

Susquehanna 1

1Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Correct Fatigue Related Cracking of the 'B' RRP Lower Seal Cavity Vent Line

A self-revealing finding of very low safety significance (Green) and associated NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for Susquehanna's failure to establish measures to assure a condition adverse to quality was corrected. Specifically, vibration induced fatigue cracking on the Unit 1 'B' reactor recirculation pump (RRP) lower seal cavity vent piping was not corrected in December 2014 after a reactor coolant pressure boundary leak had occurred. This resulted in another reactor coolant pressure boundary leakage at the same location with Unit 1 operating in Mode 1, a condition prohibited by technical specifications (TS) LCO 3.4.4.

Susquehanna's entered the issue into the corrective action program (CAP) as CR-2015-30901 and replaced and modified the union that included the weld. The finding was more than minor because it was associated with the Equipment Performance 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 shutdown as well as power operations. The inspectors evaluated the finding in accordance with Exhibit 1 of IMC 0609, Appendix A, "The significance determination process (SDP) for Findings At-Power," and determined the finding was of very low safety significance (Green) because the leakage would not have exceeded the reactor coolant system (RCS) leak rate for a small loss of coolant accident (LOCA) and it did not affect other systems used to mitigate a LOCA. This finding had a cross-cutting aspect in the area of Human Performance, Work Management, because Susquehanna did not implement a process of planning, controlling, and executing work activities such that nuclear safety is the overriding priority, in that Susquehanna did not adequately coordinate the work activities with different groups [H.5]. Specifically, welding engineers were not engaged in the decision making process during the December 2014 repair and consequently the repair was inadequate to ensure the entire crack had been removed.

Inspection Report# : [2016001](#) (*pdf*)

Significance: G Dec 31, 2015

Identified By: Self-Revealing

Item Type: FIN Finding

Inadvertent Closure of the 'B' Inboard MSIV

Green. A self-revealing finding of very low safety significance (Green) was identified when Susquehanna did not correctly validate a deficient condition associated with the Unit 1 'B' inboard main steam isolation valve (MSIV) direct current (DC) solenoid valve as an actual valve issue, vice indication-only, through the use of specific acceptance criteria as required by MT-AD-509, "Control of Minor Maintenance Activities." By incorrectly concluding the issue was indication only, testing was allowed to be performed which inserted a half-isolation by de-energizing the alternating current (AC) solenoid valve on the 'B' inboard MSIV. When this maintenance was performed, the 'B' inboard MSIV closed unexpectedly, resulting in a reactor scram. The cause of the closure was the failure of the DC solenoid valve on the 'B' inboard MSIV. Susquehanna entered the issue into the CAP as CR-2015-30721 and replaced the DC solenoid for the 'B' MSIV.

The finding is more than minor because it is associated with the equipment performance attribute of the Initiating

Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. Specifically, the maintenance activity performed to validate the DC solenoid valve continuity was inadequate and as a result the testing was allowed to be performed which relied on DC solenoid valve continuity to prevent an MSIV closure. The inadvertent closure of the 'B' inboard MSIV resulted in a high pressure scram. The inspectors evaluated the finding in accordance with IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," Exhibit 1, for the Initiating Events cornerstone. The inspectors determined the finding was of very low safety significance (Green) because it did not cause the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. Specifically, the condenser was maintained for decay heat removal via the bypass valves through the other three main steam lines following the trip. This finding had a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because Susquehanna did not stop when faced uncertain conditions and instead rationalized unanticipated test results. Specifically, the investigation of the extinguished continuity monitor focused on the possibility that it was an indication-only issue and failed to question the acceptability of the current values obtained during troubleshooting.

Inspection Report# : [2015004](#) (pdf)

Significance:  Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Multiple Violations of Work Hour Limitations by Licensed Operators

The inspectors identified a finding of very low safety significance (Green) and associated NCV of 10 CFR 26.205, "Work Hours," because Susquehanna did not ensure that the working hours of licensed operators were maintained within regulatory limits. Specifically, numerous instances of violations were identified in the operations department in which individuals exceeded the required work hour limits while performing duties subject to work hour controls. In review of the issue, the inspectors identified that Susquehanna inappropriately excluded some work hours performing non-covered work from the total accumulated work hours, which allowed individuals to perform covered work while in excess of the work hour limits without meeting the requirements for applying a waiver. Susquehanna entered the issue into the CAP as CR-2015-15708 and initiated action to evaluate the extent of the matter and communicate the issue with the operations department, reinforce the standards for work hour tracking with station personnel, and ensure work hours are appropriately tracked. The inspectors determined that the finding was more than minor because Susquehanna inadequately implemented the requirements of 10 CFR 26.205 and NDAP-QA-0025 routinely. Therefore, if the performance deficiency were left uncorrected, the continued process of not including all hours accumulated toward work hour limits and allowing workers to exceed work hour limits, had the potential to lead to a more significant safety concern. The finding was also similar to IMC 0612, Appendix E, "Examples of Minor Issues," Example 9.a. In accordance with IMC 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Exhibits 1 and 2 of IMC 0609, Appendix A, "The SDP for Findings At-Power," dated June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because no transients, loss of function of a mitigating system, or mismanagement of reactivity occurred as a result of licensed operators performing covered work while not in compliance with the work hour limits specified in 10 CFR 26.205. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Identification, because Susquehanna did not identify the issues completely, accurately, and in a timely manner. Specifically, Susquehanna identified violations of work hour limits on multiple occasions but the CRs were not in sufficient detail to ensure they were appropriately prioritized and assigned for resolution. Individuals did not recognize that work performed doing non-covered work was to be counted as hours accumulated towards the work hour limitations and thus discounted the violations as erroneous. [P.1] (Section 40A2)

Inspection Report# : [2015002](#) (pdf)

Mitigating Systems

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

RHR Shutdown Cooling Procedure Not Maintained Consistent with Technical Specification Requirements

Inspectors identified a finding of very low safety significance (Green) and associated NCV of SSES Unit 1 and 2 TS 5.4.1, "Procedures," because Susquehanna did not maintain the procedure for operation of the residual heat removal (RHR) shutdown cooling (SDC) system consistent with the requirements in TS 3.4.8, "RHR Shutdown Cooling- Hot Shutdown." As TS 3.4.8 requires two RHR SDC loops to be operable and, if no reactor recirculation pumps (RRPs) are running, one of the loops to be in-service in Mode 3 below the RHR cut in permissive pressure (98 psig), inspectors determined that OP-1(2)49-002, "RHR Shutdown Cooling," was not maintained appropriately because a change to the procedure precluded operation of the system between 40 psig and the RHR cut in permissive pressure (98 psig). Susquehanna entered the issue into the corrective action program (CAP) as CR-2015-22882 and CR-2015-24137 and revised the procedure to remove the requirement that precluded operation of the SDC system between 40 psig and the RHR cut in permissive pressure.

This finding is more than minor because it is associated with the procedure quality attribute of the Mitigating Systems cornerstone and adversely affected its objective to ensure the availability and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the 40 psig procedural limit impacted the availability and capability of RHR to be placed in SDC between 98 psi, the cut-in permissive for the system, and 40 psig. In accordance with Exhibit 2 of IMC 0609, Appendix A, "The SDP for Findings At-Power," the inspectors determined that this finding is of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Human Performance, Change Management because Susquehanna did not use a systematic process for evaluating and implementing change so that nuclear safety remains the overriding priority (H.3). Specifically, implementation of Susquehanna's procedure change process did not ensure that the RHR SDC procedure was maintained consistent with the requirements of plant TSs.

Inspection Report# : [2015003](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

'C' EDG Rendered Inoperable by Switch Manipulation during Training Simulation

A self-revealing finding of very low safety significance (Green) and associated NCV of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings," was identified when Susquehanna inadvertently operated the 'C' emergency diesel generator (EDG) mode switch during the performance of a job performance measure (JPM). Specifically, the student performing the JPM operated plant equipment that was contrary to the quality assurance program requirement to only simulate equipment operation. Susquehanna entered the issue into the CAP as CR-2015-19578, the 'C' EDG mode switch was restored to the 'Remote' position, and the operating crew performed a walk-down of the 'C' EDG to confirm proper standby alignment, restoring operability of the EDG.

Inspectors determined that the finding was more than minor because it was associated with the Human Performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the

reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, improper manipulation of the 'C' EDG mode switch while simulating a task resulted in an inoperable condition since the EDG would not have auto started, if required. In accordance with Exhibit 2 of IMC 0609, Appendix A, "The SDP for Findings At-Power," dated June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because the performance deficiency was not a design or qualification deficiency, did not involve an actual loss of safety function, did not represent actual loss of a safety function of a single train for greater than its TS allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding had a cross-cutting aspect in the area of Human Performance, Avoid Complacency because Susquehanna did not implement appropriate error reduction tools (H.12). Specifically, personnel did not implement appropriate human error prevention tools (e.g. self-check, stop-think-act-review) in accordance with station processes.

Inspection Report# : [2015003](#) (*pdf*)

Barrier Integrity

Significance:  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Loss of Safety Function of SGBT and CREOASS due to Concurrently Performing Maintenance on Redundant Trains

Green. An NRC-identified finding of very low safety significance (Green) and associated violations of TS 5.4.1, "Procedures," TS 5.5.11, "Safety Function Determination," and TS 3.7.3, "Control Room Emergency Outside Air Supply System" was identified when Susquehanna performed maintenance on redundant trains of the standby gas treatment (SGBT) system and control room emergency outside air supply system (CREOASS) concurrently. When performing these actions, operators did not apply NDAP-QA-0312, "Control of LCOs, technical requirement for operations (TROs) and Safety Function Determination Program," correctly which resulted in the unrecognized loss of safety function of SGBT and CREOASS. Susquehanna entered the issue into the CAP as CR-2015-26475 and restored one of the subsystems to service, restoring the safety function.

This finding is more than minor because it is associated with the Human Performance (Routine OPS/Maintenance Performance) attribute of the Barrier Integrity cornerstone and affected the cornerstone objective of providing reasonable assurance that physical design barriers (Secondary Containment and Control Room Ventilation) protect the public from radionuclide releases caused by accidents or events. Specifically, allowing work to be performed on redundant trains of SGBT and CREOASS concurrently, while not applying plant TSs correctly, resulted in a loss of safety function of both systems. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 3 of IMC 0609, Appendix A, "The SDP for Findings At-Power," both dated June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because the performance deficiency was only associated with the radiological barrier function of the Control Room and Secondary Containment. This finding had a cross-cutting aspect in the area of Human Performance, Avoid Complacency because Susquehanna did not recognize and plan for the possibility of mistakes, latent problems, or inherent risk, even while expecting successful outcomes. Specifically, Susquehanna did not perform a thorough review of the planned activities every time work was performed to ensure compliance with plant TSs, rather than relying on past successes and assumed conditions.

Inspection Report# : [2015004](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Secondary Containment Inoperability due to Improperly Controlled Access to the Reactor Building Roof

A self-revealing finding of very low safety significance (Green) and associated NCV of SSES Unit 1 and 2 TS 5.4.1, "Procedures," was identified because Susquehanna incorrectly implemented procedures for maintaining secondary containment integrity. Specifically, on

July 27, 2015, maintenance technicians rendered secondary containment for both units inoperable for approximately 44 minutes when a secondary containment boundary door was opened to access the reactor building roof.

Susquehanna entered the issue into the CAP as CR-2015-20857 and CR-2015-24442, restored the boundary, and verified the integrity of secondary containment.

The finding was more than minor because it was associated with the Human Performance (Routine OPS/Maintenance Performance) attribute of the Barrier Integrity cornerstone, and affected the cornerstone objective of providing reasonable assurance that physical design barriers (Secondary Containment) protect the public from radionuclide releases caused by accidents or events. Specifically, opening the secondary containment barrier did not maintain reasonable assurance that the secondary containment would be capable of performing its safety function in the event of a reactor accident. The inspectors evaluated the finding in accordance with IMC 0609, Appendix A, "The SDP for Findings At-Power," Exhibit 3, for the Barrier Integrity cornerstone, dated June 19, 2012. The inspectors determined the finding was of very low safety significance (Green) because only represented a degradation of the radiological barrier function of secondary containment provided by the standby gas treatment (SBGT) system. This finding had a cross-cutting aspect in the area of Human Performance, Teamwork because Susquehanna did not effectively communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety was maintained (H.4). Specifically, when

the work plan was changed to accessing the reactor building roof through secondary containment, the change was not effectively communicated to operations department personnel to ensure the secondary containment impairment was appropriately controlled.

Inspection Report# : [2015003](#) (pdf)

Significance:  Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Assess a Non-Conforming Condition for its Impact on Component Operability

The inspectors identified a finding of very low safety significance (Green) and associated NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," when Susquehanna staff did not assess component operability following identification of a potentially non-conforming condition. Specifically, Susquehanna did not assess for operability a potential non-conforming condition associated with inadequate testing of the primary containment airlock inboard equalizing valve which was identified during the review of industry operating experience. Susquehanna's corrective actions to restore compliance included entering this issue in their CAP as CR-2015-15187, performing a prompt operability determination of the Unit 1 primary containment airlock inboard equalizing valve, including completion of the requirements in SR 3.0.3 for a missed surveillance, and performing testing on the Unit 2 valve which adequately demonstrated that the PCIV was operable prior to entering into a mode of TS applicability. The inspectors determined that the finding was more than minor because it was associated with the SSC and Barrier performance attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that the physical design barriers (containment) protect the public from radionuclide releases caused by accidents or events. Specifically, inadequate actions to evaluate the impact of the condition adverse to quality on the operability of the Unit 1 PCIV resulted in a reasonable doubt of operability of the barrier. In accordance with IMC 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Exhibit 2 of IMC 0609, Appendix A, "The SDP for Findings At-Power," dated June 19, 2012, the inspectors determined that this

finding is of very low safety significance (Green) because the performance deficiency did not represent an actual open pathway in the physical integrity of reactor containment and heat removal components or involve the actual reduction in function of hydrogen igniters in containment. This finding has a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because Susquehanna did not perform a thorough review of the work and planned activity but rather relied on past successes and assumed conditions. Specifically, the control room staff did not assess the condition for operability believing that it was similar to previous CRs documenting a review of operating experience. [H.12] (Section 1R15)

Inspection Report# : [2015002](#) (pdf)

Significance:  Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Incorrect Implementation of the Ventilation Filter Testing Program

The inspectors identified a finding of very low safety significance (Green) and associated NCV of 10 CFR 50, Appendix B, Criterion XI, "Test Control," because Susquehanna did not ensure representative samples were obtained from Engineered Safety Feature (ESF) filter ventilation systems and did not establish written test procedures. Specifically, subsequent to refilling charcoal test canisters for the activated charcoal absorber of both trains of the SBT System, new charcoal was added to the activated charcoal absorber which was not exposed to the same service conditions as the bulk of the absorber section as required by TS 5.5.7, "Ventilation Filter Testing Program," and written test procedures were not established for this activity. As corrective action for the identified issue, Susquehanna replaced the charcoal in the 'A' and 'B' trains of SBT and the 'A' and 'B' trains of CREOASS activated charcoal absorber beds and test canisters between January and February 2015 and initiated condition reports CR-2014-39116 and CR-2015-01443. The inspectors determined that the finding was more than minor because it was associated with the Procedure Quality Attribute of the Barrier Integrity Cornerstone and it adversely affected the cornerstone objective to provide reasonable assurance that physical barriers protect the public from radionuclide releases caused by accidents or events. Specifically, since 2001, work instructions did not prevent the contamination of test canisters with charcoal that was not representative of the in-service conditions of the adsorber bed and the introduction of new charcoal into the test canisters likely provided better results during periodic surveillance testing which were not representative of actual conditions. In accordance with IMC 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Exhibit 3 of IMC 0609, Appendix A, "The SDP for Findings At-Power," dated June 19, 2012, the inspectors determined that the finding was of very low safety significance (Green) because it only represented a degradation of the radiological barrier function provided for the control room and SBT system. This finding has a cross-cutting aspect in the area of Human Performance, Documentation, because the activities for sampling the activated charcoal beds were not governed by comprehensive, high-quality programs, processes, and procedures nor were the design documentation, procedures, and work packages complete, thorough and accurate. [H.7] (Section 2RS6)

Inspection Report# : [2015002](#) (pdf)

Emergency Preparedness

Significance:  Dec 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Dose Assessment Capabilities in the Technical Support Center

Green. The inspectors identified a finding of very low safety significance (Green) and a NCV of 10 CFR 50, Appendix E, Section IV.B.1. Specifically, Susquehanna emergency plan implementing procedures did not provide the guidance for the dose assessment staff in the Technical Support Center (TSC) to determine the magnitude of, and continually assess the impact of, the release of radioactive materials. The TSC staff was procedurally limited to performing forward and back dose calculations, but not blowout panel calculations. Blowout panel release calculations were only to be performed by the Emergency Operations Facility (EOF) staff. Susquehanna entered this issue into their corrective action program as CR-2015-04701, which led to the revision of the applicable procedures to allow the TSC dose assessment staff to perform the full scope of dose calculations available to the EOF staff.

The inspectors determined that the failure to have the same scope of dose assessment capabilities available to the full emergency response organization (ERO) was a performance deficiency that was within Susquehanna's ability to foresee and correct. The performance deficiency is more than minor because it is associated with the ERO Readiness and ERO Performance attributes of the emergency preparedness cornerstone, and adversely 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. Using IMC 0609, Appendix B, Section 5.9, the finding is of very low safety significance (Green) because the finding was determined to not be an example of the overall dose projection process being incapable of providing technically adequate estimates of radioactive material releases; the deficiency was limited to the TSC staff which in fact had the capability of performing dose projections and was only limited by the lack of procedural guidance. The cause of this finding has a cross-cutting aspect in the area of Documentation, because Susquehanna did not ensure that their organization creates and maintains complete, accurate and up-to-date documentation. Specifically, Susquehanna did not provide emergency plan implementing procedures to enable the TSC dose assessment staff to perform dose projections for all required radioactive material releases.

Inspection Report# : [2015004](#) (*pdf*)

Significance:  Jun 21, 2014

Identified By: NRC

Item Type: VIO Violation

Failure to take Action to Restore Degraded Emergency Action Level Scheme

The inspectors identified a Green cited violation of 10 CFR 50.54(q)(2) for PPL's failure to follow and maintain an emergency plan that meets the requirements of the planning standards in 10 CFR 50.47(b), in that, since October 2003, PPL did not follow and maintain a standard emergency classification and action level scheme. Specifically, PPL did not take timely corrective actions to provide an adequate means to measure temperature in nine out of 21 areas, where reactor building temperatures are considered for the fission product barrier degradation emergency action levels (EALs). As a result, this deficiency adversely affected PPL's ability to classify an emergency such that a Site Area Emergency would be declared in a degraded manner. The violation is being cited because PPL has failed to restore compliance or demonstrate objective evidence of plans to restore compliance at the first opportunity in a reasonable period of time following discussion in a formal exit meeting on January 24, 2014 and documented in NRC Inspection Report 05000387;388/2013005 on February 14, 2014.

The finding is more than minor because it is associated with the Facilities and Equipment attribute of the emergency preparedness cornerstone, and adversely 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 continuing lack of installed temperature instrumentation or any other compensatory measures and the reliance on personnel dispatched to take temperature readings were insufficient to ensure a timely and accurate EAL classification could be made. Using IMC 0609, Appendix B, "Emergency Preparedness Significance Determination Process", section 5.4, the finding is of very low safety significance (Green) because the finding was determined to be an example of an ineffective EAL initiating condition, such that a Site Area Emergency would be declared in a degraded manner.

The inspectors determined that this finding had a problem identification and resolution cross-cutting aspect related to Resolution because PPL did not take corrective actions in a timely manner nor did they take appropriate interim corrective actions to mitigate the issues while more fundamental causes are being assessed. Specifically, PPL had no corrective actions planned or taken to address the degraded EALs until NRC approval of their new EAL scheme, currently scheduled to be implemented no earlier than December 2015.

Inspection Report# : [2014009](#) (*pdf*)

Occupational Radiation Safety

Significance:  Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Entry into a High Radiation Area without Radiological Briefing

A self-revealing finding of very low safety significance (Green) and associated NCV of SSES Unit 2 TS 5.7.1 was identified because Susquehanna did not comply with a radiological posting barrier and other protective measures for HRA entry. Specifically, on October 10, 2014, two workers entered the turbine building roof, a posted HRA, but the workers were not on the proper RWP and were not briefed on the radiological conditions prior to entry. Upon receiving a dose rate alarm, the workers exited the HRA and reported the issue to radiation protection personnel. Susquehanna entered the issue into the CAP as condition report CR-2014-31911. The inspectors determined that Susquehanna's inadequate adherence to a high radiation area (HRA) posting, which requires a HRA RWP and a radiological briefing prior to entry, was a performance deficiency that was within Susquehanna's ability to foresee and correct and should have been prevented. The inspectors determined that the finding was more than minor because it adversely affected the human performance attribute of the Occupational Radiation Safety cornerstone objective. Specifically, the individual violated the RWP and briefing requirements designed to protect the worker from unnecessary radiation exposure. The issue was also similar to example 6.h in IMC 0612, Appendix E. Using IMC 0609, Appendix C, "Occupational Radiation Safety SDP," dated August 19, 2008, the finding was determined to be of very low safety significance (Green) because it did not involve: (1) as low as is reasonably achievable (ALARA) occupational collective exposure planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. This finding has a cross-cutting aspect of Human Performance, Challenge the Unknown, because the workers did not stop when faced with uncertain conditions. Specifically, the workers did not use a questioning attitude during the pre-job brief or when they encountered the HRA posting on the access to the turbine building roof. [H.11] (Section 2RS1)

Inspection Report# : [2015002](#) (*pdf*)

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:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Report Loss of Safety Function as Required by 10 CFR 50.73(a)(2)(v)

Inspectors identified a Severity Level IV NCV of 10 CFR Part 50.73 (a)(2)(v) when Susquehanna did not submit a licensee event report (LER) within 60 days of identifying that both trains of the control room emergency outside air supply system (CREOASS) were rendered inoperable during surveillance testing, a condition that could have prevented fulfillment of a safety function. Susquehanna entered the issue into the CAP as CR-2016-03713 and reported the condition on May 5, 2016 in LER 50-388(387)/2015-015. Since the issue had the potential to affect the NRC's ability to perform its regulatory function, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using example 6.9.d.9 from the NRC Enforcement Policy, the inspectors determined that it was a Severity Level IV violation. The significance of the associated performance deficiency was also screened against the reactor oversight process (ROP) per the guidance of IMC 0612, Appendix B, "Issue Screening." Because this violation involves the traditional enforcement process and does not have an associated finding under the ROP, inspectors did not assign a cross-cutting aspect to this violation.

Inspection Report# : [2016001](#) (*pdf*)

Last modified : July 11, 2016