Byron 2
2Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2005
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Follow Severe Weather Procedure Results in Less than Required Essential Service Water Basin Level
A finding of very low safety significance and associated Non-Cited Violation (NCV) of Technical Specification (TS) 5.4.1 regarding procedure adherence was self revealed, when during a tornado watch, operators failed to maintain both essential service water basin levels greater than 90 percent as specified in the associated abnormal operating procedure. Upon recognizing the low level condition, operators restored basin level to greater than 90 percent. The primary cause of this violation was related to the cross-cutting area of Human Performance (personnel) because the operators failed to maintain the required basin level even though adequate guidance for maintaining basin level was provided in the associated procedure.

This finding was more than minor because the operators allowed the level to drop below the operating limit; which is similar to the more than minor examples of Section 2 of Appendix E to Inspection Manual Chapter (IMC) 0612. The finding was determined to be of very low safety significance because the condition did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available.
Inspection Report# : 2005004*(pdf)*

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Insufficient Fire Seal Material in Penetration Between Emergency Diesel Generator Rooms and Associated Switchgear Rooms
The inspectors identified a finding of very low safety significance and associated NCV of the license number NPF-66 Section 2.E, requiring that the licensee shall implement and maintain in effect all provisions of the fire protection program as described in the licensee's Fire Protection Report. Specifically, during an inspection of the Division 21 electrical switchgear room the inspectors identified that a penetration that connected the Division 21 electrical switchgear room with the Unit 2 train A diesel generator had not been properly sealed as part of the 3-hour fire barrier. The licensee's extent of condition review identified two more penetrations in the Division 22 electrical switchgear room which also had not been properly sealed. Upon identification of the degraded penetrations, the licensee established the required compensatory fire watches until the penetrations were properly sealed.

This finding was considered more than minor, because it could be reasonably viewed as a precursor to a significant event, specifically a loss of Division 21 or 22 switchgear rooms with a fire in the Unit 2 train A or B diesel-generator rooms or loss of the Unit 2 train A or B diesel generator with a fire in the Division 21 or 22 switchgear rooms. The finding was determined to be of very low safety significance because the condition reflected a fire protection program element whose performance and reliability will be minimally impacted by the inspection finding. That is, if the fire occurred in the Division 21 switchgear room or Unit 2 train A diesel generator room, the fire would be confined in the two areas and the reliance on the Division 22 switchgear power is not effected.
Inspection Report# : 2005004*(pdf)*

Mitigating Systems

Significance: G Feb 11, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
LACK OF HEAT EXCHANGER OVER PRESSURE PROTECTION
A finding of very low safety significance was identified by the inspectors for a Non-Cited Violation of 10 CFR 50.55a. The licensee did not ensure that the essential service water (SX) system contained pressure relief devices or had administrative controls to relieve excessive system pressure as required by Article ND-7110 of the American Society of Mechanical Engineers (ASME) Code, Section III. Once identified, the licensee immediately initiated actions to strengthen the administrative controls to prevent overpressure. This issue also impacted the cross-cutting aspecto of problem identification and resolution because the licensee had opportunities to identify the condition in October 2003.

This issue was more than minor because failing to provide overpressure protection to the Unit 0 Component Cooling Heat Exchanger served by

SX could result in inoperability of the component or diverted SX flow. The issue was of very low safety significance because it was not a design issue or an actual loss of the system's safety function.
Inspection Report# : 2005002*(pdf)*

Significance: G Feb 11, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
NON-SAFETY RELATED THERMOSTATS USED FOR AUXILIARY FEEDWATER PUMP ROOM COOLERS
A finding of very low safety significance was identified by the inspectors for a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." The thermostats that control the essential service water (SX) system 1/2SX168 valves were non-safety related and their failure could affect the SX cooler flow to the diesel driven auxiliary feedwater (AFW) pump rooms. The original design review of the component classification failed to address all failure modes. Once identified, the licensee immediately performed an operability determination and based on engineering judgment, concluded that the valves were operable.

This issue was more than minor because failing to ensure proper room cooling could impact the function of temperature sensitive equipment and could result in inoperability of a diesel driven AFW pump. The issue was of very low safety significance because it was a design issue which did not result in loss of function per Generic Letter GL 91-18.
Inspection Report# : 2005002*(pdf)*

Significance: G Feb 11, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY REVIEW AND MAKE PROCEDURE CHANGES
A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR Part 50, Appendix B, Criterion V, " Instructions, Procedures, and Drawings." After increasing the minimum required river screen house (RSH) temperature for securing a service water makeup pump from 50 degrees Fahreheit to 70 degrees Fahrenheit in 1998, the licensee failed to revise two operating procedures. Once identified, the licensee reviewed other procedures and initiated procedure changes.

This issue was more than minor because the licensee failed to ensure that the procedures contained the necessary precautions and steps to ensure continued operability of the SX pumps. The issue was of very low safety significance because it did not represent the actual loss of safety function.
Inspection Report# : 2005002*(pdf)*

Significance: G Feb 11, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE RIVER SCREEN HOUSE (RSH) VENTILATION CALCULATION
A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." A river screen house (RSH) ventilation calculation ventilation calculation assumed that only one Essential Service Water (SX) makeup pump would be running and calculated the maximum ambient temperature of the RSH to be 115 degrees Fahrenheit. Licensee personnel failed to consider that two SX makeup pumps could be in operation for up to five hours into an event. Since two pumps could be running, the calculation underestimated the heat input into the RSH from the operating pumps. Once identified, the licensee immediately performed an operability determination and concluded that based on current ambient temperatures, the pumps were operable. Additional assessments will be completed prior to summer temperatures.

This issue was more than minor because exceeding the temperature ratings for components could impat the ability of the diesel-driven pump to perform its safety function. The issue was of very low safety significance because it did not represent an actual loss of a safety function.
Inspection Report# : 2005002*(pdf)*

Significance: G Sep 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO ASSESS THE ADEQUACY OF A BRACING STRUCTURE INSTALLED TO PROTECT SAFETY RELATED CONDUIT IN THE EVENT OF THE TIP-OVER OF A NONSEISMICALLY MOUNTED TANK DURING AN EARTHQUAKE.
A finding of very low safety significance was identified by the inspectors for a NCV of 10 CFR 50 Appendix B, Criterion III, "Design Control." Specifically, the licensee failed to assess the adequacy of a bracing structure installed to protect safety-related conduits in the event of the tip-over of a nonseismically mounted tank during an earthquake. Subsequently the licensee evaluated the design in accordance with their temporary modification program. The primary cause of this violation was related to the cross-cutting area of Human Performance because prior to the installation, the engineers failed to assess the adequacy of the design of the bracing structure.

This finding was more than minor because it involved the design control attribute associated with the mitigating system cornerstone objective.

The finding was of very low safety significance because although there was a design deficiency, it did not result in a loss of funtion.
Inspection Report# : 2004007*(pdf)*

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO TAKE PROMPT CORRECTIVE ACTIONS TO CORRECT ENGINE DAMAGE RESULTING FROM ENGINE OVERHEATING OF THE 2B AFW PUMP DIESEL.
A finding of very low safety significance and an associated NCV of 10 CFR 50 Appendix B Criterion XVI, "Corrective Actions" was self-revealed when the licensee failed to correct a condition adverse to quality. Specifically, the licensee failed to take prompt corrective actions to correct engine damage resulting from overheating the diesel engine of the Unit 2 train B (2B) AFW pump in April 2004. On August 1, 2004, the discovery of jacket water leakage into the pump bed plate indicated that adequate corrective actions were not taken to correct the consequences of the overheated condition in April 2004. The licensee has since replaced the affected parts in the pump's diesel engine. This deficiency affected the cross-cutting area of Problem Identification and Resolution because, although the licensee had an opportunity to identify and correct the engine damage in April 2004, the extent of the damage was not identified or corrected at that time.

The issue was more than minor because it affected the equipment performance attribute of the mitigating systems cornerstone objective. The finding was of very low safety significance because there was no design deficiency, no actual loss of safety function, no single train loss of safety function for greater than the technical specification allowed outage time and no risk due to external events.
Inspection Report# : 2004007*(pdf)*

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
LACK OF COUPLING SPECIFICATIONS PROVIDED IN WORK INSTRUCTIONS RESULTS IN INADEQUATE ACTUATOR TO VALVE ENGAGEMENT.
A finding of very low safety significance and an associated NCV of TS 5.4.1 regarding procedure quality was self-revealed when the licensee found less than minimum required valve-to-actuator coupling on three safety-related valves. Specifically, the licensee failed to document the correct minimum shaft coupling engagement length for maintenance on Unit 2 containment chiller SX inlet/outlet valves; 2SX112B, 2SX114A, 2SX114B in early 2003. Following the identification of the problem, the licensee adjusted the coupling to ensure proper engagement. The primary cause of this violation was related to the cross-cutting area of Human Performance because the licensee did not provide the specifications for proper shaft coupling engagement length in the work instructions work maintenance on the valves.

This finding was more than minor because it involved the procedure quality attribute associated with the mitigating system cornerstone objective. The finding was of very low safety significance because there was no design deficiency, no actual loss of safety function, no single train loss of safety function for greater than the TS allowed outage time, and no risk due to external events.
Inspection Report# : 2004007*(pdf)*

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW CLEARANCE ORDER PROCEDURES RESULTS IN DAMAGE TO DEEP WELL PUMP DUE TO OPERATIONS WITHOUT ADEQUATE DISCHARGE PATH.
A finding of very low safety significance and an associated NCV of TS 5.4.1 regarding procedure adherence was self-revealed on July 2, 2004 when, as a result of an equipment control error, the licensee ran the Unit 0 train A (0A) deep well pump with an inadequate flow path such that it was no longer capable of performing its safety function. The licensee had since repaired the pump and placed it back into service. The primary cause of this violation was related to the cross-cutting area of Human Performance. Although procedure requirements stated that effects on components outside the clearance order boundary must be identified as acceptable or properly dispositioned, the effects of work on the 0A deep well pump discharge valve to the SX cooling tower basin were not understood. This was evidenced by the fact that the pump continued to run when the operators expected it to automatically shut off.

The finding was more than minor because the failure to follow the procedure for clearance and tagging was similar to the greater than minor examples of Section 4 of Appendix E of IMC 0612. The finding was of very low safety significance because there was no design deficiency, no actual loss off safety function, and no single train loss of safety function for greater than the TS allowed outage time. Also, there was no risk due to external events because the loss of this equipment by itself would not degrade two or more trains of a multi-train safety system function.
Inspection Report# : 2004007*(pdf)*

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO PROPERLY SPECIFY THE CORRECT SCHEDULE NUMBER FOR THE SX PUMP GLAND COOLING WATER

PIPING IN THE ASSOCIATED DRAWINGS.
A finding of very low safety significance and an associated Non-Cited Violation (NCV) of 10 CFR 50 Appendix B Criterion III, "Design Control," was self-revealed on September15, 2004 when a known leak on a gland seal cooling line on the Unit 2 train A (2A) essential service water (SX) pump worsened resulting in the licensee declaring the pump inoperable. The leakage from cracked pipe threads in gland seal cooling lines resulted from a combination of the use of thinner wall thickness pipe and hand-cut pipe threads. The thinner pipe was used because the incorrect thickness was specified in the associated drawings. The licensee replaced the existing pipe with the correct wall thickness pipe, and initiated a corrective action to revise the associated drawings. The primary cause of this violation was related to the cross-cutting area of Problem Identification and Resolution because, although the licensee had prior opportunities to identify and correct the drawing, it was not corrected.

This finding was more than minor because the failure to correctly translate the correct schedule number for the SX pump gland water line into Piping and Instrumentation Diagram Drawing was similar to the greater than minor examples of Section 3 of Appendix E of IMC 0612. The finding was of very low safety significance because even though there was a design deficiency, there was no actual loss of safety function, no single train loss of safety function for greater than the Technical Specification (TS) allowed outage time, and no risk due to external events.
Inspection Report# : 2004007*(pdf)*

Significance: G Sep 30, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO MANAGE THE INCREASE IN RISK DUE TO 2A EDG MAINTENANCE.
A finding of very low safety significance and an associated NCV of 10 CFR 50.65 was self-revealed when it was determined that Unit 2 was in a higher risk condition than was communicated by the licensee. Specifically, on July 23, 2004, Unit 2 risk was incorrectly changed from slightly elevated risk back to normal risk while the Unit 2 train A emergency diesel generator was in a configuration where it would not automatically start if called upon in an accident. Upon discovery of the error, the licensee reassigned online risk to the proper designation. The primary cause of this violation was related to the cross-cutting area of Human Performance because after the performance of a concurrent surveillance test, operators mistakenly assigned online risk to a condition of normal even though the emergency diesel generator remained unable to automatically start.

This finding was more than minor because, if left uncorrected it could have been a more significant safety concern, in that, other maintenance activities that would have raised online risk to a level higher than expected could have been started. The finding was of very low safety significance because there was no design deficiency, no actual loss of safety function, no single train loss of safety function for greater than the TS allowed outage time, and no risk due to external events.
Inspection Report# : 2004007*(pdf)*

Significance: G Jul 09, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Install Fire Detector in Accordance With NFPA 72E
The inspectors identified the lack of a smoke detector on the ceiling of the Auxiliary Building 426' general area, Fire Zone 11.6-0, in the beam pocket north of beam 7AB253, located outside of the Radwaste Evaporator Rooms. The failure to have adequate detector placement in this area is a Non-Cited Violation of the Byron operating license, which required detectors to be installed in accordance with National Fire Protection Association (NFPA) standard 72-E. The licensee initiated a corrective action to install adequate detection in the area. The finding was greater than minor because it affected the mitigating systems cornerstone attribute of protection against external factors (fire). As a result of the inadequate detector placement, detection of a fire north of beam 7AB253 could be delayed. The finding was of very low safety significance because of the low fire ignition frequency in this location.
Inspection Report# : 2004005*(pdf)*

Significance: G Jul 09, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Faulted Pressurizer PORV Power Source Restoration Directions Inadequate
A finding of very low safety significance was identified by the inspectors for failure to have adequate procedures to achieve cold shutdown conditions within 72 hours following a fire. The inspectors found that the procedures for shutdown from outside of the control room did not provide sufficient direction to restore a faulted pressurizer power operated relief valve (PORV) power source. Once identified, the licensee initiated corrective actions to evaluate and take appropriate corrective actions to restore a faulted pressurizer PORV power source. This finding was more than minor because a deficiency in the procedures for transition to cold shutdown from outside of the control room could have delayed cold shutdown. A delay in achieving cold shutdown following a fire that required shutdown from outside of the control room could have an adverse impact on safety. The finding was of very low safety significance because the finding only involved the ability to achieve cold shutdown and did not affect the ability to achieve and maintain hot standby. This issue was a violation of the licensee's operating licenses as identified in 10 CFR Part 50, Appendix R, Section III.L.3, because the procedures for shutdown from outside of thecontrol room did not provide sufficient direction to restore a faulted pressurizer PORV power source.
Inspection Report# : 2004005*(pdf)*

Significance: G Jul 09, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Design Control of Fire Loading Calculations
The inspectors identified that permanent fire loading added during a modification to install a work station for Radiation Protection personnel at Byron Station Unit 2 Auxiliary Building EL. 401', was not added to the total fire loading for the fire zone. The design change process considered fire loading less than 1000 BTUs/sq. ft. to be negligible, creating the potential to lose track of the cumulative fire loading for a given fire zone. The failure to revise the fire loading calculation to account for additional permanent fire loading in a fire zone is a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." The licensee's Quality Assurance Manual states that Quality Assurance design control requirements are applicable to fire protection. The licensee initiated a corrective action to ensure that the design control processes would account for all increases in permanent fire loading. The finding was greater than minor because if left uncorrected, it would become a more significant safety concern as it could affect the ability of systems designed to cope with a fire in a given fire zone, if the cumulative fire loading exceeded allowable values. The finding was of very low safety significance because the heat load added by this modification did not exceed the allowance for the area.
Inspection Report# : 2004005*(pdf)*

Barrier Integrity

Significance: G Mar 31, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CONTROL CONTAINMENT PENETRATIONS IN ACCORDANCE WITH TECHNICAL SPECIFICATION 3.9.4C DURING CORE ALTERATIONS.
A finding of very low safety significance and an associated NCV of TS 3.9.4c was identified by the NRC. Specifically, the inspectors determined that during the performance of local leak rate tests the licensee failed to maintain containment penetrations closed while core alterations were in progress as was required by the TS.

The finding was more than minor because it affected the configuration control, specifically containment boundary preservation, attribute associated with the Reactor Safety Barrier Integrity Cornerstone objective to provide reasonable assurance that physical barriers, specifically containment, protect the public from radionuclide releases caused by accidents or events. This finding was of very low safety significance because (1) the issue did not increase the likelihood of a loss of primary coolant system inventory; (2) the issue did not degrade the licensee's ability to terminate a leak path or add RCS inventory when needed; and (3) the issue did not degrade the licensee's ability to recover decay heat removal once lost. Furthermore, the issue only impacted the containment function without affecting core damage frequency, and was associated with a shutdown condition during periods when the reactor vessel water level was greater than or equal to the level required for fuel moves.
Inspection Report# : 2005003*(pdf)*

Significance: G Mar 31, 2005
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
EXCEEDING 100% LICENSED POWER FOLLOWING THE IMPLEMENTATION OF THE ULTRASONIC FEEDWATER FLOW MEASURING INSTRUMENTS.
A finding of very low safety significance and an associated NCV for operating in excess of the licensed thermal power limits was self-revealed. Specifically, it was determined that for periods between May 2000 and August 2003, the installed feedwater ultrasonic flow measurement instruments provided non-conservative data to the reactor power calculation which resulted in power operation greater than the licensed maximum thermal power output of 3586.6 megawatts thermal (100 percent power). Unit 1 operated with a maximum power level of 102.62 percent. Unit 2 operated with a maximum power level of 101.88 percent. This finding was related to the cross-cutting area of Problem Identification and Resolution (evaluation) because the licensee missed several opportunities to determine that an over power condition existed.

This finding was more than minor because it affected the Barrier Integrity Cornerstone objective of providing reasonable assurance that the physical design barrier of fuel cladding protect the public from radionuclide releases caused by accidents or events, and was associated with the attribute of design control (core design analysis). The finding was of very low safety significance because of the fuel cladding barrier was no degraded.
Inspection Report# : 2005003*(pdf)*

Significance: G Feb 11, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE ACCEPTANCE CRITERIA FOR FLOW TEST

A finding of very low safety significance was identified by the inspectors for a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." The acceptance criteria for the minimum service water flow through a reactor containment fan cooler (RCFC) as specified in 1/2BOSR 5.5.2-1, "Reactor Containment Fan Cooler Monthly Surveillance," was based on a higher system pressure than expected during the limiting design basis accident. Therefore, the licensee did not ensure that the TS required flow would be achieved at the lower pressure conditions. Once identified, the licensee performed an operability determination and concluded the fan coolers were operable. Additonal actions including revising the procedures were being considered.

This issue was more than minor because reduced service water flow through the RCFC could impact the heat removal capability of the RCFCs. The issue was of very low safety significance because it did not represent a reduction in defense in depth with respect to the physical integrity of the reactor containment.
Inspection Report# : 2005002*(pdf)*

Significance: G Dec 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
INADEQUATE PROCEDURES ASSOCIATED WITH CALCULATING, REVIEWING AND APPROVING DILUTIONIS AND BORATIONS
A finding of very low safety significance and an associated Non-Cited Violation (NCV) of Technical Specification 5.4.1 regarding procedure quality was self-revealed when operators miscalculated a boron addition for Unit 2, resulting in a greater than desired reduction in reactor coolant temperature. The primary cause of this finding was related to the cross-cutting area of Human Performance. Specifically, the operators failed to show adequate self-checking and technical rigor resulting in a boron addition twice as large as required. Upon recognizing the excessive temperature change, the operators properly diluted to restore reactor coolant temperature and subsequently initiated procedure changes to control the calculation and review of boration and dilution activities.

The finding was more than minor because it affects the Barrier Integrity Cornerstone objective of providing reasonable assurance that the physical design barriers of fuel cladding protect the public from radio nuclide releases caused by accidents or events, and was associated with the attribute of human performance and procedure adherence related to reactor manipulation. The finding was of very low safety significance because the fuel cladding barrier was not degraded and the reactor coolant system temperature remained within the operating criteria.
Inspection Report# : 2004009*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Mar 31, 2005
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO EVALUATE RADIOLOGICAL CONDITIONS PRIOR TO A SIGNIFICANT EQUIPMENT CONFIGURATION CHANGE.
One self-revealed finding of very low safety significance and an associated Non-Cited Violation was identified when, on March 12, 2005, the licensee failed to conduct an adequate evaluation of the radioligical conditions prior to removing the charcoal adsorber portion of HEPA units associated with work on the Unit 1 steam generators. Subsequently, Unit 1 Containment radiological conditions changed such that several air monitors went into high alarm on the iodine channel and 28 personnel were found to have unintended, low-level, internal contamination.

The issue was more than minor because it was associated with the Human Performance attribute (a cross-cutting area) of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radioactive materials in that multiple workers received unintended dose from small intakes. In that the finding was no specifically related to ALARA or planning issues, there was no radiological overexposures, nor the substantial potential for an overexposure, and the licensee's ability to assess worker dose was not compromised, the finding was determined to be of very low safety significance. The licensee's corrective actions for this issue included reinstalling the charcoal adsorbers and initiating additional containment atmosphere treatment, revising procedures to include specific criteria for charcoal adsorber removal, and modifying the outage schedule such that charcoal adsorber removal is logically tied to steam generator manway installation. One Non-Cited Violation for the failure to adequately evaluate radiological conditions in accordance with 10 CFR 20.1501 was also identified.
Inspection Report# : 2005003*(pdf)*

Significance: G Mar 31, 2005

Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO OBTAIN A RADIATION PROTECTION BRIEFING PRIOR TO AN ENTRY INTO A HIGH RADIATION AREA.
One self-revealed finding of very low safety significance and an associated NCV was identified when, on March 9, 2005, a contract radiation worker, while supporting polar crane movement of equipment used for the upper internals split pin modification, entered a High Radiation Area (HRA) without receiving a high radiation area brief from the radiation protection staff as required by the Radiation Work Permit.

The primary cause of this finding was related to the cross-cutting area of Human Performance (personnel). This issue was more than minor because it was associated with the Human Performance attribute of the Occupational Radiation Safety Cornerstone and affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radioactive materials in that two barriers (i.e., the HRA briefing and compliance with the HRA posting) in place to prevent unplanned, unintended worker dose failed. In that the finding was no specifically related to ALARA or planning issues, there were no radiological overexposures, nor the substantial potential for an overexposure, and the licensee's ability to assess worker dose was not compromised, the finding was determined to be of very low safety significance. The licensee's corrective actions for this issue included enhancing the physical and administrative RP controls over HRAs within containment. One Non-Cited Violation for the failure to obtain a HRA briefing prior to entry into the area in accordance with licensee procedures and Technical Specification 5.4.1 was also identified.
Inspection Report# : 2005003*(pdf)*

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : August 24, 2005