

Susquehanna 1

2Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of T.S. 5.5.6, IST Program

The inspectors identified a NCV of Technical Specification 5.5.6, "Inservice Testing Program," because PPL did not evaluate the cause, effect and generic concerns of safety relief valve (SRV) failures to meet the +/- 3 percent set pressure test acceptance criteria as required by 1998 ASME Operations & Maintenance (OM) Code paragraph I-1330 (c)(3) from 2005 to 2009. Inspectors identified that PPL experienced a SRV set pressure test failure rate of 30 percent over five refuel outages. The causes of these failures were not evaluated for potential effects and generic implications to other SRVs as well as other valve groups. Further, PPL incorrectly interpreted NRC approved relief from certain parts of the ASME operation and maintenance (O&M) code to include evaluation of failures in the lower direction. SRV failures in the lower direction reduce the simmer margin between operating pressures and valve pressure setpoints. Reduced simmer margin and the lack of failure evaluations can result in more significant operational challenges. As an immediate corrective action, the licensee entered this NCV into their corrective action process (CR 1162307).

This finding is greater than minor because it is associated with the equipment performance attribute of the Initiating Event cornerstone; and it negatively impacted the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during power operations. This finding is related to the Problem and Identification Resolution cross-cutting area (Corrective Action Program) because PPL did not thoroughly evaluate the SRV failures such that the causes and extent of condition were addressed. (P.1(c)), (Section 1R12)

Inspection Report# : [2009003](#) (*pdf*)

Significance: SL-IV Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Violation of 10 CFR 50.73(a)(2)(vii), Report Common Cause Failures of Independent Trains

The inspectors identified a non-cited violation of 10 CFR 50.73(a)(2)(vii), because PPL did not submit a Licensee Event Report (LER) for the common cause failure and consequent inoperability of two or more SRVs in 2005, 2008, and 2009. The inspectors determined that SRV failures of set pressure testing per the 1998 ASME O&M Code were attributed to setpoint drift resulting in two or more independent channels (two or more SRVs) to become inoperable. As an immediate corrective action, the licensee entered this NCV into their corrective action process (CR 1161398). This finding was evaluated using the traditional enforcement process because the failure to accurately report events has the potential to impact or impede the regulatory process. The finding was determined to be a Severity Level IV violation based on Supplement I, Example D.4 of the NRC Enforcement Policy. However, because this violation was of very low safety significance, was not repetitive or willful, and was entered into PPL's corrective action program, this violation is being treated as an NCV consistent with the NRC Enforcement Policy. This finding is related to the Problem Identification and Resolution cross-cutting area (Operating Experience (OE)) because PPL did not thoroughly incorporate Information Notice (IN) 2006-24 to include SRV set point drift as a reportable common cause failure method. (P.2(b)), (Section 1R20)

Inspection Report# : [2009003](#) (*pdf*)

Mitigating Systems

G**Significance:** Dec 31, 2008

Identified By: NRC

Item Type: FIN Finding

Ineffective Evaluation and Incorporation of Operating Experience into the Corrective Action Program

Green. A self-revealing finding was identified for failing to properly implement PPL procedure NDAP-QA-0725 regarding the incorporation and evaluation of operating experience (OE) into the corrective action program and control of field work. Specifically, in December 2007 an industry operating experience report regarding the control of field work for nitrogen freeze seals in plant vital areas was entered into Susquehanna's corrective action program. However, the inspectors identified that PPL's review and evaluation of this OE resulted in no corrective actions taken or planned and that the relevant information was not communicated to the affected station groups as required by NDAP-QA-0725, Appendix D. Inspectors determined that the lack of corrective actions and inadequate communication of industry OE were primary contributors to the Susquehanna Unit 2 Alert declaration on October 27, 2008. This emergency declaration was required when the oxygen level in the 2B residual heat removal (RHR) pump room, which is a plant vital area, dropped below the minimum allowable threshold of 19.5 percent, which is the Immediately-Dangerous-to-Life-and- Health (IDLH) limit.

This finding was more than minor because the failure to properly implement NDAP-QA-0725, Appendix D, to evaluate external industry OE, implement corrective actions, and communicate the OE information to those who performed the relevant tasks at Susquehanna resulted in prohibiting access to safety-related equipment in the RHR room, resulted in the declaration of an emergency event (Alert), and increased the Technical Specification (TS) out of service (OOS) time for the 2B RHR pump. This finding affected the equipment performance attribute of the Mitigating Systems cornerstone and was of very low safety significance (Green) because it was not a design or qualification deficiency, there was no loss of safety function, and it was not potentially risk significant due to external events. The finding was not a violation of regulatory requirements but represented a failure to properly implement NDAP-QA-0725, Appendix D, in that external OE was not correctly evaluated and as a result, relevant information was not communicated to the affected work groups. PPL entered this issue into their corrective action program (CR # 1086125) and implemented corrective actions that included procedure revisions, reinforcement of procedure adherence, and training and qualification revisions. The inspectors determined that this finding has a cross-cutting aspect in the area of Problem Identification and Resolution (operating experience component) because PPL did not systematically or effectively evaluate and communicate industry OE to affected internal stakeholders in a timely manner. [IMC 0305 aspect: P.2(a)]. (Section 40A3)

Inspection Report# : [2008005](#) (*pdf*)**G****Significance:** Nov 07, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Establish Adequate Procedures for Operation of the Plant Following Evacuation of the Control Room due to a Fire

• Green. The team identified a Green non-cited violation of Units 1 and 2 Technical Specification 5.4.1, "Procedures" for PPL's failure to establish appropriate procedure directions for operation of the plant from the remote shutdown panel following a control room evacuation due to a fire. PPL's guidance for control room evacuation is provided in Unit 1 (Unit 2) procedure ON-100(200)-009, Control Room Evacuation, Revision 15. However, the team found that these procedures did not contain directions for establishing alternate shutdown cooling from the Remote Shutdown Panel using the train of equipment that had been analyzed to remain free from fire damage in the event of a control room fire. The licensee initiated a condition report and implemented procedure changes to add a section for operation of Residual Heat Removal(RHR)/Low Pressure Coolant Injection(LPCI) in the alternate shutdown cooling mode from the remote shutdown panel.

This finding is more than minor because it is associated with the procedural quality attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent core damage. Specifically, this issue would have required the plant operators to implement emergency operating procedures for maintaining reactor coolant inventory and cooling without the benefit of appropriate procedure guidance. This finding is related to the cross-cutting area of Problem Identification and Resolution (Corrective Action Program) because PPL did not take appropriate corrective actions to address a safety issue in a timely manner, commensurate with its safety significance and complexity. (P.1(d)),

(Section 1R05.01)

Inspection Report# : [2008009](#) (*pdf*)

Significance: **G** Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

HPCI and RCIC Made Inoperable Due to Operator Actions During Shutdown

The inspectors identified a NCV of Susquehanna Unit 1 Technical Specifications (TS) 3.5.1 and 3.5.3 for rendering high pressure coolant injection (HPCI) and reactor core isolation cooling (RCIC) inoperable during a planned shutdown. Specifically, both the HPCI and RCIC systems were made inoperable to fulfill their TS described safety function when operators raised reactor vessel level above the HPCI and RCIC turbine trip signals in a plant mode and at a plant pressure where both of these systems were required to be fully operable. PPL Susquehanna, LLC (PPL) initiated corrective actions to revise the shutdown procedure to prevent reactor vessel water level from being raised above the trip input level until low pressure (LP) emergency core cooling system (ECCS) are capable of being used. This finding is more than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). The finding was evaluated for significance using IMC 0609, Attachment 4, "Phase 1 Initial Screening and Characterization of Findings." Since the finding did not result in a loss of safety function or the loss of a train for greater than its TS allowed outage time, and was not potentially risk significant due to external event initiators, the finding was determined to be of very low safety significance (Green). This finding is related to the cross-cutting area of Human Performance – Resources because PPL did not ensure that personnel, equipment, procedures, and other resources were available and adequate to assure nuclear safety. (H.2(c) (1R15))

Inspection Report# : [2008004](#) (*pdf*)

Significance: **SL-IV** Jul 14, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Complete and Accurate NRC License Application

Severity Level IV: The NRC identified a Level IV non-cited violation of 10 CFR 50.9, "Completeness and Accuracy of Information" because PPL submitted a license application for a reactor operator to take an initial NRC license examination that incorrectly stated that the applicant was medically qualified with restrictions. The performance was reviewed for any cross cutting aspects and none were identified.

This finding was more than minor because it impacted the NRC's ability to perform its regulatory function and was therefore evaluated using the traditional enforcement process. Specifically, PPL submitted a license application for a reactor operator to take an NRC license examination that incorrectly stated that the applicant was medically qualified with restrictions. This information could have resulted in an operator being licensed that was not medically qualified. The finding is of very low significance because it did not result in the NRC making an incorrect licensing decision and PPL took adequate corrective actions and on July 14, 2008 requested withdrawal of this reactor operator license application. (Section 40A5)

THIS NCV WAS ACTUALLY CLOSED IN IR 2008-005

Inspection Report# : [2008302](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

G**Significance:** Sep 29, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Equipment to Assess Threshold for Emergency Action Level

The inspectors identified a NCV associated with emergency planning standard 10 CFR 50.47(b)(4). The inspectors determined that a performance deficiency existed in that inadequate indications were available for operators to determine if a threshold for emergency action levels (EALs) based on sustained wind speed in the protected area, had been met. On the afternoon of July 17, 2008, a severe thunderstorm with winds in excess of 50 miles per hour (mph) passed through the plant site. The storm caused damage to non-vital structures and resulted in the loss of two, 13.2 kilovolts (kV) power lines which interrupted power to several non-power block buildings on site. Inspectors observed operators responding to the event and identified that the wind speed indicator in the control room had indicated the maximum value for several minutes. This recorder only displayed wind speeds up to a maximum of 50 mph. Inspectors also observed that the backup wind speed indication, located 6 miles from the site and which reads from 0-100 mph, was inoperable during the storm. Inspectors identified that the Unit Supervisor had mistakenly read the wind direction trace on the recorder and had determined a 65 mph wind speed in error. Based upon direct observations during this adverse weather event, the inspectors determined that the operators did not have adequate indications available to determine if the threshold, sustained winds of greater than 80 mph, for EALs OA5 or OU5, had been met. This finding is greater than minor because it was associated with the Emergency Preparedness (EP) cornerstone attribute of Facilities and Equipment, and 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. This finding is of very low safety significance (Green) because it did not result in the Risk-Significant Planning Standard Function being lost or degraded. This finding is related to the cross-cutting area of Problem Identification and Resolution Corrective Action Program because PPL did not take appropriate corrective actions to address a safety issue in a timely manner, commensurate with its safety significance and complexity. Specifically, the NRC had previously identified this potential vulnerability over two years prior to the event and the licensee had entered the concern into their CAP; however, corrective actions were not implemented. [P.1(d)] (Section 1R01)

Inspection Report# : [2008004](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : August 31, 2009