Perry 1
4Q/2013 Plant Inspection Findings

Initiating Events

Significance: N/A Jul 28, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Title10 CFR 50.59 Evaluation Did Not Consider the Freeze Seal Effect to the RCPB (Section 1R17.1.b(1))
The inspectors identified a finding of very low safety significance and associated Severity Level IV Non-Cited Violation of Title 10 Code of Federal Regulations (CFR) 50.59, “Changes, Test, and Experiments,” for the failure to perform a written evaluation, which provided the bases for the determination that a change did not require a license amendment. Specifically, the licensee failed to provide a basis for not applying for a license amendment associated with the use of a freeze seal in the reactor coolant pressure boundary when its integrity was required to protect irradiated fuel. The finding was entered into the licensee’s Corrective Action Program with recommended actions to, in part, revise the associated 10 CFR 50.59 documents.

The inspectors determined that the violation was more than minor because they could not reasonably determine the changes would not have ultimately required NRC prior approval. The finding affected the Initiating Events cornerstone attribute of equipment performance and affected 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. The inspectors determined that the underlying technical issue was of very low safety significance (Green) using a Phase II evaluation. The inspectors did not identify a cross-cutting aspect associated with this finding because it was not confirmed to reflect current performance due to the age of the performance deficiency

Inspection Report# : 2013008 *(pdf)*

Significance: G Jul 28, 2013
Identified By: NRC
Item Type: FIN Finding
Title 10 CFR 50.59 Evaluation Did Not Consider the Freeze Seal Effect to the RCPB (Section 1R17.1.b(1))
The inspectors identified a finding of very low safety significance and associated Severity Level IV Non-Cited Violation of Title 10 Code of Federal Regulations (CFR) 50.59, “Changes, Test, and Experiments,” for the failure to perform a written evaluation, which provided the bases for the determination that a change did not require a license amendment. Specifically, the licensee failed to provide a basis for not applying for a license amendment associated with the use of a freeze seal in the reactor coolant pressure boundary when its integrity was required to protect irradiated fuel. The finding was entered into the licensee’s Corrective Action Program with recommended actions to, in part, revise the associated 10 CFR 50.59 documents.

The inspectors determined that the violation was more than minor because they could not reasonably determine the changes would not have ultimately required NRC prior approval. The finding affected the Initiating Events cornerstone attribute of equipment performance and affected 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. The inspectors determined that the underlying technical issue was of very low safety significance (Green) using a Phase II evaluation. The inspectors did not identify a cross-cutting aspect associated with this finding because it was not confirmed to reflect current performance due to the age of the performance deficiency.

Inspection Report# : 2013008 *(pdf)*

Significance: G Jun 28, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement a Procedure Appropriate to the Circumstances Leads to Reactor Overfeed Event
A finding of very low safety significance and associated non-cited violation of
10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self revealed when the licensee failed to perform a procedure that was appropriate to the circumstances. Specifically, on May 12, 2013, work instruction PTI N27-P0012, Revision 5, was performed when the condition of the plant, i.e., the specific configuration of the feedwater system and the relatively low reactor pressure, was incapable of supporting the test and resulted in a reactor overfill event. The issue was entered into the corrective action program as condition report 2013-07473. The licensee performed an apparent cause evaluation to identify the most likely causal factors, citing the inadequacy of the procedure and the lack of proper planning as contributing causes.

The inspectors reviewed Inspection Manual Chapter (MC) 0612, Appendix B, "Issue Screening," and determined that the issue was more than minor because it was associated with the Initiating Events Cornerstone attribute of procedure quality and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors determined that the finding was of very low safety significance (Green) in accordance with IMC 0609, Appendix A, "Significance Determination Process." This finding has a cross cutting aspect in the area of human performance, work control, for the licensee's failure to plan work activities such that they could be performed while the plant was in an appropriate operational condition. Specifically, the licensee rescheduled the activity without performing an adequate impact review of the different plant conditions on the activity.

Inspection Report# : 2013009 *(pdf)*

Significance: G May 03, 2013
Identified By: Self-Revealing
Item Type: FIN Finding
FAILURE TO PERFORM VENDOR RECOMMENDED PREVENTIVE MAINTENANCE ON THE BALANDE-OF-PLANT STATIC TRANSFER SWITCH
A self-revealed finding of very low safety significance was identified for the licensee's failure to implement recommended preventive maintenance on a balance-of-plant (BOP) inverter and static transfer switch. Specifically, the licensee failed to implement vendor-recommended preventive maintenance requirements to replace circuit cards in both a BOP inverter and an associated static transfer switch every twelve and ten years, respectively. No violation of NRC regulatory requirements was identified because the performance deficiency involved nonsafety-related equipment. The licensee entered this issue into the corrective action program as Condition Report 2013-00954.

The inspectors determined that the failure to perform preventive maintenance on the failed BOP inverter and static transfer switch in accordance with vendor recommendations was a performance deficiency. The performance deficiency was evaluated using Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," dated September 7, 2012, and was determined to be more than minor, and thus a finding, because it was associated with the equipment performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective to limit
the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was evaluated using IMC 0609, dated June 2, 2011, and IMC 0609, Attachment 0609.04, dated

June 19, 2012, and IMC 0609, Appendix A, Exhibit 1 – Initiating Events Screening Questions, dated June 19, 2012. In answering "no" to "B. Transient Initiators, 'Did the finding 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?,'" the inspectors determined that the finding was of very low safety significance (Green). The finding has a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component in that the licensee failed to thoroughly evaluate problems such that the resolution addressed the causes. Specifically, the licensee had previously identified the reliability of the BOP inverter and static transfer switch as the cause for previous feedwater-related events but failed to implement recommended corrective actions to prevent future events (P.1(c)).

Inspection Report# : 2013002 *(pdf)*

Mitigating Systems

Significance: G Sep 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO MEET FIRE BRIGADE DRILL TRAINING REQUIREMENTS
The inspectors identified a finding of very low safety significance and associated non-cited violation (NCV) of License Condition 2.C(6) for failure to ensure that an individual met the fire drill participation requirements for fire brigade members and fire brigade leaders. Specifically, certified fire brigade members and fire brigade leaders are required to participate in at least two drills per year and in one case the licensee failed to conduct proper drills as required by the license condition. The issue was entered into the licensee's corrective action program as Condition Report 2013-12964, and the licensee initiated immediate action to ensure that all current fire brigade members/leaders met drill participation requirements prior to fulfilling those roles.

The inspectors determined that the failure to conduct proper drills was a performance deficiency and was more than minor in accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," dated September 7, 2012, because the finding was associated with the Mitigating Systems Cornerstone attribute of Protection Against External Factors for Fire and adversely affected the associated cornerstone objective of ensuring the reliability and capability of the fire brigade to respond to initiating events to prevent undesirable consequences. Because the licensee failed to ensure that fire brigade members and fire brigade leaders met the licensee's qualification requirements of participating in at least two fire drills per year, the mitigating systems cornerstone attribute to ensure the availability and reliability of the fire brigade to respond to initiating events was impacted. The finding was evaluated using IMC 0609, Significance Determination Process (SDP), Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012. Because the finding involved the Fire Brigade, Table 3, SDP Appendix Router, Section E.1, "Fire Protection," directed NRC staff to use IMC 0609, Appendix A, "The SDP for Findings At-Power," dated June 19, 2012. Exhibit 2 of IMC 0609, the Mitigating Systems Screening Questions, Section D.1.a., Fire Brigade, was checked "yes" because the finding involved the Fire Brigade training and qualification requirements. The first condition under D.1.a., "The fire brigade demonstrated the ability to meet the required times for fire extinguishment for drill scenarios," was applicable and the finding did not significantly affect the ability of the fire brigade to respond to a fire, so the finding was determined to be of very low safety significance. This finding has a cross-cutting aspect in the area of problem identification and resolution associated with the corrective action program component, in that the licensee did not take corrective actions to address safety issues and adverse trends in a timely manner, commensurate with their safety significance and complexity. Specifically, the licensee failed to identify that all drill requirements for fire brigade personnel as required in Branch Technical Position APCSB 9.5-1, Appendix A, which requires specific factors that qualify a drill for training purposes, was not used to

plan and execute drills for personnel re-qualifying for this watch position during 2012 and 2013 (P.1(d)).

Inspection Report# : 2013004 *(pdf)*

Significance: G Jul 28, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Insufficient Controls to Prevent Common Mode Flooding of ECCS Rooms (Section 4OA2.1.b(1))
The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to control drainage of the emergency core cooling system room sumps in a manner that prevents common mode flooding of these rooms. Specifically, procedures did not ensure appropriate controls to prevent backflow from the floor drain system. The licensee entered the issue into their Corrective Action Program and revised procedures to prevent opening more than one emergency core cooling system room sump isolation valve at the same time.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attribute of protection against external factors and affected the cornerstone objective of ensuring the availability, reliability, and capability of the emergency core cooling system to respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance (Green) because it did not result in either the loss of operability or an actual loss or degradation of a function designed to mitigate flooding. Specifically, a review of recent plant history did not find an instance where the configuration of the floor drain system allowed common mode flooding of the emergency core cooling system rooms when operability of this system was required. The inspectors determined that this finding had a cross-cutting aspect in the area of problem identification and resolution because the licensee did not conduct a self-assessment of sufficient depth. Specifically, the licensee evaluated a flooding incident during a self-assessment conducted in 2013 and failed to thoroughly evaluate the cause that resulted in common mode flooding of the rooms.
Inspection Report# : 2013008 *(pdf)*

Significance: G May 03, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
INADEQUATE PROCEDURE RESULTED IN LOSS OF HIGH-PRESSURE CORE SPRAY FUNCTION
A self-revealed finding of very low safety significance and associated non-cited violation of Technical Specification 5.4.1.a., "Procedures," was identified for the licensee's failure to establish and maintain a correct surveillance inspection procedure for high-pressure core spray (HPCS) emergency core cooling systems integrated testing. The surveillance procedure used for the HPCS, safety-related electrical bus, EH13, testing during refueling outage 14, directly resulted in an unplanned outage of the bus for nearly 4 hours. The licensee entered the issue into the corrective action program as Condition Report 2013-03863.

The inspectors determined that the failure to develop a correct surveillance procedure required by Technical Specification 5.4.1 a. was a performance deficiency and resulted in an unplanned loss of the EH13 safety-related electric bus and caused a loss of function for HPCS. The performance deficiency was determined to be more than minor, and thus a finding, using IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because it was associated with 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. The finding was evaluated for significance using IMC 0609, Attachment 0609.04, dated June 19, 2012, and IMC 0609, Appendix A, Exhibit 2 – Mitigating Systems Screening Questions, dated June 19, 2012. The inspectors answered "yes" to Question 2, "Does the finding represent a loss of system and/or function?" A detailed risk evaluation was conducted by the Region III Senior Reactor Analyst (SRA). The SRA

performed an evaluation using the NRC's Standardized Plant Analysis Risk model for Perry. The SRA assumed that EH13 was unavailable for 4 hours. The change in core damage frequency was estimated to be much less than 1E-6/yr, which represents a finding of very low safety significance (Green). The finding has a cross-cutting aspect in the area of human performance associated with the work control component, in that, the licensee failed to appropriately coordinate work activities by incorporating actions to address the impact of changes to the work scope or activities which could affect the plant. Specifically, the development of a new surveillance procedure did not correctly predict the plant response for the safety-related system test lineup and resulted in an unplanned loss of the EH13 safety-related electric bus (H.3(b)).

Inspection Report# : 2013002 *(pdf)*

Significance: G May 03, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
VALVE MIS-POSITION CAUSES SDV LEVEL DETECTOR INOPERABILITY
A self-revealed finding of very low safety significance and associated non-cited violation of Technical Specification 5.4.1.a., "Procedures," was identified for the licensee's failure to correctly implement a surveillance procedure for calibration of a scram discharge volume (SDV) level detector. Specifically, licensee technicians failed to open and lock open, with independent verification, the lower isolation valve to an SDV level detector. The licensee documented the issue in the corrective action program as Condition Report 2013-04452.

The inspectors determined that the failure to correctly complete the procedure and lock open the lower isolation valve was a performance deficiency which resulted in a locked in scram signal with a resulting inability to clear the signal and restore safety-related systems after the scram (to begin a refueling outage) for several days. The performance deficiency was evaluated under Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," dated September 7, 2012, and determined to be more than minor, and thus a finding, because it was associated with the human performance attribute of the Mitigating Systems cornerstone and it 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). The finding was evaluated for significance using IMC 0609, Attachment 0609.04, dated June 19, 2012, and IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," dated June 19, 2012. By answering "no" to "C. Reactivity Control Systems," questions 1, 2, and 3, the inspectors determined this finding was of very low safety significance because the finding did not affect other diverse methods of reactor shutdown, it did not add positive reactivity, nor did it result in the mismanagement of reactivity by an operator. The finding has a cross-cutting aspect in the area of human performance associated with the work practices component, in that the licensee communicates human error prevention techniques, that techniques are used commensurate with the risk of the assigned task, and personnel do not proceed in the face of uncertainty or unexpected circumstances. Specifically, the independent verifier found the valve in an unexpected condition with a locking device already installed, did not stop the process and question the valve position, but proceeded in the face of uncertainty (H.4(a))

Inspection Report# : 2013002 *(pdf)*

Significance: G May 03, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW PROCEDURES FOR CONDUCTING A STANDBY LIQUID CONTROL SYSTEM SURVEILLANCE
A self-revealed finding of very low safety significance and associated non cited violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when the licensee failed to correctly implement procedures for testing safety related equipment. Specifically, the licensee failed to correctly implement prerequisite

steps in a surveillance instruction, causing the standby liquid control (SLC) pump 'A' plunger pot drain valves to be left open, contrary to procedure. The licensee entered the finding into the corrective action program as Condition Report 2013-00114 and took immediate action to close the valves when leakage was discovered from the drain valve tailpipes.

The inspectors determined that the failure to correctly complete the prerequisite steps in surveillance instruction (SVI)-C41-T2001-A was a performance deficiency which resulted in a water spill in containment, an associated lockup of the rod control and information system (RCIS), and required the licensee to enter two off-normal instructions (ONIs). The performance deficiency was determined to be more than minor, and thus a finding, using Inspection Manual Chapter (IMC) 0612, Appendix E, “Examples of Minor Issues,” dated August 11, 2009, because it is similar to Example 4.b and resulted in an unexpected, “Inhibit Rod Motion RCIS OOS,” alarm and caused the operating crew to enter ONI-C11-1, “Inability to Move Control Rods.” The finding was evaluated for significance using IMC 0609, Attachment 0609.04, dated June 19, 2012, and IMC 0609, Appendix A, Exhibit 2, “Mitigating Systems Screening Questions,” dated June 19, 2012. In answering “no” to “C. Reactivity Control Systems,” questions 1, 2, and 3, the inspectors determined that the finding was of very low safety significance because the finding did not affect a reactor protection system trip signal, did not add positive reactivity, nor did it result in the mismanagement of reactivity by an operator. The finding has a cross-cutting aspect in the area of human performance associated with the work practices component, in that licensee personnel failed to use human error prevention techniques, such as holding a pre-job briefing, self and peer checking, and proper documentation of activities. Specifically, the operation to position the plunger pot drain valves on the 'A' and 'B' SLC pumps was not coordinated by the field supervisor in accordance with the SVI and operations personnel proceeded in the face of uncertainty or unexpected circumstances (H.4(a)).

Inspection Report# : 2013002 *(pdf)*

Barrier Integrity

Significance: G Nov 22, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO COMPLY WITH TECHNICAL SPECIFICATION 3.4.11
. The inspectors identified a finding of very low safety significance (Green) and associated Non-Cited Violation of Technical Specification 3.4.11, “RCS Pressure and Temperature (P/T) Limits,” for failure to comply with reactor pressure vessel pressure/temperature limits. Specifically, in 2011 the inspectors identified the pressure/temperature limits in Technical Specification 3.4.11 only contained values for reactor pressure vessel pressures greater than 0 pounds per square inch gauge. However, between June 2011 and July 2013, the licensee operated the plant with a vacuum in the reactor pressure vessel during 5 cold startups and 1 cooldown. The licensee entered the finding into its corrective action program as Condition Report CR 2013-18689.

The performance deficiency was determined to be more than minor because the finding was associated with the area of Routine Operations Performance within the Human Performance attribute of the Barrier Integrity Cornerstone and had the potential to adversely affect the associated cornerstone objective of providing reasonable assurance that a physical design barrier (reactor coolant system) protects the public from radionuclide releases caused by accidents or events. The finding screened as very low safety significance because it was determined that there was no change in risk due to the performance deficiency. This finding has a cross-cutting aspect in the area of human performance, resources. Specifically, complete, accurate, and up-to-date procedures were not available to operators to ensure operations within the requirements of Technical Specification 3.4.11, (H.2(c)).

Inspection Report# : 2013007 *(pdf)*

Significance: G Nov 22, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROMPTLY CORRECT A NON-CONCERVATIVE TECHNICAL SPECIFICATION
The inspectors identified a finding of very low safety significance (Green) and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for failure to promptly correct a non-conservative Technical Specification. Specifically, the inspectors identified on November 14, 2013, that the licensee failed to promptly correct the non-conservative Technical Specification 3.4.11 by not submitting a license amendment request in accordance with NRC Administrative Letter 98-10, which required submittal within 1 year or 1 operating cycle. The licensee had determined Technical Specification 3.4.11, "RCS Pressure and Temperature (P/T) Limits," to be non-conservative on October 16, 2009, and implemented administrative controls as allowed by the Administrative Letter. As of November 14, 2013, the licensee had not submitted the license amendment request, over 4 years and 2 operating cycles after determining the Technical Specification was non-conservative. The licensee entered the finding into the corrective action program as Condition Report CR 2013-18983.

The performance deficiency was determined to be more than minor because the finding was associated with the area of Routine Operations Procedures within the Procedure Quality attribute of the Barrier Integrity Cornerstone and had the potential to adversely affect the associated cornerstone objective of providing 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 finding was screened as very low safety significance because it was determined that operators followed the appropriate reactor coolant system P/T curves even though the Technical Specification was non-conservative.
The finding has a cross-cutting aspect in the area of human performance, decision-making, where licensee decisions demonstrate that nuclear safety is an overriding priority. Specifically, from the time of discovery of the non-conservative technical specification until now, various decisions had been made by the licensee that have delayed the timely submittal of the license amendment request (H.1(c)).

Inspection Report# : 2013007 *(pdf)*

Significance: G Jun 28, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Procedural Requirements for RWCU System Fill and Vent
A finding of very low safety significance and associated non-cited violation of Technical Specification 5.4, "Procedures," was self revealed when the licensee failed to adhere to procedural requirements during the filling and venting of the reactor water cleanup (RWCU) system. Specifically, on April 26, 2013, valves 1G33-F008A and F556A were left in the open position, contrary to the requirements of step 7.16.9 of procedure SOI-G33, revision 36, and resulted in the RWCU system being aligned to the condensate transfer and storage system. This valve misposition event also resulted in the TS 3.6.1.3 inoperability of the containment isolation valve 1P11F0545. Upon discovery of the condition, the licensee promptly corrected the error and the entered the condition into its corrective action program as condition report 2013 07483, and performed an apparent cause evaluation.

The inspectors reviewed Inspection Manual Chapter (MC) 0612, Appendix B, "Issue Screening," and determined that the issue was more than minor because it was associated with the Barrier Integrity Cornerstone attribute of configuration control and adversely affected the cornerstone objective of providing 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 determined that the finding was of very low safety significance (Green) in accordance with IMC 0609, Appendix A, “Significance Determination Process.” This finding has a cross cutting aspect in the area of human performance, work practices, for the licensee’s failure to successfully incorporate human error prevention techniques, such as self and peer checks.

Inspection Report# : 2013009 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Sep 30, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
WORKER ACCESS INTO A HIGH RADIATION AREA CONTRARY TO THE REQUIREMENTS OF THE RADIATION WORK PERMIT
A finding of very low safety significance and an associated non-cited violation (NCV) of Technical Specification 5.4.1 was self-revealed through an electronic dosimeter alarm when, on August 6, 2013, a licensee worker inappropriately entered a high radiation area in the overhead of Auxiliary Building 574’. The inspectors concluded that the worker failed to comply with the requirements of his radiation work permit that prohibited work 6 feet above floor level until a radiological survey is performed and radiation protection verifies that the area met the requirements of the radiation work permit. This issue was entered into the licensee’s corrective action program as Condition Report 2013 12077. Corrective actions focused on performance management of the individual involved.

The inspectors reviewed Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," dated August 11, 2009, and determined that the issue was more than minor because it was similar to Example 6(h). The inspectors also determined that the finding was of very low safety significance in accordance with IMC 0609, Appendix C, “Occupational Radiation Safety Significance Determination Process,” dated August 19, 2008. The inspectors identified no cross-cutting issues associated with this finding.
Inspection Report# : 2013004 *(pdf)*

Significance: G Sep 30, 2013
Identified By: Self-Revealing
Item Type: FIN Finding
UNPROFESSIONAL WORKER CONDUCT INSIDE A LOCKED HIGH RADIATION AREA IN THE TURBINE BUILDING 620' AUXILIARY STEAM TUNNEL
The inspectors reviewed a self-revealed finding (FIN) of very low safety significance involving an unauthorized activity inside a radiologically contaminated locked high radiation area. Specifically, on April 30, 2013, licensee contract personnel inappropriately placed a plastic container of goldfish inside the Turbine Building 620’ auxiliary steam tunnel. This issue was entered into the licensee’s corrective action program as Condition Report 2013-06758. Corrective actions included performance management of the individuals involved.

The inspectors determined that the finding was more than minor, in accordance with Inspection Manual Chapter (IMC) 0612 because it was associated with the Occupational Radiation Safety Cornerstone attribute of program and

process of radiological exposure and contamination control and adversely affected the associated cornerstone objective to ensure adequate protection of worker health and safety from exposure to radioactive materials during routine civilian nuclear reactor operation. The inspectors also determined that the finding was of very low safety significance in accordance with IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," dated November 28, 2011. Additionally, the inspectors determined that the primary cause of this finding was related to the cross-cutting aspect in the area of human performance in work practices. Specifically, the licensee did not ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety was supported (H.4(c)).

Inspection Report# : 2013004 *(pdf)*

Significance: G Jun 28, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement the Operational and Radiological Controls Necessary to Prevent Plant Manipulations from Adversely Impacting Dose Rates or Airborne Radioactivity Levels
The inspectors identified a finding of very low safety significance and associated non-cited violation of Technical Specification (TS) 5.4, "Procedures." Specifically,
TS 5.4 "Procedures", Step 5.4.1 states, in part, that the licensee shall establish, implement, and maintain applicable procedures recommended in Regulatory Guide
(RG) 1.33, Revision 2, Appendix A. Section 7 of Appendix A of RG 1.33 specifies radiation protection procedures for control of radioactivity for limiting personnel exposures. Licensee procedure NOP-OP-4107, "Radiation Work Permit," requires that radiological controls identify "critical steps or critical instructions for positive radiological control of the work to ensure no change on unexpected change in radiological conditions, and prevent unplanned exposure." Contrary to this, on six occasions during the spring 2013 refueling outage, the licensee failed to implement operational and radiological controls necessary to prevent plant manipulations from adversely impacting ambient radiological dose rates or airborne radioactivity levels in the plant when workers were in the areas. The licensee documented this issue in it's corrective action program as condition report 2013-09891. As an immediate corrective action, the licensee instituted the appropriate operational and radiological controls to ensure personnel safety.

The inspectors reviewed Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening" and determined that the issue was more than minor because, if left uncorrected, the performance deficiency could have led to a more significant safety concern. Specifically, not implementing the operational and radiological controls necessary to prevent plant manipulations from adversely impacting ambient radiological conditions in the plant could result in unnecessary and unplanned radiation exposures. The inspectors determined that the finding was of very low safety significance (Green) in accordance with IMC 0609, Appendix C, "Occupation Radiation Safety Significance Determination Process." This finding has a cross-cutting aspect in the area of human performance, work-control, because the licensee did not appropriately plan work activities when developing the work packages and authorizing the work.
Inspection Report# : 2013009 *(pdf)*

Significance: G Jun 28, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Lock or Continuously Guard Doors to Prevent Unauthorized Entry to an LHRA
A finding of very low safety significance and an associated non-cited violation of Technical Specification 5.7, "High Radiation Area," was self-revealed when the access point to the locked high radiation area of the auxiliary steam tunnel on the 620'-elevation of the turbine building was left unattended on May 1, 2013, for about

8 minutes. This issue was entered into the licensee's corrective action program as condition report 2013-06892. As immediate corrective actions, access to the area was guarded and appropriate controls were instituted.

The inspectors reviewed Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," and determined that the issue was more than minor because it was similar to Example 6(g). The inspectors also determined that the finding was of very low safety significance (Green) in accordance with IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process." This finding has a cross-cutting aspect in the area of human performance, work practices, because the licensee did not ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety was supported.

Inspection Report# : 2013009 *(pdf)*

Significance: G Jun 28, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Post and Barricade a HRA in the Under-Condenser Area Turbine Building Cubicles 13 and 14
The inspectors identified a finding of very low safety significance and an associated non-cited violation of Technical Specification 5.7. "High Radiation Area," when the inspectors identified an unposted, unbarricaded high radiation area under the condenser in turbine building cubicles 13 and 14 that was accessible to personnel by scaffold. This issue was entered into the licensee's corrective action program as
condition report 2013-06139. As an immediate corrective action, the scaffold was removed and appropriate controls were instituted.

The inspectors reviewed Inspection Manual Chapter (IMC) 0612, Appendix E, "Examples of Minor Issues," and determined that the issue was more than minor because it was similar to Example 6(g). The inspectors also determined that the finding was of very low safety significance (Green) in accordance with IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process." This finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program, because the licensee did not thoroughly evaluate and address this issue when initially identified by the NRC in 2011 or during the licensee's extent of condition evaluations.
Inspection Report# : 2013009 *(pdf)*

Public Radiation Safety

Significance: G Sep 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM REPRESENTATIVE SAMPLING OF FISH IN ORDER TO ACCURATELY ASSESS INGESTION RADIATION AS REQUIRED BY THE OFF-SITE DOSE CALCULATION MANUAL
The inspectors identified a finding of very low safety significance and an associated non-cited violation (NCV) of Technical Specification 5.5.1, "Offsite Dose Calculation Manual (ODCM)." Specifically, the licensee failed to follow the "Fish and Invertebrates" sampling requirements specified in the ODCM. Corrective actions were being developed in the corrective action program (Condition Report 2013 14987) and senior plant management expressed the understanding that sampling was important and the condition would be corrected.

The finding was more than minor because it was associated with the Public Radiation Safety Cornerstone attribute of

program and process of projected offsite dose and adversely affected the associated cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials released into the public domain. The finding was assessed using Inspection Manual Chapter (IMC) 0609, Attachment D, dated February 12, 2008, for the Public Radiation Safety Significance Determination Process and determined to be of very low safety significance because it involved the Environmental Monitoring Program. Additionally, the inspectors determined that the primary cause of this finding was related to the cross cutting aspect in the area of human performance in work practices. Specifically, the licensee did not effectively communicate expectations regarding procedural compliance and personnel following procedures (H.4(b)).

Inspection Report# : 2013004 *(pdf)*

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 : February 24, 2014