

## Palo Verde 1

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### Initiating Events



**Significance:** May 07, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

#### **Isolation of reactor level instrumentation during partial drain condidtions**

TS 5.4, "Procedures," requires that written procedures be implemented and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Section 3.a of this Regulatory Guide includes instructions for draining the RCS. Procedure 40OP-9ZZ16, "RCS Drain Operations," Revision 24, provides instructions for draining the RCS and includes instrumentation requirements for reactor water level monitoring. On May 7, 2001, this procedure was being implemented to maintain Unit 1 in a partially drained condition. Due to personnel error involving plant configuration control, required reactor level instrumentation was isolated for a period of time as described in CRDR 2385849 and is being treated as a NCV. This finding is of very low safety significance because reactor water level was maintained within the operating band at all times.

Inspection Report# : [2001003\(pdf\)](#)

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### Mitigating Systems



**Significance:** Mar 31, 2001

Identified By: NRC

Item Type: FIN Finding

#### **Anomalies in testing and test results for essential cooling water heat exchangers leads to ineffective trending**

The inspector identified that the licensee was not effectively trending essential cooling water heat exchanger thermal performance. Ineffective heat exchanger performance trending could allow thermal performance to degrade below design bases limits without detection, which is a credible impact on safety. The essential cooling water system is a mitigating system. The finding was of very low safety significance, because the actual cumulative effect of these errors was less than the available thermal performance margin and in all cases, the heat exchangers remained operable.

Inspection Report# : [2001002\(pdf\)](#)



**Significance:** Feb 22, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to promptly identify and correct an inadequate HPSI system venting procedure**

A non-cited violation was identified when the licensee failed to promptly identify and correct an inadequate surveillance procedure that was used to periodically vent the high pressure safety injection (HPSI) system. The procedure failed to include guidance for conducting HPSI system venting and the acceptance criteria to ensure successful venting. This failure resulted in inadequate HPSI system venting since February 1997. This was a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI. This violation was entered into the licensee's corrective action program as CRDR 2316659. The underlying technical issue, an inadequate surveillance procedure, was assessed by the significance determination process and determined to have very low safety significance because the high pressure safety injection system remained operable.

Inspection Report# : [2001004\(pdf\)](#)

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### Barrier Integrity

### Emergency Preparedness

## Occupational Radiation Safety



**Significance:** Jul 13, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

### **Failure to follow radiation exposure permit instructions**

TS 5.4.1 requires the implementation of procedures listed in Regulatory Guide 1.33, Appendix A. Procedure 75DP-ORP01, "RP Program Overview," Revision 3, requires individuals to follow special instructions listed in the radiation exposure permit. On July 13, 2001, an auxiliary operator failed to follow radiation exposure permit instructions to obtain a prejob briefing before entering a high radiation area (NCV 50-528/01-006-01). This occurrence was documented in the licensee's corrective action program as CRDR 2405644. The safety significance of this violation was determined to be very low by use of the occupational radiation safety significance determination process because there was no actual over-exposure, or substantial potential for over-exposure, and the ability to assess dose was not compromised.

Inspection Report# : [2001006\(pdf\)](#)



**Significance:** May 01, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

### **Failure to wear required dosimetry when entering a high radiation area**

TS 5.7.1 requires, in part, that any individual entering a high radiation area be provided a radiation monitoring device which continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received. On October 8, 1999, an individual entered a high radiation area without an alarming dosimeter. The violation was of very low safety significance because the event did not involve a very high radiation area, a personnel over exposure, or a substantial potential for an over exposure, and the ability to assess dose was not compromised because the individual was wearing thermoluminescent dosimetry. This violation is in the licensee's corrective action program as CRDR 107125 and is being treated as a NCV.

Inspection Report# : [2001002\(pdf\)](#)



**Significance:** Apr 04, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

### **Failure to wear a radiation monitoring device that continuously integrated the radiation dose rate in a high radiation area**

TS 5.7.1.b states, in part, that any individual or group of individuals permitted to enter a high radiation area shall be provided with a radiation monitoring device that continuously integrates the radiation dose rate in an area. On April 4, 2001, the licensee identified that between March 27 and April 4, 2001, 37 individuals using four different nonfunctioning electronic dosimeters entered high radiation areas. The cause of the electronic dosimeter problem was a vendor related firmware problem. The failure to wear a radiation monitoring device that continuously integrated the radiation dose rate in a high radiation area is a violation of Technical Specification 5.7.1. These events are described in the licensee's corrective action program, reference CRDR 2376601. The safety significance of this finding was determined to be very low by the Occupational Radiation Safety Significance Determination Process because there was no overexposure or unintended dose as a result of these nonfunctioning dosimeters

Inspection Report# : [2001003\(pdf\)](#)



**Significance:** Feb 22, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to conduct adequate radiation surveys**

Three examples of a failure to conduct adequate radiological surveys. On December 21, 1999, radiological surveys failed to detect changing radiological conditions at the "B" concentrate monitor tank. On May 4, 2000, radiological surveys failed to detect changing radiological conditions at the "B" LPSI pump cyclone separator and changing radiological conditions following a drain down of the spent fuel transfer canal. As a result, radiological area postings and controls for these areas were inappropriate. These three examples of inadequate radiological surveys were a violation of 10 CFR Part 20.1501. This violation was entered into the licensee's corrective action program as CRDRs 113251, 117874 and 117970. These findings were determined to have very low risk significance because there was no overexposure or substantial potential for an overexposure and the ability to assess radiation doses was not compromised.

Inspection Report# : [2001004\(pdf\)](#)

## Public Radiation Safety

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### Physical Protection



**Significance:** Nov 29, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

**Failure to properly secure safeguards information.**

10 CFR 73.21(d)(2) states that, while safeguards information is unattended, the information shall be stored in a locked security storage container. Procedure 20DP-OSK43, Revision 4, paragraph 3.8.3, states that, while unattended, materials containing safeguards information shall be stored in an approved, locked safeguards storage container. Contrary to the above requirements, on July 28, 2000, the licensee left a safeguards safe unlocked outside the protected area. This condition was identified by the licensee and corrective actions were specified in Condition Report/Disposition Request 2308078. This condition was reported in LER 50-528;-529;-530/2000-S01-00. This issue was determined to be of very low safety significance (Green) by the significance determination process because there were not greater than two similar findings in the last four quarters.

Inspection Report# : [2000010\(pdf\)](#)

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### Miscellaneous

**Significance:** N/A Mar 19, 2002

Identified By: NRC

Item Type: FIN Finding

**Identification and resolution of problems.**

The licensee was generally effective at identifying problems and placing them into the corrective action program. The licensee effectively used risk information in prioritizing the extent of evaluation of individual problems and the schedule for implementation of corrective actions. The licensee effectively prioritized and evaluated issues with few exceptions. One exception involved a final operability evaluation which concluded that the main steam and feedwater isolation system actuation circuitry was operable took approximately 5 months to complete. Another example involved a failure to fully determine the extent of a condition associated with Borg-Warner check valve failures which resulted in additional failures. Corrective actions, when specified, were implemented in a timely manner. Based on interviews conducted during this inspection, workers at the site felt free to input safety issues into the problem identification and resolution program (Section 4OA2).

Inspection Report# : [2002005\(pdf\)](#)

**Significance:** N/A Feb 22, 2001

Identified By: NRC

Item Type: FIN Finding

**Identification and resolution of problems was effective**

The licensee was effective at identifying problems and putting them into the corrective action program. The licensee's effectiveness at problem identification was evidenced by the relatively few deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee during the review period. The licensee effectively used risk information in prioritizing the extent of evaluation of individual problems and the schedule for implementation of corrective actions. Corrective actions, when specified, were generally implemented in a timely manner. However, there was one instance that is discussed below, where the licensee did not promptly identify and correct an inadequate procedure. Licensee audits and assessments were effective. Based on the interviews conducted during this inspection, workers at the site felt free to input safety issues into the problem identification and resolution program (Sections 4OA2.1b;2b;3b;4b).

Inspection Report# : [2001004\(pdf\)](#)

Last modified : July 22, 2002