCA of Human Performance, Work Practices, in that PPL personnel did not use human error prevention techniques, such as holding pre-job briefings, self and peer checking, and proper documentation of activities, commensurate with the risk of the assigned task, such that work activities are performed safely. Specifically, PPL did not perform adequate human error prevention techniques such that the incorrect assembly of delivery valve springs and stops avoided. (H.4(a)) (Section 1R13)

Inspection Report# : [2011005](#) (pdf)

Significance: SL-IV Nov 08, 2011

Identified By: NRC

Item Type: VIO Violation

Violation of 10CFR55.25, Failure to Notify NRC of a Change in Medical Status and Request a Conditional License

The inspectors identified a SL IV NOV of 10 CFR 55.25, "Incapacitation Because of Disability or Illness," for PPL failing to notify the NRC of a known permanent change in medical status of a licensed operator, and 10 CFR 55.3, "License Requirements," for failing to ensure that an individual license holder, in the capacity of a reactor operator (RO), met the medical prerequisites prior to performing licensed operator duties. Specifically, an RO failed a medical examination in both 2009 and 2011 which identified a disqualifying condition and performed licensed duties without an NRC-approved, amended license. He performed the function of an RO while on watch from April 2009 through August 2011, when the NRC identified this issue. However, the operator did wear corrective lenses while standing watch since April 2009. Upon notification PPL submitted, and the NRC approved, a conditional license to address the disqualifying medical condition. PPL entered this issue into their corrective action program (CAP) as condition report (CR) 1450138.

The inspectors determined that PPL's failure to notify the NRC of a known permanent change in a licensed operator's medical status and request an amended license in order to assume licensed duties was a performance deficiency. This finding was evaluated using the traditional enforcement process because the issue had the potential to impact or impede the regulatory process. Specifically, there was a potential for license termination or the issuance of a conditional license to accommodate for a medical condition. The RO performed licensed duties from April 2009 through August 2011 with a disqualifying condition that required his license to be amended. Using the NRC Enforcement Policy, this violation was characterized at SL IV, in accordance with Section 6.4.

This violation is being cited in the enclosed Notice in accordance with NRC Enforcement Manual Section 3.1.2, because the violation was determined to be repetitive of NRC Enforcement Action (EA) 09-248 dated January 28, 2010, an SLIII Notice of Violation related to a Senior Reactor Operator (SRO) standing watch without meeting a medical qualification requirement. The medical conditions in both the former and current cases were similar; therefore, it was reasonable that an adequate extent of condition review for EA-09-248 should have identified the additional discrepancy.

This significance of the associated performance deficiency was screened against the Reactor Oversight Process (ROP) per the guidance of IMC 0612, Appendix B. No associated ROP finding was identified and no cross-cutting aspect

was assigned. (Section 1R11)

Inspection Report# : [2011004](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: FIN Finding

Scenarios for NRC Annual Operating Examinations Did Not Meet Quantitative Standards for Total Malfunctions

The inspectors identified greater finding in that 20% of the NRC annual operating exam simulator scenarios reviewed did not meet the quantitative standard for total malfunctions, 4 to 8 for a single scenario, and 10 to 14 for a scenario set established in NUREG-1021, "Operator Licensing Examination Standards for Power Reactors," Form ES-604-1, "Simulator Scenario Review Checklist." In addition, the licensee's procedures NTP-QA-31.11, "Operator Requalification Exam Preparation and Implementation" and NTP-QA-31.7, "Simulator Scenario Writers Guides," recommend these same quantitative standards. The quantitative guidelines for malfunctions is an important metric because it establishes an objective standard used throughout the nuclear industry to ensure that the simulator portion of the NRC-required annual operating exams are written at an appropriate level of difficulty. As an immediate corrective action, the licensee entered this finding into their corrective action process (CR 1187760).

This finding was more than minor because it was associated with the Human Performance attribute of the Mitigation Systems cornerstone and affected the objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the finding affected the level of difficulty of simulator operating exams which potentially impacted PPL's ability to appropriately evaluate licensed operators. A review of the possible cross-cutting aspects was performed and no cross-cutting aspect was identified that would be considered a contributor to the cause of the finding.

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

Barrier Integrity

Significance:  Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correct Secondary Containment Bypass Leakage Condition Adverse to Quality

The inspectors identified a Green NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for PPL's failure to prevent recurrence of a significant condition adverse to quality (SCAQ) when secondary containment bypass leakage (SCBL) was in excess of its TS allowed value for two consecutive tests. In this case, the SCAQ, as defined by PPL procedure NDAP-QA-0702, "Action Request (AR) and Condition Report (CR) Process," was the same condition as reported in LER 05000387/2010-001 and actions taken in 2010 to prevent recurrence were inadequate because they did not fully consider all the penetrations that account for SCBL. PPL subsequently entered the issue into the CAP as CR 1582747.

The finding was determined to be more than minor because it was associated with the structures, systems and components (SSCs) and barrier performance attribute of the Barrier Integrity cornerstone and affected its objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The inspectors assessed the finding to be of very low safety significance (Green) because it did not represent a degradation of the barrier function of the control room, did not represent an actual open pathway in the physical integrity of reactor containment, and did not involve an actual reduction in function of hydrogen igniters in containment. This finding has a cross-cutting aspect in the area of Human Performance, Decision Making, because PPL did not use conservative assumptions in decision making and 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 decisions to not rework valve HV151F016B or perform work on valve 141818A when leakage was at a value that potentially challenged the SCBL limit was not based on conservative assumptions. [H.1(b)] (Section 1R12)

Inspection Report# : [2012003](#) (pdf)

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Significance: Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Correct Outboard MSIV LLRT failure Condition Adverse to Quality

An NRC-identified Green NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for PPL's failure to correct excessive seat leakage associated with the Unit 1 'D' outboard MSIV, HV141F028D, such that the leakage was in excess of the Technical Specification (TS) allowed value for two consecutive tests.

Specifically, work instructions to perform maintenance and post-maintenance testing on the valve following a local leak rate test (LLRT) failure in 2010 were inadequate to ensure the CAQ was corrected. PPL subsequently entered the issue into the CAP as CRs 1554813 and 1590506.

The finding was determined to be more than minor because it was associated with the SSCs and barrier performance attribute of the Barrier Integrity cornerstone and affected its objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The inspectors assessed the finding to be of very low safety significance (Green) because it did not represent a degradation of the barrier function of the control room, did not represent an actual open pathway in the physical integrity of reactor containment, and did not involve the actual reduction in function of hydrogen igniters in containment. This finding has a cross-cutting aspect in the area of Human Performance, Resources, because PPL did not ensure that personnel, equipment, procedures, and other resources were available and adequate to assure nuclear safety. Specifically, the instructions used to perform maintenance and testing on the MSIVs were inadequate to ensure that excessive seat leakage was corrected. [H.2(c)] (Section 1R12)

Inspection Report# : [2012003](#) (pdf)

G

Significance: Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Improperly Performed Maintenance Impacts Secondary Containment

A self-revealing Green NCV of TS 5.4.1, "Procedures," was identified regarding PPL's conduct of maintenance during a Unit 1 refueling outage which impacted the operating unit, Unit 2. Specifically, improperly performed maintenance on a Unit 1 main stop valve (MSV) and outboard main steam isolation valve (MSIV) affected safety-related equipment to include the standby gas treatment system (SGTS) and Unit 2 secondary containment in an unplanned manner.

PPL entered this issue in their CAP via CRs 1558764, 1558718, and 1560235 and performed a root cause analysis (RCA) on this.

Improperly performed MSIV and MSV maintenance was a performance deficiency within PPL's ability to foresee and correct. This finding was considered more than minor because it was similar to IMC 0612, Appendix E, Examples 3.j and 3.k, in that a physical plant condition and subsequent engineering calculation resulted in a condition where there was reasonable doubt on the operability of a system or component, in this case secondary containment. Further, the performance deficiency affected the procedure quality and SSC and barrier performance attributes of the Barrier Integrity cornerstone and its objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. In this case, lack of coordination resulted in a loss of reasonable assurance that secondary containment was operable. The issue screened to Green via IMC 0609, Attachment 4, since it did not represent a degradation of the barrier function of the control room, did not represent an actual open pathway in the physical integrity of reactor containment, and did not involve the actual reduction in function of hydrogen igniters in containment. The issue was determined to have a cross-cutting aspect in the area of Human Performance to plan and coordinate work activities, consistent with nuclear safety. In this case, the MSV and MSIV work activities were not coordinated amongst various departments to address the operational impact of sequence changes on plant configuration. [H.3(b)] (Section 1R15)

Inspection Report# : [2012003](#) (pdf)

G**Significance:** Nov 08, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Surveillance Procedure Results in Missed Technical Specification Surveillance Requirements for Secondary Containment

An NRC-identified Green NCV of Susquehanna Unit 1 and 2 TS 5.4.1, "Procedures," was identified for an inadequate surveillance procedure for implementing Technical Specifications (TS) Surveillance Requirement (SR) 3.6.4.1.4 and 3.6.4.1.5. Specifically, the implementing procedure was revised allowing the SR to be missed and subsequently required entry into SR 3.0.3. PPL entered this issue in their CAP as CR 1460362.

The finding is more than minor because it was similar to example 3.d in IMC 0612 Appendix E, "Examples of Minor Issues" in that the failure to implement the TS SR as required is not minor if the surveillance had not been conducted. In this case, the SR had not been completed for all configurations of secondary containment and required both Unit 1 and Unit 2 to enter SR 3.0.3 for a missed surveillance. Additionally, it is associated with the procedure quality attribute to maintain functionality of containment and the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the inadequate surveillance procedure resulted in missed surveillances, SRs 3.6.4.1.4 and 3.6.4.1.5 and entry into SR 3.0.3 for missed surveillances. The finding was evaluated for significance using IMC 0609, Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings." Since the finding only represented a degradation of the radiological barrier function provided for the reactor building (RB) (i.e. secondary containment), the finding was determined to be of very low safety significance (Green). This finding is related to the cross-cutting area of Human Performance – Resources because PPL did not ensure that personnel, equipment, procedures, and other resources were available and adequate to assure nuclear safety. Specifically, the procedures did not ensure surveillance requirements (SRs) required by TS 3.6.4.1 were implemented.

Inspection Report# : [2011004](#) (*pdf*)**Significance:** SL-IV Nov 08, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

Inaccurate RCS PI Data Submittal

An NRC-identified SL-IV NCV of 10 CFR 50.9(a), "Completeness and Accuracy of Information," occurred when PPL inaccurately reported reactor coolant system (RCS) leakage values under the RCS leakage performance indicator (PI) for both units since inception of the PI in April 2000. PPL entered the issue in their CAP as CR 1441824, completed an apparent cause evaluation, and plans to revise PI data previously submitted. No performance indicator crossed the Green/White threshold once the values were updated.

Because violations of 10 CFR 50.9 are considered to potentially impede or impact the regulatory process, they are dispositioned using the traditional enforcement process. The inspectors concluded that PPL had reasonable opportunity to foresee and correct the inaccurate information prior to the information being submitted to the NRC. PPL's failure to identify and correct the recurring errors over this period of time indicated the existence of a programmatic issue. Additionally, verification of the corrected PI data in a subsequent inspection will have more than an insignificant regulatory impact on the NRC. Accordingly, although none of the affected PIs in this case would have crossed the threshold, the NRC has determined that the violation is of more than minor significance. The finding was not considered to be more significant since had this information been accurately reported, it would not have likely caused the NRC to reconsider a regulatory position or undertake a substantial further inquiry. The significance of the associated performance deficiency was screened against the ROP per the guidance of Manual Chapter 0612, Appendix B. No associated ROP finding was identified and no cross-cutting aspect was assigned

Inspection Report# : [2011004](#) (*pdf*)

Emergency Preparedness

G**Significance:** Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Instrumentation to Implement EALs for Unplanned Radiological Effluent Release

The inspectors identified a Green NCV of 10 CFR Part 50.54 q and 50.47(b)(4) because PPL did not have adequate instrumentation to assess and determine if an abnormal radiological effluent release was in progress such that the EAL classification process would declare an Alert accurately and in a timely manner. Specifically, the maximum range for the liquid radwaste discharge radiation monitor was inadequate to ensure the meter was onscale when the threshold value of 200 times the alarm setpoint established by the discharge permit was reached.

The finding was more than minor because it is associated with the Emergency Preparedness (EP) cornerstone attribute of Facilities and Equipment, and affected the cornerstone objective of ensuring that a licensee is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. Specifically, the effective range for the liquid radwaste discharge monitor was insufficient to ensure a timely and accurate EAL classification could be made. Using IMC 0609, Appendix B, Section 5.4, the finding is of very low safety significance because the finding was determined to be an example of an ineffective EAL, such that an Alert would be declared in a degraded manner. This finding is related to the cross-cutting area of Pl&R - CAP because PPL did not thoroughly evaluate problems such that the resolutions address the causes and extent of conditions, to include properly classifying, prioritizing and evaluating for operability. Specifically, PPL failed to appropriately evaluate the extent of condition from similar NCVs issued in November 2008 and 2010 regarding inadequate instrumentation to support EAL declarations. [P.1(c)] (Section 1EP6)

Inspection Report# : [2012002](#) (*pdf*)

Occupational Radiation Safety

G**Significance:** Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to follow radiation protection procedures

The inspector identified a non-cited violation (NCV) of Technical Specification (TS) 5.4.1.a, which requires that written procedures be implemented covering the activities in the applicable procedures recommended by Regulatory Guide 1.33, including procedures for as low as reasonably achievable (ALARA) program. Specifically, the Station ALARA Committee (SAC) did not review the scaffold work prior to the Refueling and Inspection Outage (RIO) 17 for unit 1. Procedure NDAP-QA-1191, ALARA Program, Appendix A, provides specific criteria for tasks that must be reviewed by the SAC. One of these criteria is to review job specific Radiation Work Permits (RWP) evolutions where the initial dose estimate is greater than 5 person-rem. All of the actions were not completed prior to the start of the refueling outage. Specifically, the SAC did not review the scaffold work inside the drywell even though it was estimated to be 7 person-rem. The performance deficiency could lead to additional unexpected personnel exposure without additional evaluation by and approval of the SAC. The licensee subsequently entered the issue into the corrective action program as condition report (AR) (1555458).

The finding is more than minor because it is associated with the Radiation Safety –Occupational Radiation Safety cornerstone attribute of program and process and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, the licensee did not take the appropriate actions defined in the procedure to evaluate the activity and challenge the actions to reduce dose for the task. Using the Inspection Manual Chapter (IMC) 0609, Appendix C, Occupational Radiation Safety Significance Determination Process, the inspector determined that the finding was of very low safety significance (Green) because Susquehanna's three year rolling average is less than 240 person-rem and it did not involve: (1) an overexposure, (2) a substantial potential for overexposure, or (3) an impaired ability to assess dose. This finding was caused by inadequate procedure compliance that resulted in a lack of planning and review of a risk significant task. Consequently, the cause of this deficiency had a cross-cutting aspect in the area of Work Controls (H.3(a)). Specifically, the licensee failed to appropriately plan the scaffold work activity by incorporating risk insights or radiological safety and the need for planned contingencies,

compensatory actions, and abort criteria. (Section 2RS02)

Inspection Report# : [2012003](#) (pdf)

G

Significance: Mar 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Noncompliance with Radiological Barrier

A self-revealing, Green NCV of Technical Specification (TS) 5.7.1 was identified when a worker did not comply with a radiological barrier and protective measures for high radiation area (HRA) entry. Specifically, the worker entered a HRA but was not on the proper radiation work permit (RWP) and had not been briefed for HRA entrance. Upon identification, PPL conducted a Susquehanna Error Prevention Team Assessment (SEPTA), entered this issue into their CAP as Condition Report (CR) 1546827, and issued both an Effluents department clock reset and a Radiological Safety Note to station personnel.

The finding was determined to be more than minor based on similarity to IMC 0612, Appendix E, Example 6.h, which describes an improper entry into an HRA. Specifically, the individual was not authorized entry into a HRA. It was also more than minor based on association with the human performance attribute of the Occupational Radiation Safety cornerstone and its objective to ensure the adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The finding was evaluated in accordance with IMC 0609, Appendix C, where it was determined to be Green since PPL's three year average collective dose is less than 240 person-rem/unit. The inspectors determined that this issue had a cross-cutting aspect in Human Performance - Work Practices. Human error prevention techniques, such as pre-job briefings and self-checking are expected to be used commensurate with the risk of the assigned task, such that work activities are performed safely. Personnel also do not proceed in the face of uncertainty or unexpected circumstances. In this case, the worker did not adhere to the pre-job briefings associated with the assigned RWP that prohibited HRA entry and the worker's health physics (HP) briefing that did the same. Further, the individual proceeded in the face of uncertainty by breaching the HRA boundary. [H.4(a)] (Section 4OA2.1)

Inspection Report# : [2012002](#) (pdf)

G

Significance: Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Radiation Protection Procedures

The inspectors identified a Green NCV of TS 5.4.1.a, which requires that written procedures be implemented covering the activities in the applicable procedures recommended by Regulatory Guide (RG) 1.33, including procedures for RWPs. On December 5, 2011, a work crew identified that dose rates exceeded the "Alert" levels specified on their RWPs used to transfer an 1100 Curie Cesium 137 source from a shipping cask to a calibration irradiator. Procedure NDAP-QA-0626, "Radiological Controlled Area (RCA) Access and RWP System," Appendix X, provides specific actions that the radiation protection technician providing job coverage must take when "Alert" levels are exceeded. All of the actions were not completed prior to restarting the work on December 5, 2011. Specifically, higher levels of supervision were not notified, the RWP was not changed, and no additional actions or precautions were documented in the RWP remarks log as required by NDAP-QA-0626, Appendix X. PPL subsequently entered the issue into their CAP as CR 1521467.

The finding is more than minor because it is associated with the Radiation Safety - Occupational Radiation Safety cornerstone attribute of program and process and affected the cornerstone objective of protecting worker health and safety from exposure to radiation. Specifically, PPL did not take the appropriate actions defined in the procedure to evaluate actions to prevent recurrence prior to restarting work when RWP alert levels had been exceeded. Using the IMC 0609, Appendix C, "Occupational Radiation Safety SDP," the inspector determined that the finding was of very low safety significance (Green) because it did not involve: (1) an as low as is reasonably achievable (ALARA) planning and controls deficiency, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. This finding was caused by inadequate procedure compliance. Consequently, the cause of this deficiency had a cross-cutting aspect in the area of Human Performance. Specifically, PPL did not follow procedures. [H.4(b)] (Section 4OA2)

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : September 12, 2012