

Susquehanna 2

4Q/2016 Plant Inspection Findings

Initiating Events

Significance:  Jul 22, 2016

Identified By: NRC

Item Type: FIN Finding

Failure to Implement or Develop Timely Interim or Final Corrective Actions for a Degraded Condition (40A2.1.c(3))

The inspectors documented a self-revealing finding of very low safety significance (Green) against Susquehanna procedures LS-125 Revision 4, "Corrective Action Program (CAP)," and OI-AD-096 Revision 18, "Operator Challenges," for the failure to correct and establish appropriate corrective actions for a known degraded condition for an uninterruptable power supply (UPS) for vital 120 VAC load centers. Specifically, Susquehanna did not correct nor establish compensatory actions for the transfer switch for a UPS which was failed for over one year. The degraded condition subsequently complicated operator response to the loss of a vital 480 VAC switchboard and resulted in an unplanned manual reactor scram and valid emergency core cooling system (ECCS) actuation on May 13, 2016. Susquehanna entered this issue into their CAP, conducted an apparent cause evaluation, and repaired the UPS transfer switch. The finding was more than minor because it was associated with the Equipment Performance attribute of the Initiating Events cornerstone and adversely affected the associated cornerstone 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 long standing degraded condition of UPS 2D14212/2B246082 was not corrected or compensated for and did not function as designed, as a result operators had to manually scram the reactor following the loss of a vital bus on May 13, 2016. In accordance with IMC 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Exhibit 1 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 cause both a reactor trip and loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. Specifically, while this performance deficiency resulted in a reactor scram, it was not the cause of the loss of mitigation equipment credited in the Susquehanna safety analysis. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution – Resolution because the organization did not take effective corrective actions to address issues in a timely manner commensurate with its safety significance. Specifically, failing to establish appropriate compensatory actions for this known degraded condition, prevented the operators from responding appropriately to a loss of a vital 480 VAC switchboard initiating event. [P.3].

Inspection Report# : [2016008](#) (*pdf*)

Significance:  Jul 22, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Promptly Identify and Correct a Condition Adverse to Quality on Vital 480 VAC MCCs (40A2.1.c(4))

The inspectors documented a self-revealing Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for failure to identify and correct a condition adverse to quality. Specifically, in October and December 2006 and July 2009, Susquehanna did not identify a non-conforming condition with the design and performance requirements of several 480 volt motor control center (MCC) breaker assemblies during receipt inspections. These non-conforming breaker assemblies were installed in vital 480 VAC applications and subsequently led to a phase to

ground short and loss of a 480 volt safety-related motor control center on May 12, 2016. Susquehanna entered this issue into their CAP, conducted an apparent cause evaluation, replaced the damaged breaker assembly, and is conducting an extent of cause review for other susceptible breaker assemblies. The finding was more than minor because it was associated with the Design Control attribute of the Initiating Events cornerstone and adversely affected the associated cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, on May 12, 2016, an electrical transient on vital AC bus 2B246 occurred as a result of a phase to ground fault in breaker cubicle 2B24609, which resulted in a loss of bus 2B246 and associated safety related loads. In accordance with IMC 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Exhibit 1 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 cause both a reactor trip and loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. This finding did not have a cross-cutting aspect because the performance deficiency was a historical issue with the actions taken in 2005, 2006, and 2009, and is not indicative of current licensee performance.

Inspection Report# : [2016008](#) (pdf)

Mitigating Systems

Significance:  Oct 21, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Specify and Maintain Safety-Related Quality Standards and Materials Essential for Reactor Core Isolation Cooling

The team identified a Green non-cited violation of Title 10 of the Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion III, "Design Control," for the failure to classify and maintain reactor core isolation cooling (RCIC) system components as safety-related as specified by Updated Final Safety Analysis Report Table 3.2-1 and Section 7.1.1. Specifically, although Talen, the operator of Susquehanna Steam Electric Station, classified the RCIC system as safety-related, this classification did not extend to the Unit 1 and Unit 2 RCIC barometric condenser relief valves. The team determined failure of the non-safety related barometric condenser relief valves could result in a loss of RCIC lube oil cooling and failure of RCIC to perform its design basis safety function. Talen entered the issue into the corrective action program as condition report 2016-23615 and performed an immediate operability determination, which concluded RCIC remained operable. The finding was more than minor because it was associated with the Design Control 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. The team evaluated this finding using IMC 0609, Attachment 4, "Initial Characterization of Findings," and IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2 - Mitigating System Screening Questions. The team determined the finding screened as very low safety significance (Green), because the finding was a design deficiency which did not result in an actual loss of functionality of the RCIC system. This finding was not assigned a cross-cutting aspect because the performance deficiency occurred during original plant design and did not reflect current licensee performance.

Inspection Report# : [2016007](#) (pdf)

Significance:  Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Work Instructions for Breaching Internal Flood Barrier

The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," because Susquehanna did not ensure that work instructions to breach a flood barrier appropriately incorporated design requirements for internal flooding so that equipment necessary to achieve and maintain safe shutdown would not be impacted. From August 30, 2016 to September 2, 2016, work instructions directed a breach of a flood barrier that was credited to provide assurance that equipment necessary for safe shutdown of the plant was protected against the effects of medium energy line breaks and, therefore, were not appropriate to the circumstances. Susquehanna entered this issue into their corrective action program (CAP) as condition report CR-2016-20472 and CR-2016-20859 and revised the work instructions to require a worker remain in the vicinity of the penetration to ensure that flooding could be secured prior to impacting equipment necessary to reach and maintain safe shutdown. This finding is more than minor because if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. Specifically, had the breach been completed, it could have allowed a medium energy line break in one flooding area to communicate with another area, potentially impacting equipment necessary to achieve and maintain safe shutdown. The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 2, "Mitigating System Screening Questions," and determined the finding to be of very low safety significance (Green) because the PD 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 technical specification allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The finding has a cross-cutting aspect 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. Implementation of Susquehanna's work planning process did not ensure that the maintenance incorporated all requirements for protection against internal flooding and did not ensure that job site conditions were consistent with assumptions in engineering analyses. [H.5].

Inspection Report# : [2016003](#) (pdf)

Significance:  Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Risk Management Actions Not Adequately Implemented

The inspectors identified a Green NCV of 10 CFR 50.65(a)(4) because Susquehanna did not assess and manage the increase in risk from online maintenance activities. From September 11 to 16, 2016, there were multiple affected areas that the fire protection engineer or designee did not walk down to inspect for fire impairments resulting in deficiencies not being corrected prior to releasing work and no fire watch was established for the impairments. Susquehanna removed the combustible materials from the areas or stationed a fire watch, and entered these issues into their CAP as CR-2016-21125, CR 2016-21423, CR-2016-21616, and CR-2016-21741. This finding is more than minor because it adversely impacted the protection against external factors attribute of the Mitigating Systems cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, not implementing the required risk management actions (RMAs) for the only available safe shutdown pathway placed the station in a much higher risk condition in the event of an internal fire. The inspectors evaluated the finding in accordance with IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process." Since the performance deficiency was related to maintenance activities affecting structure, system, and components needed for fire mitigation, Appendix K directed the significance to be determined by an internal NRC management review using risk insights. IMC 0609, Appendix F, Attachment 1 "Fire Protection Significance Determination Process Phase 1 Worksheet," was used to develop this risk insight. Based on the nature and quantity of combustible materials in the areas, combined with the relatively short duration of which the fire risk was unmitigated, inspectors determined that it was of very low safety significance (Green). The finding was determined to have a cross-cutting aspect in the area of Human Performance, Avoid Complacency, in that, individuals did not plan for latent issues and inherent risk, even while expecting successful outcomes. Specifically, combustible materials were not appropriately controlled as required by OI-013-002, "Fire Risk Management," Revision 10, because in some cases they were assumed to be exempt from the program requirement or staff did not tour the areas because they assumed there were no combustible materials present based on past experience. [H.12]

Inspection Report# : [2016003](#) (pdf)

Significance: G Jul 22, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Implement and Maintain Quality Procedure Results in Control Room Chiller Inoperability (40A2.1.c(2))

The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for failure to implement and maintain a quality procedure, MT-GE-021, "Chiller Maintenance and Inspection." This resulted in the safety related 0K112A chiller being operated outside of its design specifications and being declared inoperable. Specifically, on January 9, 2014, a system engineer directed the maintenance personnel to overcharge 0K112A with R-114a refrigerant, which led to higher power consumption by the chiller's compressor motor, and the failure of the next biennial surveillance test on December 10, 2015 due to excessive compressor motor current. Susquehanna entered the issue into the CAP, conducted testing to establish the proper refrigerant charge, removed the excess refrigerant, and revised the procedure. The finding was determined to be more than minor because it was associated with the Mitigating System cornerstone attribute of Equipment Performance and adversely affected the associated cornerstone objective to ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The refrigerant overcharge condition resulted in the 0K112A chiller being inoperable and unable to fulfil its safety function to cool safety related switchgear and equipment during accident conditions for a period of 23 months. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined a detailed risk evaluation would be required because the finding involved an actual loss of function of at least a single Train for greater than its Technical Specification allowed outage time of 30 days. A detailed risk assessment was performed by a Region 1 Senior Reactor Analyst (SRA). The SRA determined the finding to be of very low safety significance (Green.) This finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence because individuals did not follow processes, procedures, and work instructions. Specifically, for many years maintenance and engineering personnel relied upon informal work practices vice referring to the procedure when charging the chillers with refrigerant. [H.8]

Inspection Report# : [2016008](#) (pdf)

Significance: G Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Promptly Correct a Condition Adverse to Quality with 'A' EDG MOC Switch

A self-revealing finding of very low safety significance (Green) and associated NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for failure to correct a condition adverse to quality. Specifically, on March 23, 2016, the 'A' emergency diesel generator (EDG) failed its technical specification (TS) surveillance test in that the emergency switchgear room cooler, 1V222A, started immediately when the EDG loaded onto the emergency bus following a simulated loss of off-site power (LOOP) and simulated Emergency Core Cooling System (ECCS) Initiation, rather than sequencing onto the bus as intended by design. Susquehanna identified the direct cause of the failure was due to a misadjustment of the mechanism-operated cell (MOC) linkage switch (S1) in the 'A' EDG output breaker to the 1A 4 kilovolt (kV) bus, which provides the electrical logic to the 1V222A load timer. The repeat failure was entered into the corrective action program (CAP) as CR 2016-08643, the MOC linkage was realigned, and the functions satisfactorily tested. The finding was determined to be 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 capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the failure to correct the degraded condition rendered the 'A' EDG inoperable for longer than the TS allowed outage time. 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 required a detailed risk assessment because the finding represents an actual loss of function of a single train for greater than the TS allowed outage time. Specifically, the 'A' EDG was inoperable from July 19, 2010 until April 2, 2016, because TS requires functioning of the sequencing timers for the EDG to be operable. In coordination with a Region 1 Senior Risk Analyst, the issue was qualitatively screened as Green (very low safety significance) based on the low initiating event frequency associated with a loss of coolant accident (LOCA) co incident with a LOOP event, and observed successful EDG function during multiple LOOP/LOCA tests over the period in question. This would result in a delta core damage frequency substantially less than E-6. Additionally, it was reasonable to conclude that the 'A' EDG remained available to perform its function given the minimal increased load on the machine as evidenced during the performance of the LOOP-LOCA surveillance testing in 2012, 2014, and 2016. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because Susquehanna did not thoroughly evaluate the issue to ensure that the resolution addressed the cause and extent of conditions commensurate with their safety significance. Specifically, Susquehanna corrected a suspected condition without appropriate troubleshooting until the third identical failure of the 1V222A load timer. [P.2]

Inspection Report# : [2016002](#) (pdf)

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure of B EDG to Reach Rated Frequency within 10 Seconds

A self-revealing finding of very low safety significance (Green) and associated NCV of TS 5.4.1.a, "Procedures," was identified when Susquehanna failed to implement procedures for loading EDGs promptly following extended unloaded operation. Specifically, Susquehanna did not load the 'B' EDG promptly following over 6 hours of unloaded operation which resulted in the slow starting time during the subsequent surveillance test due to insufficient fuel delivery caused by clogged fuel injectors. The failure was entered into the CAP as CR-2016-13220 and the EDG was run loaded for an extended period to ensure any unburned fuel had been removed from the machine. The finding was more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone and affected the objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the failure to load the 'B' EDG following extended operation unloaded resulted in the slow starting time of the EDG during subsequent surveillance testing due to clogged fuel injectors. The inspectors evaluated the finding in accordance with Exhibit 2 of IMC 0609, Appendix A, "The SDP for Findings At-Power," dated June 19, 2012 and determined that it was of very low safety significance (Green) because it did not affect the design or qualification of the EDG, did not represent a loss of system function, and did not represent a loss of a single train for greater than its TS allowed outage time. The finding is related to the cross-cutting area of Human Performance, Consistent Process, because Susquehanna did not use a consistent, systematic approach to make decisions which incorporated risk insights. Specifically, Susquehanna did not appropriately coordinate the loaded run of the 'B' EDG with maintenance on the 'C' EDG to ensure 'B' EDG availability was not unnecessarily challenged. [H.13]

Inspection Report# : [2016002](#) (pdf)

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

HPCI Overridden Prior to Manual Reactor Scram

An NRC-identified finding of very low safety significance (Green) and associated NCV of TS 5.4.1.a, "Procedures," was identified when Susquehanna failed to implement procedures for controlling the high pressure coolant injection (HPCI) system. Specifically, operators overrode automatic initiation of the system prior to inserting a manual scram, contrary to the requirements of OP-252-001, "HPCI System," and OP-AD-300, "Administration of Operations." This was entered into the CAP as CRs 2016-12854 and 2016-13118 and 2016-13136, the operator's involved in the event

were remediated, and lessons learned communicated to other station personnel. The finding was more than minor because it was associated with the Human Performance attribute of the Mitigating Systems Cornerstone and affected the objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, overriding the HPCI system prior to initiating a plant scram rendered the system unavailable to respond to a level transient or failure of the non-safety related feedwater system. The inspectors evaluated the finding in accordance with Exhibit 2 of IMC 0609, Appendix A, “The SDP for Findings At-Power,” dated June 19, 2012 and determined that it required a detailed risk assessment because it represented a loss of the single train system’s function. The Region 1 SRA performed a detailed risk evaluation using the Susquehanna Unit 2 standardized plant analysis risk (SPAR) Model, version 8.23. The issue was conservatively modeled with a HPCI failure to start due to the system automatic start signal being overridden.

The change in core damage frequency per year was determined to be in the E-10 range due to the very short duration the system auto start feature was defeated. Therefore the issue was determined to be of very low safety significance (Green). The finding is related to the cross-cutting area of Human Performance, Procedure Adherence because Susquehanna did not follow processes, procedures and work instructions. Specifically, operators did not ensure that their actions were appropriately authorized by procedures when taking action to override a key safety system prior to a plant transient. [H.8]

Inspection Report# : [2016002](#) (pdf)

Significance:  Mar 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Assess and Manage Risk of Maintenance Activities for a SLC System Flow Surveillance

The inspectors identified a Green NCV of 10 CFR 50.65(a)(4) because Susquehanna did not adequately assess the risk of performing maintenance in accordance with station procedures. Specifically, Susquehanna did not assess the risk of performing a standby liquid control (SLC) system flow surveillance in conjunction with having the ‘D’ emergency diesel generator (EDG) unavailable and therefore did not specify appropriate risk management actions (RMAs). Susquehanna entered the issue into the CAP as CR-2016-04137. The inspectors determined that this performance deficiency is more than minor because it was associated with the Human Performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Additionally, the finding is similar to example 7.e. in NRC IMC 0612 Appendix E, “Examples of Minor Issues.” This example states, in part, that failure to perform an adequate risk assessment when required by 10 CFR 50.65 (a)(4) is not minor if the overall elevated plant risk would put the plant into a higher licensee-established risk category or would require, under plant procedures, RMAs or additional RMAs. In this case, the combination of the ‘D’ EDG maintenance and SLC flow surveillance resulted in changing risk to Yellow which required additional RMAs in accordance with station procedures. The inspectors evaluated the finding using IMC 0609 Appendix K, “Maintenance Risk Assessment and Risk Management SDP.” The inspectors and the Region I senior resident analyst used Appendix K, Flowchart 1, “Assessment of Risk Deficit,” and determined that the inadequate risk assessment was of very low safety significance (Green). The basis for this determination was that the short duration of the actual planned maintenance activities (3.5 hours) associated with the SLC unavailability results in less than E-9 calculated incremental core damage probability deficit (ICDPD) using Susquehanna’s risk model. Since the resultant ICDPD is below 1 E-8 threshold, the finding was determined to be Green. This finding

was determined to have a cross-cutting aspect in the area of Human Performance, Work Management in that Susquehanna did not appropriately incorporate insights from probabilistic risk assessments into the daily work activities [H.5]. Specifically, Susquehanna did not appropriately assess the risk of performing maintenance activities as specified in station procedures.

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

Barrier Integrity

Emergency Preparedness

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Critique an Incorrect PAR Notification

An NRC-identified finding of very low safety significance (Green) and associated NCV of 10 CFR 50.54(q) (2), "Emergency Plans" was identified when Susquehanna failed to identify that an incorrect notification of wind direction was made to the senior state official (SSO) during a full-scale drill. This failure was entered into the CAP as CRs 2016-14303 and 2016-14128, ERO personnel involved in the incorrect communication and the drill controllers that failed to identify the deficiency were remediated, and lessons learned communicated to other emergency response organization personnel. The finding was more than minor because it is associated with the emergency response organization (ERO) Performance attribute of the Emergency Preparedness Cornerstone and affected the cornerstone objective to ensure that the 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 failure of Susquehanna personnel to effectively identify an exercise weakness associated with a risk significant planning standard (RSPS) caused a missed opportunity to identify and correct a drill-related performance deficiency. The inspectors assessed the issue using the Emergency Preparedness SDP, Appendix B to IMC 0609, dated September 23, 2014. Susquehanna's failure to critique the inaccurate notification met the NRC's definition of a weakness in a full-scale drill. However, because four previous notifications had accurately reported the wind direction and the miscommunication was inconsistent with the correct protective actions recommendation (PAR) that was communicated simultaneously, in consultation with a senior emergency preparedness inspector, inspectors determined the communication would likely have been corrected prior to the offsite response organizations (OROs) acting on the incorrect information, did not result in an incorrect PAR, and therefore determined that that the failure to critique the drill weakness only constituted a degradation of the planning standard (PS) function. Therefore the finding is characterized as having very low safety significance (Green). The finding is related to the cross-cutting area of Problem Identification and Resolution, Identification, in that Susquehanna did not identify a RSPS issue completely, accurately, and in a timely manner commensurate with the safety significance. Specifically, during the full-scale drill, Susquehanna failed to recognize and critique that a RSPS was not met and did not place this issue into the CAP until prompted by inspectors. [P.1]

Inspection Report# : [2016002](#) (*pdf*)

Occupational Radiation Safety

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Entry into a High Radiation Area without Radiological Briefing

A Green self-revealing NCV of TS 5.7.1, High Radiation Area Controls, was identified when a worker did not comply with a radiological posting barrier and other access control requirements for high radiation area (HRA) entry. Specifically, on December 26, 2015, a security officer entered into a posted HRA without proper authorization. This was entered into the CAP as CR-2015-33947, the HRA barrier was moved further out, and a shield rack was placed in

front of the condenser bay door to reduce radiation dose rates. The finding was determined to be more than minor based on similarity to example 6.h in IMC 0612, Appendix E, and it is associated with Human Performance attribute of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective to ensure adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Specifically, the individual violated the HRA posting, radiation work permit (RWP) and briefing requirements designed to protect the worker from unnecessary radiation exposure. 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. The finding is related to the cross-cutting area of Problem Identification and Resolution, Resolution, in that the organization did not ensure that corrective actions to address the cause of repetitive electronic dosimeter alarms in this area of the plant and had not been sufficiently evaluated and had not enhanced radiological controls to prevent this issue from recurring. [P.3]

Inspection Report# : [2016002](#) (*pdf*)

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Entry into a Locked High Radiation Area without Radiological Briefing

A Green self-revealing NCV of TS 5.7.2, High Radiation Area Controls, was identified when workers entered the wrong reactor unit condenser bay (Unit 2) that was posted and controlled as a locked high radiation area (LHRA). Specifically, on May 3, 2016, four Susquehanna staff were briefed to enter the Unit 1 condenser bay to check for steam leaks during start up, however the staff entered the Unit 2 condenser bay during full power operations in error and received electronic dosimeter alarms. This was entered into the CAP as CR-2016-11944, the use of master keys for routine entry into LHRA was discontinued, and a radiation safety stand down was conducted. The finding was determined to be more than minor based on a similar example 6.h in IMC 0612, Appendix E, and it is associated with Human Performance attribute of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective to ensure adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. Specifically, Susquehanna staff violated the RWP and briefing requirements designed to protect workers from unnecessary radiation exposure. 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) ALARA occupational collective exposure planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose. The finding was self-revealing because Susquehanna was made aware of the situation as a result of an electronic dose rate alarm. The finding is related to the cross-cutting area of Human Performance, Teamwork because the workers did not conduct peer checking and recognize and communicate that they were in the wrong reactor unit for the work they were conducting. Specifically, four Susquehanna staff were briefed to enter the Unit 1 condenser bay to check for steam leaks during start up, however the staff entered the Unit 2 condenser bay. [H.4]

Inspection Report# : [2016002](#) (*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.

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Miscellaneous

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