

Susquehanna 2

1Q/2013 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Restoration from Clearance Order Results in Degradation of Main Condenser Vacuum and Plant Downpower

A self-revealing NCV of very low safety significance (Green) was identified when PPL incorrectly implemented the clearance order process while returning the common offgas recombiner to service after maintenance. NDAP-QA-0322, "Energy Control Process," Revision 42, requires that "upon completion of the [clearance order] restoration plan, the system should be restored to the design operating condition (e.g. running, automatic standby, etc.)." Additionally, it requires the System Operating Representative (SOR) and Operations Supervision to "ensure restoration of the clearance order prevents introduction of system or plant transients." Contrary to these requirements, on December 12, 2012, when restoring from a clearance order, a manual isolation valve for the common recombiner was incorrectly left in the closed position. This resulted in a degradation of main condenser vacuum when the common recombiner was subsequently placed in service on February 5, 2013, requiring operator action to decrease reactor power to maintain main condenser vacuum within limits. PPL entered the issue into the CAP as CR 1668013.

The performance deficiency is more than minor because it was associated with the Configuration Control attribute of the Initiating Events cornerstone and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. Specifically, when PPL operators attempted to place the common recombiner in service on February 5, 2013, the closed manual isolation valve caused a loss of process flow to the recombiner and ultimately a degradation of main condenser vacuum. In responding to the reduction in vacuum, a recirculation pump runback was initiated and thermal power was rapidly reduced by approximately 32 percent. Additionally, the performance deficiency was similar to example 4.b in IMC 0612, Appendix E, "Examples of Minor Issues," which states that a procedural error is more than minor if it caused a reactor trip or other transient. The inspectors evaluated the finding using IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," and determined the finding did not cause a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. Consequently, the finding is of very low safety significance (Green). The finding is related to the cross-cutting area of Human Performance, Work Practices in that PPL did not communicate human error prevention techniques such as self and peer checking to ensure work activities are performed safely. Specifically, both the SOR and Operations Supervision reviews were insufficient to ensure the manual steam isolation valve for the common recombiner was restored to the correct position during clearance order removal.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 31, 2013

Identified By: NRC

Item Type: FIN Finding

Inaccurate USwC PI Data Submittal

The inspectors identified a Green Finding related to implementation of NDAP-QA-0737, "Reactor Oversight Process (ROP) Performance Indicators," Revision 9, and associated severity level (SL) IV NCV of 10 CFR 50.9(a),

“Completeness and Accuracy of Information” because PPL staff did not accurately report the Unplanned Scrams with Complications (USwC) performance indicator (PI) for the period of October 2012 through December 2012. Specifically, PPL did not report the Unit 2 reactor scram, which occurred on December 16, 2012, in this PI. PPL entered the issue in their CAP as CR 1688235 and corrected the data on March 20, 2013. This scram, when combined with a second complicated scram, which was accurately reported in the same quarter, caused the PI to cross the Green-White threshold. This was discussed in an NRC follow-up assessment letter dated April 1, 2013 (ML13092A011).

The finding was evaluated in accordance with IMC 0612 Appendix B, “Issue Screening,” which states, in part, that a performance deficiency is more than minor if it is related to a performance indicator and caused the performance indicator to exceed a threshold. In this case, when the December 16 scram was re-classified under the USwC PI, the performance indicator crossed the Green-White threshold. The inspectors evaluated the finding using IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power” and determined the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. Consequently, the finding is of very low safety significance (Green). Additionally, the issue was evaluated in the traditional enforcement process because it had the potential to impact the NRC’s ability to perform its regulatory function. The inspectors determined the finding was a Severity Level IV violation using the examples of the NRC Enforcement Policy. Specifically, example 6.9.d.11 states “a 10 CFR Part 50 licensee submits inaccurate or incomplete PI data to the NRC that would have caused a PI to change from green to white” is an example of a SL IV violation. This finding has a cross-cutting aspect in the area of Human Performance, Decision-Making because PPL personnel did not communicate decisions and the basis for decisions to personnel who have a need to know the information in order to perform work safely, in a timely manner. Specifically, PPL did not adequately document the basis for determining the scram, which occurred on December 16, 2012, should be classified under the USwC PI to enable reviewers to adequately challenge the decision to ensure the appropriate classification was made.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Feb 01, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to maintain Adequate Feedwater Procedures

Inspectors identified a Green NCV of Technical Specification (TS) 5.4.1, Procedures, related to the requirement to operate the feedwater system in accordance with procedures and implement the procedure change process. The PPL procedures implementing these requirements state that if an approved document that addresses the circumstances does not exist, then create a procedure or perform the task using another approved method (i.e., troubleshooting plan or work order). Contrary to this requirement, on December 19, 2012, Pennsylvania Power and Light (PPL’s) operators opened the breaker to the ‘A’ Reactor Feed Pump (RFP) discharge isolation valve (3A) valve motor operator (i.e., when the 3A valve failed to open as expected) without establishing or implementing procedural guidance or implementing another process such as a troubleshooting plan or work order. This action resulted in the feedwater control system logic causing closure of other feedwater valves, isolating all normal feedwater flow to the Reactor Pressure Vessel (RPV), and a subsequent automatic reactor shutdown (scram) on low water level. The PPL staff entered this issue into their corrective action program (CAP) as Condition Report (CR) 1668242, and conducted sitewide training on procedural use and adherence standards.

The inspectors identified a performance deficiency because on December 19, 2012, PPL did not implement an approved procedure to open the breaker to the 3A valve motor operator, which resulted in a subsequent unplanned reactor scram. This finding is more

than minor because it is associated with the human performance attribute of the Initiating Events Cornerstone and adversely impacted the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Additionally, this finding was similar to example 4.b of IMC 0612, Appendix E, "Examples of Minor Issues." The finding was evaluated using NRC IMC 0609 Appendix A, "User Guidance for Significance Determination for At-Power Situations," and the Station Standardized Plant Analysis Risk (SPAR) Model for a detailed risk assessment. Based upon the detailed risk assessment, the change in core damage frequency associated with this performance deficiency was in the low E-7 range, or of very low safety significance (Green). The inspectors determined that this finding had a cross-cutting aspect in the area of Human Performance, Work Control, because PPL operators did not appropriately plan work activities associated with opening the 3A valve manually by incorporating the need for planned contingencies, compensatory actions and abort criteria consistent with nuclear safety. [H.3(a)] (Section 3)

Inspection Report# : [2013007](#) (*pdf*)

Significance:  Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for Acts of Nature

The inspectors identified a Green NCV of TS 5.4.1, "Procedures," when PPL did not maintain adequate procedures to respond proactively to acts of nature. Specifically, PPL's adverse weather procedure did not ensure timely risk management activities for imminent adverse weather were completed despite a National Weather Service (NWS) declaration of a high wind watch, high wind advisory, and a tornado watch. PPL entered this item in their Corrective Action Program (CAP) as condition report (CR) 1628452.

The issue was evaluated in accordance with IMC 0612 and determined to be more than minor since it affected the procedure quality attribute of the Initiating Events cornerstone and its objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the inadequate procedure prevented PPL from taking proactive steps to limit the likelihood of high wind or tornado-related missile hazards upsetting plant electrical power systems.

The finding screened to Green in accordance with IMC 0609, Attachment 4, and Appendix A, Exhibit 1, since it did not cause a reactor trip, involve the complete or partial loss of mitigation or support equipment, or impact the frequency of a fire or internal flooding event.

The finding was determined to have a cross-cutting aspect in the area of Problem Identification and Resolution - CAP because PPL did not identify issues completely, accurately, and in a timely manner commensurate with their safety significance.

Specifically, PPL did not identify that the Off Normal procedure was inadequate both during the 2011 periodic procedural review and during documentation of inspector observations in May 2012 as part of CR 1579977. [P.1(a)] (Section 1R01)

Inspection Report# : [2012004](#) (*pdf*)

Mitigating Systems

Significance:  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Combustible Storage in Restricted Areas Without Approval

The inspectors identified a Green NCV of Unit 2 Operating License Condition 2.C.(3), regarding its fire protection program, when PPL stored transient combustibles in restricted areas without evaluations by the site fire protection group. PPL procedure NDAP-QA-0440, “Control of Transient Combustible/Hazardous Materials,” Revision 10, section 6.2.4 states that, for restricted areas, “transient combustibles or hazardous materials shall not be stored in these areas without specific instructions to do so.” It continues that “specific approvals for storage in Restricted Areas must be from the Site Fire Protection Group.” PPL removed transient combustibles from the restricted areas, established hourly fire watches as appropriate, revised procedures, conducted walkdowns for the extent of the condition, and entered the issues in their CAP.

The inspectors evaluated this finding using IMC 0612 Appendix B and determined it to be more than minor based on affecting the Protection against External Factors attribute of the Mitigating Systems cornerstone and its objective to ensure the availability, reliability, and capability of systems that respond to initiating events, in this case fire, to prevent undesirable consequences. Additionally, it was similar to IMC 0612 Appendix E example 4.k in that in all of the observations, transient combustibles were in a combustible free zone required for separation of independent trains and, in one case, the fire loading was not within fire hazard analysis limits. The finding was qualitatively screened in accordance with IMC 0609 Appendix F where the finding was categorized under Fire Prevention and Administrative Controls. The degradation was assigned a Low rating and screened to Green based on the Low degradation rating. The finding was determined to have a cross-cutting aspect in the area of Human Performance, Work Practices, for the need to ensure supervisory and management oversight of work activities such that nuclear safety is supported. Specifically, PPL supervisory and management oversight had not sufficiently coached and reinforced the knowledge of station and procedural standards regarding restricted area requirements.

Inspection Report# : [2013002](#) (*pdf*)

Significance: N/A Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate 10 CFR 50.59 Screening of TS Bases Change

The inspectors identified a Severity Level IV (SL-IV) NCV of 10 CFR 50.59, “Changes, Tests, and Experiments,” when PPL made changes that affected Unit 1 and Unit 2 TS 3.8.3 without obtaining a license amendment pursuant to 10 CFR 50.90. Specifically, PPL changed the TS 3.8.3 bases to support raising the American Petroleum Institute (API) gravity of acceptable diesel fuel oil by crediting the fuel oil day tank capacity to meet the onsite fuel requirements. This change altered the intent of TS 3.8.3. PPL entered this item in their CAP as CR 1678266, made urgent changes to surveillance procedures, evaluated the issue, and ultimately agreed with this conclusion.

The inspectors determined that the failure to implement the requirements of 10 CFR 50.59 for changes to the TSBs was a performance deficiency within PPL’s ability to foresee and correct. The inspectors evaluated the finding in accordance with IMC 0612 Appendix B. The inspectors determined that this issue impacted the regulatory function by failing to receive prior NRC approval for changes in licensed activities. Therefore, the violation was compared to examples in Enforcement Policy section 6. The violation was determined to be more than minor based on similarity to SLIV example 6.1.d.2, a 10 CFR 50.59 violation that resulted in conditions evaluated as having very low safety significance. The inspectors also evaluated the performance deficiency under the ROP and determined that the associated ROP finding was minor since PPL had not accepted fuel oil deliveries with a higher gravity. As such, no cross-cutting aspect was assigned to this finding.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for Control Room Cooling Fan Train Failure

A self-revealing NCV of 10 CFR 50 Appendix B, Criteria V “Instructions, Procedures, and Drawings,” was identified because PPL did not ensure alarm response procedures (ARPs) for control room cooling fan train failures were adequate, which resulted in the subsequent loss of both trains of cooling during clearance order (CO) application for fan repair work. Specifically, the ARP actions were deficient in allowing an abnormal system control switch configuration that led to the inadvertent shutdown of the in-service ‘B’ train fans during the application of the CO process to perform work on the failed ‘A’ control room cooling fan train. PPL entered the issue into their CAP to repair the failed damper and also evaluate the extent-of-condition to ensure the adequacy of other applicable ventilation procedures.

The inspectors determined the deficiency was more than minor because it was associated with the Procedure Quality attribute of the Mitigating System Cornerstone. The inadequate procedure resulted in the loss of control room cooling fans, which affects the objective to ensure the availability and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined through a review of IMC 0609 Appendix A, Exhibit 2, “Mitigating Systems Screening Questions,” that the finding was of very low safety significance (Green) because the finding was not related to a design or qualification deficiency, did not represent a loss of a credited mitigating system safety function because cooling was restored in a timely manner, and did not screen as potentially risk significant due to external initiating events. The control room operators immediately recognized the loss of cooling and took manual action to restart the ‘B’ cooling train within 15 minutes to ensure control room temperatures were not adversely affected. The finding did not have a cross-cutting aspect because the inadequate ARP was an historical issue not indicative of current performance. Specifically, the procedures had not been adequately identified and revised in 2003 and this occurred outside of the nominal three-year period for evaluating present performance as defined in IMC 0612, section 03.15. Additionally, PPL has instituted procedure and CAP improvements since that time which would have prevented the performance deficiency.

Inspection Report# : [2013002](#) (*pdf*)

Significance:  Feb 01, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish and Implement Written Procedures for Operating Plant Equipment

A self-revealing Green NCV of TS 5.4.1, “Procedures,” was identified involving the failure to incorporate the results of a Failure Modes and Effects Analysis (FMEA) completed in January 2010 into applicable operating procedures. The FMEA identified a vulnerability involving operator response to a loss of power to the RFP discharge isolation valves 3A (B, C) during the transfer from Discharge Pressure Mode (DPM) to Flow Control Mode (FCM). Specifically, PPL’s FW operating procedures were not maintained to ensure operators could adequately recover RPV water level control when challenged with a system failure such as the condition that resulted in the Unit 2 scram on December 19, 2012. The PPL staff entered this issue into the CAP as AR-OPG-1654037, CR 1666244, and CR 1666253.

The finding was more than minor because it was associated with the procedure quality attribute of the Mitigating Systems Cornerstone and adversely impacted the objective to ensure 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 NRC IMC 0609, Attachment 0609.04, “Initial Characterization of Findings,” and Appendix A, “User Guidance for Significance Determination for At-Power Situations,” and screened as very low safety significance (Green) per Exhibit 2. The inspectors determined that this finding had a cross-cutting aspect in the area of Human

Performance, Resources, because PPL staff did not ensure that procedures were complete, accurate and up-to-date to assure nuclear safety. Specifically, PPL's engineering modification procedures and checklists did not ensure that known single point design vulnerabilities were adequately addressed in FW procedures to ensure operators could adequately recover reactor water level prior to the Unit 2 reactor scram on December 19, 2012. [H.2(c)] (Section 3)

Inspection Report# : [2013007](#) (*pdf*)

Significance: G Feb 01, 2013

Identified By: NRC

Item Type: FIN Finding

Failure to Implement the Corrective Action Process

A self-revealing finding (FIN) of very low safety significance (Green) was identified for PPL staff's failure to follow their CAP procedure, NDAP-QA-0702, "Action Request and Condition Report Process," in response to an identified issue with the FW system. Specifically, on August, 23, 2011, PPL's staff did not initiate an action request (AR) or condition report (CR) after determining that ICS digital FW valve control needed to be placed in Manual Valve Control mode prior to de-energizing the 3A motor operated valve (MOV) in order to prevent a loss of all FW flow. This issue went unaddressed and subsequently on December 19, 2012, Unit 2 scrambled on low RPV water level when operators, while attempting to open the stuck 3A valve, opened the 3A valve power supply breaker with the 'A' RFP FW valve controls in automatic causing a loss of all normal FW. The PPL staff entered this issue into the CAP as CR 1653480.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems Cornerstone and adversely impacted the objective to ensure 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 NRC IMC 0609, Attachment 0609.04, "Initial Characterization of Findings," and Appendix A, "User Guidance for Significance Determination for At-Power Situations," and screened as very low safety significance (Green) per Exhibit 2. The inspectors determined that this finding had a cross-cutting aspect in the area of Problem Identification and Resolution, CAP, because PPL's staff did not implement the CAP with a low threshold for identifying issues completely, accurately, and in a timely manner commensurate with their safety significance. Specifically, PPL's staff did not identify non-conforming issues for FW valve control, design and operation that eventually led to a loss of normal FW and scram of Unit 2 on December 19, 2012. [P.1(a)] (Section 5)

Inspection Report# : [2013007](#) (*pdf*)

Significance: G Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Demonstrate Effective Preventive Maintenance Under 50.65(a)(2)

Inspectors identified a Green NCV of 10 CFR 50.65(a)(2) for PPL staff not demonstrating that the performance of the Unit 2 125 volt direct-current (VDC) system was being effectively controlled through appropriate preventive maintenance. Specifically, PPL did not properly classify a functional failure of the Unit 2 125 VDC system on November 23, 2011 as maintenance preventable until prompted by questions from the inspectors. Consequently, PPL staff declared the functional failure as maintenance preventable, determined a maintenance rule performance criteria was exceeded and moved the Unit 2 125 VDC system from a(2) to (a)(1) status in order to establish goals and monitoring as required by 10 CFR 50.65. PPL staff entered this issue in their CAP as CRs 1496655 and 1643158.

This finding was more than minor because it was associated with the Equipment Performance attribute of the Mitigating System cornerstone, and adversely affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, this finding was similar to example 7.d of IMC 0612, Appendix E. Using Section A of Exhibit 2 of NRC IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," inspectors determined this finding was of very low safety significance (Green) because the finding did not represent an actual loss of function of one or more non-TS trains of equipment designated as high safety-significant in accordance with PPL's maintenance rule program for greater than 24 hours. The inspectors determined that this finding had a cross-cutting aspect in the area of Problem Identification and Resolution (PI&R), CAP, because PPL staff did not thoroughly evaluate the Unit 2 125 VDC system functional failure such that the resolution addressed the cause to include proper classification. The inspectors determined that PPL staff not thoroughly evaluating the maintenance preventable aspects of a functional failure was due to the CAP process evaluation not fully addressing the cause such that appropriate classification under the maintenance rule could be made [P.1(c)] (Section 1R12).

Inspection Report# : [2012005](#) (*pdf*)

Significance:  Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Risk Management Actions

The inspectors identified a Green NCV of 10 CFR 50.65(a)(4) when PPL did not implement risk management actions (RMAs) during maintenance as required by station procedures. The inspectors identified multiple examples of PPL non-compliance with 10 CFR 50.65(a)(4); PPL's implementing procedures NDAP-QA-0340, "Protected Equipment Program;" and NDAP-QA-1902, "Integrated Risk Management." PPL entered the issue in their CAP as CRs 1611044, 1604007, 1601929, 1602495, and 1611876.

The finding was more than minor because it was similar to IMC 0612, Appendix E, examples 7.e and 7.f. Specifically, elevated plant risk required RMAs or additional RMAs that were not implemented as required by plant procedures. The finding also 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. In accordance with IMC 0609, Attachment 4, the issues were determined to involve PPL's assessment and management of risk associated with performing maintenance activities and was further assessed under IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management SDP." The issue was evaluated by a Senior Reactor Analyst utilizing flowchart 2, and the finding was determined to be of very low safety significance (Green) since it did not result in an increase to either the incremental core damage probability (ICDP) or to the incremental large early release probability (ILERP). The finding was determined to have a cross-cutting aspect in the area of Human Performance, Work Control, in that PPL did not plan work activities, consistent with nuclear safety, by incorporating risk insights. Specifically, PPL did not incorporate RMAs into its work activities despite recognition of increased risk. [H.3(a)] (Section 1R13)

Inspection Report# : [2012004](#) (*pdf*)

Significance:  Sep 10, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Compensatory Actions for Inadequate MOV Grease Analysis Procedures

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," because PPL did not take appropriate action to promptly correct an identified condition adverse to quality associated with PPL's motor-operated valve (MOV) lubrication program. PPL did not adhere to the corrective action timeliness standards specified in its corrective action process procedure NDAP-QA-0702, "Action Request and Condition Report Process," Revision 36. Section 7.56.1 states, in part, that compensatory action will be provided if permanent action will not be performed

in a timely fashion. Specifically, while evaluating permanent revisions to the program to address the deficiencies, PPL did not take compensatory actions to address MOV grease analysis procedure and engineer qualification program deficiencies before sixty MOV grease analyses were completed in refueling outage 15. PPL entered this performance deficiency into their CAP under CR 1562326.

The inspectors determined that the performance deficiency was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, failure to implement compensatory actions to analyze grease samples in MOVs affects the reliability of these valves. An MOV lubrication program is an integral part of the station's Generic Letter 89-10 program for safety-related MOVs. PPL uses the results of the MOV grease analysis to determine the need for a valve actuator overhaul. The inspectors screened this issue to Green via Inspection Manual Chapter 0609, Attachment 4 and Appendix A, because the finding does not represent a loss of system and/or function, does not represent an actual loss of function of at least a single train for greater than its technical specification allowed outage time or two separate safety systems out-of-service for greater than its technical specification allowed outage time, and does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's Maintenance Rule program for greater than 24 hrs. The inspectors determined that this issue had a cross-cutting aspect in the area of human performance, work practices, because PPL personnel did not follow PPL corrective action program requirements regarding compensatory actions [H.4(b)]. (Section 40A2.1.c(1))

Inspection Report# : [2012009](#) (pdf)

Significance: G Sep 10, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Correct a CAQ Associated with a Safety-Related Battery Maintenance Procedure

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," because PPL did not identify and correct the inadequate weekly testing procedure that resulted in the inoperability of the safety-related 24-volt battery 1D670 that occurred on March 1, 2012. Specifically, because the engineer assigned to perform the Apparent Cause Evaluation (ACE) for the March 1, 2012, failure did not interview the technicians who performed the last weekly surveillance on the battery before the failure, PPL did not identify that the weekly testing procedure did not provide adequate instructions for restoring low battery electrolyte level. PPL entered this performance deficiency into their CAP as CR 1602339.

The inspectors determined that this performance deficiency was more than minor because it affected the equipment performance attribute of the Mitigating Systems cornerstone and its objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, as evidenced by the events on March 1, 2012, the use of the inadequate procedure resulted in the inoperability of the 1D670 battery that supports operation of the safety-related source range and intermediate range instrumentation. The inspectors determined that the inadequate procedure problem was a condition adverse to quality. The inspectors screened this issue to Green via Inspection Manual Chapter 0609, Attachment 4 and Appendix A, because the finding does not represent a loss of system and/or function, does not represent an actual loss of function of at least a single train for greater than its technical specification allowed outage time or two separate safety systems out-of-service for greater than its technical specification allowed outage time, and does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's Maintenance Rule program for greater than 24 hrs. The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution, corrective action program, because PPL did not appropriately evaluate the unexpected inoperability of a safety-related battery such that a condition adverse to quality, the inadequate maintenance procedure that likely caused the battery inoperability, was identified and corrected [P.1.(c)]. (Section 40A2.1.c(2))

Inspection Report# : [2012009](#) (pdf)

Significance: G Sep 10, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify and Correct a CAQ Associated with Reactor Recirculation Valve Exercising Surveillance Procedure

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," because PPL did not identify an inadequate recirculation valve surveillance procedure when the licensee completed the extent of condition review that was performed as part of the root cause analysis for the Reactor Core Isolation Cooling (RCIC) ramp generator signal converter (RGSC) failure on June 29, 2011. Specifically, PPL did not adhere to the extent of condition determination standards established in PPL procedure NDAP-00-0752, "Cause Analysis." The actions taken to address the extent of condition were not of a depth sufficient to identify the same deficiency that existed in the RCIC flow surveillance procedure in other applicable surveillance procedures. As a result, the inadequate recirculation valve surveillance procedure was not identified. PPL entered this performance deficiency into their CAP as CR 1596633.

The inspectors determined that this performance deficiency was more than minor because it affected the procedural quality attribute of the Mitigating Systems cornerstone and its objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, PPL did not complete an evaluation of the extent of condition for the identified inadequate RCIC surveillance procedure to a depth that would have identified the same deficiency in other similar procedures. As a result, an independent review by inspectors identified a similar condition associated with the reactor recirculation valve exercising procedure. The inspectors determined that this procedure problem was a condition adverse to quality. The inspectors screened this issue to Green via Inspection Manual Chapter 0609, Attachment 4 and Appendix A, because the finding does not represent a loss of system and/or function, does not represent an actual loss of function of at least a single train for greater than its technical specification allowed outage time or two separate safety systems out-of-service for greater than its technical specification allowed

outage time, and does not represent an actual loss of function of one or more non-technical specification trains of equipment designated as high safety-significant in accordance with the licensee's Maintenance Rule program for greater than 24 hrs. The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution, corrective action program, because, although the root cause analysis appropriately bounded and defined the necessary actions to address the extent of condition, the implementation of those actions was insufficient to ensure similar conditions did not exist in other site procedures [P.1.(d)]. (Section 40A2.1.c(3))

Inspection Report# : [2012009](#) (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)

Inspection Report# : [2012005](#) (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:  Sep 30, 2012

Identified By: NRC

Item Type: FIN Finding

Inadequate Troubleshooting Results in Loss of Secondary Containment and Protected Equipment

A self-revealing Green finding against PPL procedure NDAP-QA-0510, “Troubleshooting Plant Equipment,” was identified when inadequate troubleshooting caused repeated inoperability of secondary containment, an associated unplanned Unit 2 entry into a 4-hour limiting condition for operation (LCO) action statement, and a loss of the ‘1C’ fuel pool cooling (FPC) pump during equipment restoration. The FPC pump had been designated as protected equipment as a risk management action. The failure to perform adequate troubleshooting activities to identify and correct equipment problems prior to restoration was a performance deficiency that was within PPL’s ability to foresee and prevent. PPL entered this issue into their CAP as CR 1628250.

The inspectors determined that the finding was more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone and adversely affected its objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the event resulted in the inoperability of secondary containment and loss of a FPC pump. The finding was evaluated in accordance with IMC 0609, Attachment 4, and Appendix A - Exhibit 3, and was determined to be of very low safety significance (Green) because the finding did not only represent a degradation of the radiological barrier function provided for the standby gas treatment system and it did not: a) cause the spent fuel pool to exceed a maximum temperature limit; b) cause mechanical fuel damage and detectable release of radio-nuclides; c) result in the loss of spent fuel pool water inventory; or d) affect spent fuel shutdown margin. This finding is related to the cross-cutting area of Human Performance – Decision-Making because PPL did not make safety-significant or risk-significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained. Specifically, PPL failed to restore equipment in a systematic manner, given the intermittent nature of heater faults, to preclude a repeated loss of protected equipment and secondary containment.

[H.1(a)] (Section 1R12)

Inspection Report# : [2012004](#) (*pdf*)

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*)

Emergency Preparedness

Significance: G Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure of Full-Scale Drill Critique to Identify an RSPS Weakness

. Inspectors identified a Green NCV associated with emergency preparedness planning standard 10 CFR 50.47(b)(14) and the requirements of Section IV.F.2.g of

10 CFR 50, Appendix E. Specifically, PPL personnel did not identify an Emergency Response Organization (ERO) performance weakness associated with an untimely notification of an emergency declaration during their critique following the full-scale emergency preparedness (EP) drill. In the case of ERO performance, simulator equipment issues prevented the ability of drill controllers to satisfactorily evaluate performance of the ERO and PPL staff did not identify that all off-site response organizations (OROs)

were not notified within fifteen minutes. The critique deficiency was entered into PPL's CAP as CR 1648380.

The finding is more than minor because it is associated with the ERO attribute of the Emergency Preparedness cornerstone and affected the cornerstone objective to ensure that PPL staff are capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The inspectors assessed the issue, related to the failure to make a timely notification to the OROs, using NRC IMC 0609 Appendix B, "Emergency Preparedness Significance Determination Process." PPL's drill critique not identifying the untimely notification met the NRC's definition of a weakness in a full-scale drill. However, because of the unique nature of the equipment failures associated with the notification of the first ORO, inspectors determined that the failure to critique the drill weakness only constituted a degradation of the planning standard (PS) function. Therefore the finding is characterized as very low safety significance (Green). The finding is related to the cross-cutting area of PI&R, CAP, in that PPL staff did not identify a risk significant planning standard (RSPS) performance issue completely, accurately, and in a timely manner commensurate with the safety significance. Specifically, during the critique of the full-scale drill conducted on October 14, 2012, PPL staff did not recognize and critique that an RSPS was not met and did not place this issue into the CAP until prompted by inspectors. [P.1(a)] (Section 1EP6)

Inspection Report# : [2012005](#) (*pdf*)

Occupational Radiation Safety

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

Significance: N/A Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Report Actuation of the Reactor Protection System

The inspectors identified a SL IV NCV of 10 CFR 50.72(b)(3)(iv)(A) and (B) when PPL operators did not report a valid actuation of the Unit 2 RPS on November 9, 2012 within eight hours of occurrence as required. The concern was entered into PPL's CAP as CR 1643096 and an Emergency Notification System (ENS) report was submitted restoring compliance.

This finding was evaluated using the traditional enforcement process because the failure to accurately report events has the potential to impact or impede the regulatory process. The finding was determined to be a Severity Level IV violation based on example 6.9.d.9 of the NRC Enforcement Policy. This example states that a licensee failing to make a report required by 10 CFR 50.72 or 10 CFR 50.73 is an example of a Severity Level IV violation. Because this violation involves the traditional enforcement process and does not have an underlying technical violation that would be considered more-than-minor, inspectors did not assign a cross-cutting aspect to this violation in accordance with IMC 0612, Appendix B. (Section 4OA3)

Inspection Report# : [2012005](#) (*pdf*)

Last modified : June 04, 2013