Susquehanna 1

Initiating Events

Significance: G Jun 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Off-Normal Operation Procedure for Reactor Pressure Control
On June 14, the inspectors observed that Unit 2 reactor pressure control was swapped over from the "A" electro-hydraulic control system pressure regulator to the "B" regulator, due to drift on the "A" regulator. The instrument and controls technicians performed the activity with no written instructions or procedures, and were under the direct technical supervision of a system engineer. This issue was considered to have very low safety significance because the verbal technical direction provided by the system engineer to the instrument and controls technicians was adequate, in this instance, to control the activity. The inspectors identified a Non-Cited Violation for failure to satisfy Technical Specification requirements to implement written procedures.
Inspection Report# : 2000004*(pdf)*

Significance: G Dec 01, 2000
Identified By: NRC
Item Type: FIN Finding
Identification and Problem Resolution Effectivenessof Corrective Actions
The inspectors identified a finding regarding the effectiveness of corrective actions for breaker over-current protection relays. In 1998, PPL established a relay replacement schedule for over-current protection relays due to a manufacturing defect. PPL did not re-evaluate the effectiveness of the relay replacement schedule following two electro-hydraulic control (EHC) system pump trips due to over-current protection relay failures. This condition is more than minor because the EHC pump malfunction could contribute to the likelihood of a reactor trip, and since EHC is required to maintain the turbine bypass valves open, it could affect a mitigating system used to remove reactor core decay heat. The risk of this finding was determined to be low since multiple mitigating systems (high pressure injection system, low pressure injection system and automatic depressurization system) remained available to respond to a transient. The EHC system is not safety-related and no violations of NRC requirements were identified. This is a cross-cutting issue covering two cornerstones. It also covers Mitigation systems.
Inspection Report# : 2000006*(pdf)*

Mitigating Systems

Significance: G Jun 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
No procedure to maintain the environmental qualification associated with T-drains on motors inside primary containment
The inspectors identified a non-cited violation for failure to have procedures or instructions to maintain the required environmental qualification configuration associated with motor T-drains for motor-operated valve actuators located within the primary containment (10 CFR 50 Appendix B, Criterion III, "Design Control") This violation was of very low safety significance because the specific component qualification deficiency was determined not to result in a loss of safety function, and therefore, did not impact system or component operability. In addition, the finding did not represent an actual open pathway in the primary containment since the redundant isolation valves, located outside of the primary containment, were not affected and remained operable. This issue also covers Barrier Integrity
Inspection Report# : 2001006*(pdf)*

Significance: G May 12, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to include and conduct appropriate valve testing in the IST Program as required by Technical Specification 5.5.6
The inspectors identified a Non-cited violation of Technical Specifications 5.5.6, "In-service Testing Program," for failure to leak test eight reactor building closed cooling water system and eight turbine building closed cooling water system valves. This finding was of very low safety significance

because the leakage through the valves was subsequently determined to be less than the maximum flow that can be diverted from the emergency service water system to non-safety related loads during an accident.
Inspection Report# : 2001005*(pdf)*

Significance: G Apr 06, 2001
Identified By: NRC
Item Type: FIN Finding
Inadequate Corrective Action to Preclude Recurrence of SLC Pump Discharge Pressure Relief Valve Setpoint Drift
The team found that the as-found relief setpoints of the Unit 1 SLC pump discharge valves were outside the specified tolerance 20 of the 27 times the in-service test (IST) of the valves was conducted. The failure rate of the Unit 2 valves was similarly high. The team determined that the recurrence of the setpoint drift outside the valve performance criteria was of very low risk significance (Green) by the SDP screening process. This conclusion was based on the fact that the licensee's engineering assessment determined that even with both relief valves lifting, sufficient boron solution would be injected in the reactor to maintain the integrity of the RPV, fuel, and containment barriers.
Inspection Report# : 2001004*(pdf)*

Significance: G Apr 06, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Non-Conservative Test Acceptance Criteria for RCIC System Surveillance
The team found that the reactor core isolation cooling (RCIC) pump in-service test acceptance criteria was non-conservative because it would not have ensured that the system design function was maintained. This was determined to be of very low risk significance (Green) by the significance determination process (SDP) phase 1 screening because an actual loss of the system safety function had not occurred. The failure to establish adequate test acceptance criteria for the RCIC pump was considered a non-cited violation of 10CFR50, Appendix B, Criterion XI, Test Control.
Inspection Report# : 2001004*(pdf)*

Significance: G Apr 06, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Meet ATWS Rule in the Design of SLC System
The team determined that during an anticipated transient without scram (ATWS) loss-of-offsite power (LOOP) scenario, the standby liquid control (SLC) system would not satisfy the ATWS rule requirement in that one or both SLC pump relief valves could lift and inhibit full flow to the reactor. The team determined this issue to be of very low risk significance (Green) through phase I of the SDP screening process. This conclusion was based upon the fact that the licensee's engineering assessment determined that, even with both relief valves lifting, sufficient boron solution would be injected in the reactor to maintain the integrity of the fuel, reactor pressure vessel, and containment barriers. In addition, the event itself has a low occurrence probability. The failure by the licensee to ensure that the required ATWS rule flow rate would be injected into the reactor vessel was considered a non-cited violation of 10CFR50.62.
Inspection Report# : 2001004*(pdf)*

Significance: G Apr 06, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Test the Motor Operated Valve Thermal Overload Bypass Circuit
The team found that the licensee had neither tested nor developed test procedures that verified the ability of the safety-related motor operated valve (MOV) thermal overloads (TOLs) bypass relay contacts to perform their bypass function. The team also found that the TOL setpoints had not been selected to ensure that the valves would be able to perform their safety-related function. The team determined that the licensee's failure to test the TOL bypasses periodically was of very low risk significance (Green) by the SDP screening process. This determination was based upon the results of a subsequent PPL analysis and test conclusions that the current sizing of all TOLs provided reasonable assurance of operability of the affected valves. The failure by the licensee to verify the integrity of the bypass circuit was considered an additional example of a non-cited violation of 10CFR50, Appendix B, Criterion XI, Test Control.
Inspection Report# : 2001004*(pdf)*

Significance: G Dec 31, 2000
Identified By: NRC
Item Type: FIN Finding
HPCI Operation After a Main Steam Isolation Valve Closure Transient Without Automatic Reactor Shutdown

PPL has not taken timely actions to resolve an issue regarding the ability of the high pressure coolant injection (HPCI) system to respond to a transient in which the main steam line isolation valves close and the reactor does not automatically shut down. Since 1991, PPL documents have recognized: that continued HPCI operation during this transient requires prompt operator action outside of the control room to bypass high suppression pool level signals to prevent HPCI valves from automatically changing the HPCI suction source from the condensate storage tank to the suppression pool; it was unreasonable to expect that the specified prompt operator actions would be reliably completed within the required time; and that this automatic HPCI suction transfer feature should be removed. To date, PPL has not removed this automatic HPCI suction transfer feature. A phase 2 significance determination process assessment concluded that this issue was very low safety significance based on the availability of safety relief valves and low pressure injection systems to respond if HPCI failed
Inspection Report# : 2000009*(pdf)*

Significance: G Dec 31, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform a Risk Assessment Prior to Planned Maintenance Activities
The inspectors identified a Non-Cited Violation for failure to assess risk prior to performing maintenance activities. PPL did not assess the risk of performing a Unit 1 high pressure coolant injection (HPCI) system test concurrent with a test of the "B" emergency diesel generator (EDG). This resulted in the inappropriate removal of the Unit 1 HPCI from service during the EDG testing and an unnecessary increase in risk for the one hour period that both the "B" EDG and Unit 1 HPCI were removed from service for testing. This finding was of very low safety significance because HPCI would have been available for vessel injection with minimal operator action. Independent calculation of the increase in core damage frequency associated with removal of both the EDG and HPCI system for one hour determined the risk to be within the very low safety significance band.
Inspection Report# : 2000009*(pdf)*

Significance: G Dec 31, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Post Accident Residual Heat Removal System Operation
The inspectors identified a Non-Cited Violation for inadequate alarm response procedures related to residual heat removal service water radiation monitors. The alarm response procedures were inadequate because, although residual heat removal service water process radiation levels are not expected to be high, the expected area background radiation levels during a loss of coolant accident would cause the radiation monitors to alarm and the procedures would then direct the operator to inappropriately shut down the residual heat removal and residual heat removal service water systems when they were required to mitigate the accident. This finding was determined to be of very low risk significance because sufficient information was available for operators to recognize that these alarms were due to background radiation and not cause the systems to be shutdown.
Inspection Report# : 2000009*(pdf)*

Significance: G Nov 11, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Multiple Test Failures of Main Steam Safety Relief Valves
Technical Specification (TS) 3.4.3, "Safety Relief Valves (SRVs)," requires an allowable pressure band of +/- 1% for opening individual SRVs. Five of eight SRVs tested on April 14, 2000, opened outside of the TS band, as described in condition report 249300.
Inspection Report# : 2000008*(pdf)*

Barrier Integrity

Significance: G Sep 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Main Steam Isolation Valve Total Leakage Exceeded Technical Specification
PPL determined that the "as-found" maximum pathway leakage for the Unit 1 inboard MSIV on the "C" steam line and the outboard MSIV on the "A" steam line were in excess of the limit specified in TS 3.6.1.3, "Primary Containment Isolation Valves." This finding affects the Barrier Integrity Cornerstone and is considered to have very low safety significance using the Significance Determination Process because the redundant valve in the "A" and "C" line functioned and would have limited the leak rate to less than the leakage assumed in the offsite dose limit calculation for MSIV

leakage. The failure to satisfy Technical Specification 3.6.1.3 "Primary Containment Isolation Valves," leakage limits is a violation of NRC requirements.
Inspection Report# : 2000007*(pdf)*

Significance: G Aug 12, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Missed Surveillance Testing on the Hydrogen/Oxygen Analyzer Systems
On February 2, 2000, PPL identified that Technical Specification required leakage rate surveillance testing had not been performed on the Unit 1 or Unit 2 Hydrogen/Oxygen Analyzer System or the Post Accident Sampling System. This issue was of very low safety significance because the likelihood of an accident leading to core damage was not affected, the probability of early primary containment failure was negligible, and the as-found leakage results for these systems in both units was determined to be acceptable. The inspectors identified a Non-Cited Violation for failure to perform leakage rate testing as required by Technical Specification 5.5.12, "Primary Containment Leakage Rate Testing Program 10 CFR 50 Appendix J."
Inspection Report# : 2000005*(pdf)*

Significance: G Jun 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Suppression Chamber-to-Drywell Vacuum Breaker Valve Multiple Test Failures
In March 2000, four out of ten Unit 1 vacuum breakers had as-found lift setpoints which exceeded the Technical Specification limits. This was of very low safety significance because the vacuum breakers would have performed their design function. The inspectors identified a Non-Cited Violation for failure to satisfy Technical Specification requirements.
Inspection Report# : 2000004*(pdf)*

Significance: G May 13, 2000
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Actuation of Reactor Water Cleanup (RWCU) High Differential Flow Isolation Logic during RWCU Draining
During a Unit 1 refueling outage operators inadvertently drained approximately 1100 gallons of water from the reactor vessel/cavity. Operators failed to close valves to isolate the reactor water cleanup system from the reactor vessel/cavity during a planned activity to drain the reactor water cleanup system. This was of very low safety significance because more than one million gallons of water were still available in the reactor vessel/cavity to cool the fuel in the core and in the spent fuel pool. The inspectors identified a noncited violation for not correctly performing a procedure.
Inspection Report# : 2000003*(pdf)*

Significance: G May 13, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Invalid Local Leak Rate Tests for Testable Spectacle Flanges
PPL, Inc (PPL) determined that Unit 1 and Unit 2 residual heat removal system spectacle flanges did not have valid leakage tests as required by technical specifications because an extra o-ring was installed which may have prevented the performance of a valid leakage test. This was of very low safety significance because the extra o-ring had little effect on the leak tightness of the flanged connection (containment integrity) and significant margin existed to technical specification leakage limits. The inspectors identified a noncited violation for not having performed valid technical specification required leakage tests. Unit 1 properly leak tested the flanges during the refueling outage. For Unit 2, since it was at power, PPL requested that the NRC exercise discretion to not enforce compliance with the actions required in the technical specification to shutdown the unit. The NRC issued enforcement discretion since this condition had minimal safety impact, was consistent with the enforcement policy and staff guidance, and had no adverse impact on the health and safety of the public.
Inspection Report# : 2000003*(pdf)*

Significance: G Feb 09, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Unit 1 reactor water cleanup overflow and floor contamination due to the failure to follow a plant operating procedure
Technical Specification section 5.4.1 states: "Written procedures shall be established and implemented that meet the requirements of NRC's

Regulatory Guide 1.33, Rev. 2, February 1978. Operations procedure OP-161-002, "RWCU Filter Demineralizers," Rev. 22. Section 3.3.3, states "If backwashing "1B" filter, CLOSE reactor water cleanup (RWCU) filter demineralizer "B" effluent isolation valve 145041B. On January 21, 2002, a plant operator failed to close the RWCU 14541B manual isolation valve. The error resulted in overflow of radioactive water and contamination in the Unit 1 Reactor Building on the 670 foot elevation. The issue was documented in condition report 379343.
Inspection Report# : 2001012*(pdf)*

Emergency Preparedness

Significance: G Sep 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Emergency Action Level for Reactor Coolant System Leakage Change Without NRC Approval
In 1984, PPL departed from the guidance in NUREG-0654, Criteria for Preparation and Evaluation of Radiological Response Plans and Preparedness in Support of Nuclear Power Plants. According to NUREG-0654, an initiating condition for an alert would be "primary coolant leakage rate greater than 50 gpm." PPL originally used that criteria but later added the phrase "for greater than four hours." There was no 10 CFR 50.54(q) evaluation documentation to support the licensee's change nor documentation of NRC approval of the change. Although, licensee's expectation is for an alert to be declared as soon as a greater than 50 gpm leak is identified, the wording of the initiating conditions allows for a four hour delay in declaration and thus decreases the effectiveness of the emergency plan and is contrary to 10 CFR 50.54(q).
Inspection Report# : 2000007*(pdf)*

Significance: G Feb 04, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
E-Plan changes decreased the effectiveness of the plan
The inspectors identified a non-cited violation of 10 CFR 50.54(q) because PPL made changes in the E-Plan which eliminated some on-shift emergency positions which decreased the effectiveness of the E-Plan without obtaining prior NRC approval. The finding was of very low safety significance because the change was administrative in nature since individuals on-shift could have performed the functions of those eliminated positions had they been needed for emergency response.
Inspection Report# : 2002009*(pdf)*

Significance: G Sep 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Emergency Action Level Changes
The inspectors identified a non-cited violation for failure to follow and maintain the emergency plan as required by 10 CFR 50.54(q) and 10 CFR 50 Appendix E, "Emergency Planning and Preparedness." This violation was of very low safety significance because some inconsistencies between the Emergency Plan and emergency classification procedures resulted in the NRC receiving an event classification reference that did not agree with the actual event.
Inspection Report# : 2001009*(pdf)*

Significance: G Aug 16, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate procedures in place to describe the communication steps needed to alert or activate emergency personnel
The inspectors identified a non-cited violation for failure to adequately describe, in approved procedures, the communication steps needed to alert or activate emergency personnel under each class of emergency. (10 CFR 50.47(b)(5), "Emergency Plan Procedures," and 10 CFR 50 Appendix E, Section IV C., "Activation of Emergency Organization") This violation was of very low safety significance because some inadequacies contained in the control room communicator emergency procedure may have contributed to a delayed notification of emergency response personnel. The delayed notification contributed to emergency response facility activation times in excess of the emergency plan requirements.
Inspection Report# : 2001008*(pdf)*

Significance: W Jun 30, 2001

Identified By: NRC
Item Type: VIO Violation
Not maintaining minimum on-shift staffing in accordance with the E-Plan
This inspection identified a violation of planning standard 10 CFR 50.47(b)(2) because on several occasions in 2000 and 2001, PPL's operation on-shift staff was below the minimum staffing requirements specified in the Emergency Plan for the positions of plant control operator and the assistant unit supervisor. The safety significance of this finding was of low to moderate safety significance because, on these occasions, the emergency preparedness function associated with these on-shift staff positions was not met. The emergency preparedness function that was not met associated with the plant control operator was either the emergency communicator function in the control room or the function to monitor for safety in the unaffected unit during an emergency at the site. The emergency preparedness function that was not met associated with the assistant unit supervisor was that of the operations support center coordinator. The NRC issued the results of the final significance determination in a letter dated September 13, 2001. This supplemental inspection was performed by the NRC using inspection procedure 95001, to assess the licensee's evaluation associated with a violation of White significance which was identified in Inspection Report 50-387/01-06, 50-388/01-06. The NRC identified that on several occasions, the licensee on-shift staffing was below the minimum requirements of the E-Plan. The NRC identified that the root cause evaluation was narrowly focused which resulted in the licensee not conducting a thorough review to understand the causal factors contributing to the violation. Therefore, it was not evident that the problems associated with this issue were sufficiently understood to provide reasonable assurance that the corrective actions would prevent recurrence. Consequently, the NRC was not able to complete the inspection objectives.
Inspection Report# : 2001006*(pdf)*
Inspection Report# : 2002009*(pdf)*

Significance: G Nov 06, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Meet the Regional 90 Minute EOF Activation
During the 1997 biennial exercise, (IR 50-387;388/97-08) it was identified that the emergency operations facility (EOF) was not able to assume control of the emergency within 90 minutes of the Alert declaration. Had the emergency started at the site area emergency level, the licensee would not have met its commitment in the emergency plan of activation within 90 minutes. During this exercise, the licensee was not able to meet the 90 minutes activation goal for the EOF from the time of emergency response organization notification. The licensee has reviewed this issue but has not been able to adequately correct the problem. This is contrary to 10 CFR 50.47b(14) which states that "Periodic exercises are conducted to evaluate major portions of emergency response capabilities.....and deficiencies identified as a result of exercises or drills are (will be) corrected." This issue was evaluated under the SDP process as a failure to implement a regulatory requirement and the failure does not appear to be programmatic. Therefore, the issue was determined to be of very low safety significant (Green) and is a non-cited violation.
Inspection Report# : 2000010*(pdf)*

Occupational Radiation Safety

Significance: G May 13, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Control a High Radiation Area (greater than 1000 millirem/hour at 30 cm) in accordance with Technical Specification 5.7.2.a
PPL identified that a barricade to prevent unauthorized or inadvertent entry to the drywell was not sufficiently secured to prevent unauthorized access. Since the drywell contained areas that had dose rates greater than1 rem/hour at 30 centimeters, technical specifications required a locked door or gate to prevent unauthorized entry. This was of very low safety significance because there was no substantial potential for exposure in excess of regulatory limits and there was no significant unplanned exposure. The inspectors identified a noncited violation against technical specifications.
Inspection Report# : 2000003*(pdf)*

Significance: W Dec 31, 2000
Identified By: NRC
Item Type: VIO Violation
Failure to Conduct an Adequate Radiological Survey in Accordance with 10 CFR 20.1501
During the period September 2000 through December 14, 2000, workers performed work on irradiated reactor hardware disposal equipment and tools, contaminated with highly radioactive particles on the refueling floor. While PPL took action to evaluate some aspects of the radiological hazards posed by these highly radioactive particles, PPL's organization and program: (1) did not adequately evaluate and characterize the radiation exposure hazards posed by these particles; and (2) did not establish and implement adequate radiological controls to prevent shallow-dose and deep-dose equivalent personnel exposure from exceeding regulatory requirements. While no personnel exposures in excess of 10 CFR 20 occupational limits are known to have occurred, the radiological conditions were such that a minor alteration in exposure circumstances could

result in personnel exposure in excess of regulatory limits. Failure to effectively evaluate the radiological hazard as necessary to assure that the regulatory dose limits of 10 CFR 20.1201 were not exceeded is an apparent violation of 10 CFR 20.1501(a). This issue was assessed using the Occupational Safety Significance Determination Process (SDP) described in NRC Inspection Manual Chapter (IMC) 0609, Appendix C, and characterized as a preliminary WHITE finding. By letter dated March 12, 2001, EA-01-012, the NRC has determined that the event should be assessed as White, an issue with low to moderate increased importance to safety. This results in a White finding. During the supplemental inspection performed in accordance with Inspection Procedure 95001, IR 05000377&378/2001-007) the inspector determined that the licensee performed acceptable evaluation of the radiological significance of the hazards associated with the presence of highly radioactive particles. The inspection determined that PPL Susquehanna's efforts in characterizing problems associated with effective radiological control of discrete radioactive particles, evaluating the root and contributing causes that led to substantial potential for personnel exposure in excess of the regulatory limits, and subsequently discerning appropriate corrective measures to prevent recurrence were acceptable. Appropriate actions were initiated to further develop root causes associated with hydrolazing of equipment prior to removal from underwater storage and use locations. The extent of condition review was adequately accomplished, and corrective actions were sufficient to address identified root and contributing causes. Due to the licensee's acceptable performance in addressing the characterization and control of highly radioactive particles, the White finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program." Implementation of the licensee's corrective actions will be reviewed during a future inspection.
Inspection Report# : 2000009*(pdf)*
Inspection Report# : 2001007*(pdf)*

Significance: G Dec 31, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Post a High Radiation Area
10 CFR 20.1501(a)(1), requires that surveys be made to comply with the regulations in 10 CFR Part 20 including 10 CFR 20.1902(b) for posting of high radiation areas (defined as an area greater than 100 mR/hr at 30 centimeters(cm)). On November 12, 2000, a shipping cask had not been surveyed properly and, as a result, an area measuring 700 mR/hr at 30 centimeters was undetected and constituted an unposted high radiation area. This event is documented in Condition Report No. 297422.
Inspection Report# : 2000009*(pdf)*

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Aug 12, 2000
Identified By: NRC
Item Type: FIN Finding
Missed 10 CFR 50 Appendix J Testing
Performance deficiencies in communications and coordination between engineering groups had allowed the failure to perform Technical Specification required leakage tests on the Hydrogen/Oxygen Analyzer System to remain unidentified for an extended period of time. Specifically, the group that was knowledgeable of the leakage rate testing program requirements did not understand the Hydrogen/Oxygen Analyzer System primary containment isolation valve design configuration and the groups that were knowledgeable of the primary containment isolation valve configuration design did not understand leakage rate testing program requirements. PPL determined that they had multiple opportunities to identify this issue from August 1996 until February 2000.
Inspection Report# : 2000005*(pdf)*

Significance: SL-IV Aug 12, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Demonstrate Adequate System Performance as Required by the Maintenance Rule
PPL failed to demonstrate that the performance of the Turbine Building Closed Cooling Water (TBCCW) system and the secondary containment isolation system had been effectively controlled through the performance of appropriate preventive maintenance and did not monitor against established goals. PPL did not identify that the TBCCW heat exchangers had exceeded their unavailability performance criteria and the secondary containment isolation system had exceeded its reliability performance criteria and, as a result, goal setting and monitoring were not performed as

required by 10 CFR 50.65, "The Maintenance Rule." The actual safety significance of this issue was very low because (1) TBCCW remained functional at the system level, and (2) a failure of the secondary containment isolation system does not influence the likelihood of an accident leading to core damage and does not affect the probability of an early primary containment failure. The inspectors identified a Non-Cited Violation for failure to meet the criteria in 10 CFR 50.65, paragraph (a)(2).
Inspection Report# : 2000005*(pdf)*

Significance: SL-IV Aug 12, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Control of Worker Overtime
PPL did not adequately control the use of worker overtime in accordance with Technical Specification Section 5.2.2.e, "Administrative Controls - Unit Staff." Specifically, from February 11, 1999 to May 5, 1999, several plant personnel worked in excess of 72 hours in a seven day period and PPL did not pre-approve the overtime deviations. The safety significance of this violation was very low because there were no issues that were linked to personnel fatigue. The inspectors identified a Non-Cited Violation for failure to control worker overtime, as required by Technical Specifications.
Inspection Report# : 2000005*(pdf)*

Significance: N/A Dec 01, 2000
Identified By: NRC
Item Type: FIN Finding
Effectiveness of Problem Identification and Resolution Program
The team concluded, based on the samples reviewed, that the implementation of the corrective action program at Susquehanna was adequate. Generally, the Susquehanna staff appropriately identified and entered problems into the condition report (CR) system. There was a low threshold for initiation of CRs. A recent initiative was a focused review of the CR database to identify adverse trends in performance. CRs were generally classified at the correct significance level and the actions identified on the CRs were generally adequate. The engineering and maintenance backlogs appeared to be adequately managed. The depth of the PPL analysis for the apparent and root causes of problems were generally appropriate. However, the team noted that the cause determination for certain relay failures was unsupported. The team also noted a separate example where corrective actions were not re-evaluated when subsequent relay failures occurred.
Inspection Report# : 2000006*(pdf)*

Significance: N/A Nov 06, 2000
Identified By: Licensee
Item Type: FIN Finding
Untimely General Emergency Declaration and Overly Conservative Dose Projections
Two problems were identified by the licensee from their critique in the dose assessment area. One was an error in dose projection calculation and the other was a potentially overconservative default dose projection. Both reflect a risk significant planning standard implementation problem. It is a finding due to extenuating circumstances - potential generic issue based on observations at recent exercises.
Inspection Report# : 2000010*(pdf)*

Last modified : March 29, 2002