

Palo Verde 2

1Q/2005 Plant Inspection Findings

Initiating Events

G**Significance:** Nov 11, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow the Operability Determination Process

A noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for not following the timeliness requirements noted in Procedure 40DP-9OP26, "Operability Determination," following the identification of a nonconforming condition associated with a pressurizer heater sleeve modification tolerances. Procedure 40DP-9OP26 requires that the shift manager or shift technical advisor be immediately notified of indications of a potential non-conformances. A condition report/disposition request was initiated on November 9, 2004, but neither the shift manager, nor the shift technical advisor were notified until Wednesday, November 10, 2004. This issue also had problem identification and resolution crosscutting aspects associated with engineering personnel not informing the control room in a timely manner and is similar to issues noted in adverse Condition Report/Disposition Requests 2733983 and 2734037, issued on August 26, 2004. The issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2754848.

This finding is greater than minor since the failure to follow the operability determination process, if left uncorrected, would become a more significant safety concern. Using the Phase 1 Worksheet in Manual Chapter 0609, "Significance Determination Process," the finding is determined to have very low safety significance because it only affected the initiating events cornerstone and did not result in actual degradation of the reactor coolant system boundary.

Inspection Report# : [2004005\(pdf\)](#)**G****Significance:** Aug 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURS FOR OPERATION OF THE SPENT FUEL HANDLING MACHINE

The inspectors identified a noncited violation of Technical Specification 5.4.1 associated with a failure to operate the spent fuel handling machine in accordance with Procedure 78OP-9FX03, "Spent Fuel Handling Machine," Revision 16. There were three instances of this: (1) On October 4, 2002, the spent fuel handling machine operator moved fuel assemblies of two differing weights and was not cognizant of design differences of the fuel assemblies and did not stop fuel movement when the load was greater than 50 lbs. different from expected; (2) On October 4, 2002, the spent fuel handling machine operator failed to verify that the hoist was in its full up position prior to moving a spent fuel assembly, and (3) later on October 4, 2002, another spent fuel handling operator failed to verify that the hoist was in its full up position prior to moving a spent fuel assembly. In both Examples (2) and (3), the operators failed to verify the "UP LIMIT" light was on and failed to verify the hoist indicator was at the "UPLIMIT." As a result, in Example (3), the one fuel assembly was damaged. These issues were contrary to Procedure 78OP-9FX03 and resulted in damage to the lower grid assembly of Fuel Assembly P1M316.

This finding is greater than minor because it had an actual impact of damage to an irradiated fuel assembly and, therefore, could be reasonably viewed as a precursor to a significant event. If the fuel cladding had failed, it could have caused a release of fission products to the environment. The finding is of very low safety significance because all mitigation systems were available during the fuel movement operations and should have prevented an unplanned release of radioactive material to the environment above the limits of 10 CFR Part 100. This finding also had crosscutting aspects in the area of human performance.

Inspection Report# : [2004011\(pdf\)](#)**G****Significance:** Aug 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PRESCRIBE ADEQUATE INSTRUCTIONS FOR ENTRY INTO ABNORMAL OPERATING PROCEDURE, PVNGS PROCEDURE 40AO-9ZZ22, "FUEL DAMAGE," REVISION 2 THROUGH 6

The inspectors identified a noncited violation of Technical Specification 5.4.1 associated with an inadequate abnormal operating procedure. Specifically, the inspectors determined that Palo Verde Nuclear Generating Station Procedure 40AO-9ZZ22, "Fuel Damage," Revisions 1 through 6, were not adequate in that the entry conditions never required operations personnel to enter the procedure and take actions to mitigate the event. Step 1.1 states, in part, "Section 3.0, Irradiated Fuel Damage may be entered when any of the following conditions exist . . . when equipment or component failures result in any of the following: irradiated fuel assembly contacting a solid structure; bubbles emerging from a spent fuel assembly; bent, twisted, or warped spent fuel assembly; or visual damage to spent fuel pin cladding." Since this abnormal operating

procedure was never entered, applicable actions were never considered during the Fuel Assembly P1M316 event.

This finding is greater than minor because actions taken in response to fuel handling errors could result in significant fuel cladding damage and effect the barrier cornerstone. The finding is of very low safety significance because all mitigation systems were available and should have prevented an unplanned release of radioactive material to the environment above the limits of 10 CFR Part 100. This finding also had crosscutting aspects in the area of problem identification and resolution.

Inspection Report# : [2004011\(pdf\)](#)

G

Significance: Jul 08, 2004

Identified By: NRC

Item Type: FIN Finding

POOR MATERIAL CONDITION OF THE SPENT FUEL HANDLING MACHINE

The inspectors identified a self-revealing finding of very low safety significance (green) associated with the material condition of the spent fuel handling machine. A number of issues related to material condition, which affected spent fuel handling machine operations, was identified. These included intermittent overload and underload conditions with no identified cause, upender limit switches that often failed or required adjustments during fuel movement, an unreliable hydraulic power unit for the upender machine which occasionally resulted in the upender drifting from the vertical position, and the spent fuel handling machine trolley occasionally stopped for no apparent reason.

This finding is greater than minor because it had an actual impact resulting in damage to an irradiated fuel assembly and, therefore, could be reasonably viewed as a precursor to a significant event. If the fuel cladding had failed, it could have caused a release of fission products. The finding is of very low safety significance because all mitigation systems were available and should have prevented an unplanned release of radioactive material to the environment above the limits of 10 CFR Part 100.

Inspection Report# : [2004011\(pdf\)](#)

G

Significance: Jul 08, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS CONTRIBUTED TO DAMAGE TO FUEL ASSEMBLY

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for failing to effectively correct conditions adverse to quality that contributed to the damage to irradiated Fuel Assembly P1M316. Specifically, Criterion XVI states, in part, that ". . . conditions adverse to quality, such as malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected." The licensee failed to effectively correct conditions adverse to quality, which included repeated violations of equipment operating procedures and conduct of operations procedures, as well as long-standing degraded material condition of the fuel handling equipment, that ultimately contributed to the damage of irradiated Fuel Assembly P1M316.

This finding is greater than minor because it had an actual impact of damage to an irradiated fuel assembly and, therefore, could be reasonably viewed as a precursor to a significant event. If the fuel cladding had failed, it could have caused a release of fission products. The finding is of very low safety significance because all mitigation systems were available and should have prevented an unplanned release of radioactive material to the environment above the limits of 10 CFR Part 100. This finding also had crosscutting aspects in the area of problem identification and resolution.

Inspection Report# : [2004011\(pdf\)](#)

G

Significance: Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PREVENT LOSS OF SPENT FUEL POOL INVENTORY EVENTS THROUGH TIMELY CORRECTIVE ACTIONS

A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the failure to identify the root cause of spent fuel pool inventory loss events and implement corrective actions to preclude recurrence. Specifically, the improper positioning of a fuel pool cleanup suction valve and inadequate level monitoring resulted in three losses of spent fuel pool inventory events. This finding involves problem identification and resolution cross-cutting aspects associated with the failure to identify root causes and implement corrective actions. The issue also involved human performance cross-cutting aspects associated with mispositioned valves and awareness of plant conditions by operations personnel. This issue was entered into the corrective action program as CRDR 2599869.

The finding is greater than minor because it affected the configuration control and human performance attributes of the initiating events cornerstone objective. This finding cannot be evaluated by the significance determination process because Manual Chapter 0609, "Significance Determination Process," Appendix A, "Significance Determination of reactor Inspection Findings for At-Power Situations," and Appendix G, "Shutdown Operations Significance Determination Process," do not apply to the spent fuel pool. This finding is determined to be of very low safety significance by management review because radiation shielding was provided by the spent fuel pool water level, the spent fuel pool cooling and fuel building ventilation systems were available, and there were multiple sources of makeup water.

Inspection Report# : [2004003\(pdf\)](#)

G**Significance:** Jun 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW HEAVY LOAD MOVEMENT PROCEDURE

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified when personnel failed to follow a maintenance procedure preceding a 12 to 24 inch heavy load drop of a 7000 pound steam generator snubber level plate inside the Unit 2 containment. The drop was due to a series of errors between the engineering contractor and rigging crews. The snubber plate was dropped in the vicinity of reactor coolant and shutdown cooling piping. This issue was entered into the corrective action program as CRDR 2639721.

The finding was greater than minor because it affects the equipment performance and human performance attributes of the initiating events cornerstone objective to limit the likelihood of events that challenge safety functions during shutdown conditions. Using Manual Chapter 0609, "Significance Determination Process," Appendix G, "Shutdown Operations Significance Determination Process," the senior reactor analyst concluded that this finding did not significantly increase the likelihood of losing the residual heat removal function and did not significantly increase the likelihood that systems that could mitigate a loss of residual heat removal function would be degraded. Therefore, this finding is of very low safety significance.

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** May 21, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO ESTABLISH AN ADEQUATE PROCEDURE FOR PERFORMING PRESSURIZER SPRAY VALVE MAINTENANCE

NRC inspectors previously identified an unresolved item (URI 05000529/2003004-01) with pressurizer spray valve maintenance. This URI resulted from the NRC review of Licensee Event Report 05000529/2003001-00. Based upon further review during this inspection, the team identified a self-revealing non-cited violation of Technical Specification 5.4.1(a) for failure to establish an adequate procedure for performing pressurizer spray valve maintenance. The procedure was not adequate since the valve failed shortly after maintenance on the valve and valve positioner.

This finding was more than minor since it affected the likelihood of an initiating event to upset plant stability and challenge critical safety functions. Based on the results of an SDP Phase 1 analysis, this finding had very low safety significance (Green) since it did not inhibit the performance of a mitigating system, and did not increase the likelihood of a loss of coolant accident.

Inspection Report# : [2004006\(pdf\)](#)

Mitigating Systems

Significance: SL-IV Mar 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO OBTAIN PRIOR NRC APPROVAL FOR A DESIGN CHANGE TO THE FACILITY

A Severity Level IV non-cited violation of 10 CFR 50.59 requirements was identified for the failure to obtain a license amendment for a permanent modification to all six station emergency diesel generators. The inspectors determined that there were two modifications performed on the jacket water system of each emergency diesel generator. Condition Report/Disposition Request (CRDR) 130208, in 1993, directed the abandonment of the jacket water surge tank makeup valves on both emergency diesel generators of all three units. A recent modification, Design Modification Work Order 220055 in 2003, removed the surge tank low level alarm on both emergency diesel generators of all three units. The licensee replaced these two automatic actions (automatic makeup and low level alarm) with a manual operator action to fill, as necessary, every 12 hours during rounds. The inspectors reviewed the updated final safety analysis report (UFSAR) and design basis documents, and found that the automatic jacket water surge tank makeup, and the low level alarm, were both shown in UFSAR descriptions, drawings, and design value tables.

The issue was determined to be more than minor, through Inspection Manual Chapter 0612, Appendix B, in that it affected the mitigating systems cornerstone attribute of equipment performance, and was repeated for all of the station emergency diesel generators. The issue was determined to result in more than a minimal increase in the consequences of a malfunction of an structure, system, or component important to safety evaluated in the UFSAR, since jacket water leakage could go undetected for up to 12 hours and affect diesel operability. Thus, a license amendment was required. In accordance with the NRC Enforcement Manual, violations of 10 CFR 50.59 are not processed through the significance determination process. Therefore, this issue was considered applicable to traditional enforcement. Although the significance determination process is not designed to assess significance of violations that potentially impact or impede the regulatory process, the result of a 10 CFR 50.59 violation can be assessed significance through the significance determination process. The lead inspector and the Region IV senior reactor analyst discussed the significance of this finding. An SDP Phase 1 screening was performed and the finding was determined to have very low safety significance because there was no actual loss of the mitigating system safety function. The licensee entered this issue into its corrective action program as CRDR 2711244.

Inspection Report# : [2005002\(pdf\)](#)

Significance: TBD Mar 16, 2005

Identified By: NRC

Item Type: FIN Finding

FAILURE TO TRACK CONTROL ROOM DISCREPANCIES

The inspectors identified a finding for the failure to follow administrative guidelines provided to operations personnel for identifying, documenting, and tracking main control room deficiencies. Specifically, approximately 75 control room instrument and control room meter face plates in Units 1, 2, and 3 were degraded and were not individually tracked in the control room discrepancy log. Furthermore, discrepancy labels containing the control room discrepancy log number and description of the discrepancy were not placed adjacent to or as close as possible to each affected device. This issue was entered into the corrective action program as Condition Report/Disposition Request 2782501.

The finding is determined to be greater than minor because if left uncorrected, it could become a more significant safety concern in that the condition could cause an operator to take an inappropriate action based on expected plant response or conversely cause an operator not to take action when action is required. The senior reactor analyst determined that this finding was not appropriate to be evaluated using the significance determination process since this finding was associated with multiple human performance actions. Based on management review, the finding is determined to have very low safety significance because it only affected the mitigating systems cornerstone, and there was no adverse impact to plant equipment.

Inspection Report# : [2005002\(pdf\)](#)

Significance:  Feb 25, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

SCAFFOLDING ERECTED WITH INADEQUATE CLEARANCES AND NO ENGINEERING EVALUATION

The inspectors identified a noncited violation of Technical Specification 5.4.1.a for failing to follow a maintenance procedure and associated engineering specification governing scaffold erection near safety-related components. Specifically, the licensee built approximately 85 scaffolds within the 2-inch clearance requirement and did not obtain engineering approval for the scaffolding installed in close proximity to safety-related equipment, as specified in Engineering Design Change 2000-00463. This issue involved human performance crosscutting aspects (personnel) associated with not following work instructions. This issue was entered into the corrective action program as Condition Report/Disposition Request 2779469.

The finding is determined to be greater than minor because if left uncorrected, the finding would become a more significant safety concern in that improperly installed scaffolding could impact the availability of mitigating equipment. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance because it only affected the mitigating systems cornerstone, and all subsequent engineering evaluations determined that there was no adverse affect to the mitigating equipment.

Inspection Report# : [2005002\(pdf\)](#)

Significance:  Dec 09, 2004

Identified By: NRC

Item Type: VIO Violation

FAILURE TO MAINTAIN DESIGN CONTROL OF CONTAINMENT SUMP RECIRCULATION PIPING

The team identified an apparent violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to establish measures to assure design basis information was translated into specifications, drawings, procedures, and instructions. Specifically, the licensee failed to maintain the safety injection sump suction piping full of water in accordance with the Updated Final Safety Analysis Report. This nonconformance had the potential to significantly affect the available net positive suction head described in the Updated Final Safety Analysis Report for the high pressure safety injection and containment spray pumps, since the analysis assumed the piping would be maintained full of water.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. The finding has a potential safety significance greater than very low significance (i.e., Greater than Green) based on the results of a Significance Determination Process, Phase 3 analysis.

Inspection Report# : [2004014\(pdf\)](#)

Significance:  Dec 09, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURE

The team identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," involving the failure of engineering and operations personnel to implement requirements in the station's condition reporting and operability determination procedures following identification of a degraded condition. Specifically, engineering personnel did not promptly notify operations personnel of a condition that impacted the safety function of the high pressure safety injection and containment spray systems. In addition, operations

personnel did not complete an immediate assessment of operability once they were informed of the degraded condition. This finding had crosscutting aspects associated with problem identification and resolution, since engineering personnel did not forward corrective action program documents regarding the degraded condition to the control room in a timely manner and operations personnel did not complete a prompt operability assessment. This finding also involved crosscutting aspects associated human performance, since engineering and operations personnel did not adequately communicate the status of the engineering department's efforts to review the degraded condition.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. This finding has very low safety significance based on the results of a Significance Determination Process, Phase 3 analysis.

Inspection Report# : [2004014\(pdf\)](#)

Significance: SL-III Dec 09, 2004

Identified By: NRC

Item Type: VIO Violation

FAILURE TO OBTAIN PRIOR NRC APPROVAL FOR A CHANGE TO THE FACILITY INVOLVING MAINTAINING A SIGNIFICANT SEGMENT OF CONTAINMENT SUMP SAFETY INJECTION RECIRCULATION PIPING VOID OF WATER

The team identified an apparent violation of 10 CFR 50.59 requirements for the licensee's failure to perform a written safety evaluation and receive NRC approval prior to implementing changes to the facility in 1992 which involved draining, and maintaining drained, a significant segment of containment sump safety injection recirculation piping during normal plant operations. This change resulted in the failure to maintain the safety injection piping full of water in accordance with the Updated Final Safety Analysis Report. This represented an unreviewed safety question since it increased the probability of a malfunction of equipment important to safety previously evaluated in the safety analysis report.

In accordance with Inspection Manual Chapter 0612, Appendix B, "Issue Disposition Screening," the team determined that traditional enforcement applied because this finding may have impacted the NRC's ability to perform its regulatory function. This is an apparent violation pending the results of a predecisional enforcement conference.

Inspection Report# : [2004014\(pdf\)](#)

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Significance: Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

UNTIMELY LUBRICATION OF REACH RODS FOR SAFETY-RELATED MANUAL VALVES

Green. A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the failure to promptly correct degraded conditions associated with reach rods on safety-related manual valves. The issue involved problem identification and resolution cross-cutting aspects associated with untimely prioritization of work necessary to correct degraded equipment conditions. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2328588.

The finding was greater than minor safety significance because if left uncorrected, it could become a more significant safety concern in that the failure to perform maintenance on reach rod assemblies could result in an inability to operate safety-related manual valves. This finding is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the reliability of systems that respond to initiating events. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," the finding is determined to have very low safety significance because it only affected the mitigating systems cornerstone and there was not a loss of safety function.

Inspection Report# : [2004004\(pdf\)](#)

G

Significance: Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

TURBINE DRIVEN AUXILIARY FEEDWATER PUMP GOVERNOR POWER SUPPLY RESISTOR FAILURES

Green. A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the failure to correct a significant condition adverse to quality. The adverse condition involved failed resistors in the power supply to the turbine driven auxiliary feedwater pump governor control circuits in Units 2 and 3 that had transportability to Unit 1. The finding involved problem identification and resolution cross-cutting aspects associated with engineering personnel not performing an adequate extent of condition review. The finding also involved human performance cross-cutting aspects associated with engineering and maintenance personnel not communicating correct technical information. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2746954.

The finding was greater than minor because if left uncorrected, it could have become a more significant safety concern in that the Unit 1 turbine driven auxiliary feedwater pump could have experienced an unnecessary failure. This finding is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the reliability of systems that respond to initiating events. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," the finding is determined to have very low safety significance because it only affected the mitigating systems cornerstone and did not result in an actual loss of safety function for the auxiliary feedwater system.

Inspection Report# : [2004004\(pdf\)](#)

G**Significance:** Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IDENTIFY AND CORRECT A CONDITION ADVERSE TO QUALITY

Green. A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the failure to assure that significant conditions adverse to quality were promptly identified and corrected. Specifically, maintenance personnel failed to promptly identify that retaining ring slots were not adequately sized to allow the use of the standard lock pins, contributing to the damage to the steam generator nozzle dam diaphragms. Subsequent to the identification, maintenance personnel failed to correct the condition by not implementing the actions recommended by plant engineers. The finding involved problem identification and resolution cross-cutting aspects associated with engineering personnel not performing an adequate extent of condition review. That is, this finding was the direct result of licensee personnel's failure to promptly identify and correct a condition adverse to quality. This issue was entered into the licensee's corrective action program as Condition Report/Discrepancy Requests 2686201 and 2686271.

This finding was greater than minor because it is associated with the mitigating systems cornerstone and affects reactor coolant system boundary performance. Specifically, the plant operated for an extended period in reduced inventory as a result of not correcting the incompatibility between the nozzle dams and the locking ring. Using Manual Chapter 0609, "Significance Determination Process," this finding is determined to have very low safety significance because the senior reactor analysts' Phase 2 and 3 analyses determined that the increase in core damage frequency was approximately $3X10^{-7}$.

Inspection Report# : [2004004\(pdf\)](#)**G****Significance:** Sep 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INEFFECTIVE CORRECTIVE ACTIONS TO ADDRESS AN INADEQUATE SERVICE WATER PIPING INSPECTION PROGRAM

Green. The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to promptly correct the lack of an adequate routine inspection and maintenance program for essential spray pond system piping and components. The finding has been entered into the licensee's corrective action program as Condition Report/Disposition Request 2732683. The finding had problem identification and resolution crosscutting aspects associated with engineering personnel not entering deficiencies into their licensee commitment tracking system and not generating a condition report/disposition request.

This finding is greater than minor because it affected the reactor safety mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. If left uncorrected the finding could become a more significant safety concern in that inspections of spray pond piping was not performed as committed to in the licensee's Generic Letter 89-13 response. The finding is of very low safety significance because the issue constituted a qualification deficiency that did not result in a loss of function per Generic Letter 91-18, "Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions," Revision 1.

Inspection Report# : [2004004\(pdf\)](#)**G****Significance:** Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADDRESS EMERGENCY DIESEL GENERATOR CIRCUIT FAILURE

A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified because the licensee failed to implement their corrective action program when an emergency diesel-generator excitation circuit failed. The failure precluded the emergency diesel generator from achieving rated voltage within the required time.

The finding was greater than minor because it was associated with the equipment performance attributes of the mitigating systems cornerstone and affected the associated cornerstone objective of equipment availability. The finding had very low significance because it only affected the mitigating systems cornerstone and did not result in the actual loss of a safety function at the time.

Inspection Report# : [2004013\(pdf\)](#)**G****Significance:** Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW INADEQUATE EMERGENCY OPERATING PROCEDURE

A noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Procedures," with two examples, was identified because the licensee failed to implement contingency actions when two circuit breakers failed to operate during recovery operations in Units 1 and 3. Specifically, operators deviated from the Emergency Operating Procedure for Loss of Offsite Power/Loss of Forced Circulation when they initiated maintenance on the two failed breakers instead of performing the contingency actions prescribed by the procedure. In addition, for Unit 1, the procedure was inadequate because it did not list all available contingency actions available to operators for restoring power to the electrical bus.

The finding was greater than minor because it was associated with the equipment performance attributes of the mitigating systems cornerstone and affected the associated cornerstone objective of equipment availability. The finding had very low significance because it only affected the mitigating systems cornerstone and redundancy existed in other electrical buses.

Inspection Report# : [2004013\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT CORRECTIVE ACTIONS FOR AUXILIARY FEEDWATER

A noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the team because the licensee failed to implement timely corrective actions to ensure that the feedwater system was operated in a manner that would minimize the possibility of thermally induced vibration that could affect auxiliary feedwater system operability.

The finding was greater than minor because it was associated with the equipment performance attributes of the mitigating systems cornerstone and affected the associated cornerstone objective of equipment availability. The finding had very low significance because it only affected the mitigating systems cornerstone and because no transient occurred that necessitated implementation of the needed corrective actions.

Inspection Report# : [2004013\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE EMERGENCY OPERATING PROCEDURE FOR AUXILIARY FEEDWATER OPERATION

A noncited violation of Technical Specification 5.4.1 was identified because the licensee implemented an inadequate Emergency Operating Procedure. Specifically, the procedure failed to provide direction to maintain turbine-driven auxiliary feedwater pumps operable following a main steam isolation signal.

The finding was greater than minor because it was associated with the equipment performance attributes of the mitigating systems cornerstone and affected the associated cornerstone objective of equipment availability. The finding had very low significance because it only affected the mitigating systems cornerstone and because the turbine-driven auxiliary feedwater pumps did not become inoperable.

Inspection Report# : [2004013\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MANAGE STATION RISK

A noncited violation of 10 CFR 50.65, "Maintenance Rule," was identified because the licensee failed to perform a risk assessment. Specifically, the licensee inappropriately decided to begin draining the Unit 1 turbine-driven auxiliary feedwater pump steam traps first, without addressing the higher risk profile in Unit 2 which resulted from having an inoperable emergency diesel generator.

The finding was greater than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and affected the cornerstone objective of equipment availability. The finding had very low significance because it only affected the mitigating systems cornerstone and because the turbine-driven auxiliary feedwater pumps were not needed.

Inspection Report# : [2004013\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT LOOP EMERGENCY OPEARTING PROCEDRE

A noncited violation of Technical Specification 5.4.1 was identified because the licensee failed to follow emergency operating procedures. Specifically, the control room operator and an auxiliary operator performed the incorrect steps in Emergency Operating Procedure 40EP-9EO07, "Loss of Offsite Power/Loss of Forced Circulation," Revision 10. The Unit 2, Positive Displacement Charging Pump "E" was temporarily lost due to these human performance errors and resulted in a total loss of Unit 2 charging flow for a short period.

The finding was greater than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and affected the cornerstone objective of equipment availability. The finding had very low significance because it only affected the mitigating systems cornerstone and did not result in the actual loss of a safety function and no significant delays occurred that adversely impacted operator response to the event.

Inspection Report# : [2004013\(pdf\)](#)

Significance: SL-IV Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM A COMPLETE SHUT DOWN COOLING HEAT EXCHANGER TEMPERATURE LOOP CHANNEL CALIBRATION

A Severity Level IV noncited violation of Technical Specification 3.3.11 was identified for the failure to include the resistance temperature detectors in the channel calibration for the shutdown cooling heat exchanger temperature instruments. Specifically, prior to the implementation of Improved Technical Specifications, the licensee did not perform testing of the resistance temperature detectors. Following the implementation of Improved Technical Specifications, the licensee did not perform an in-place qualitative assessment of the resistance temperature detectors' behavior. This issue was entered into the corrective action program as CRDR 280178.

The failure to perform a complete shutdown cooling heat exchanger temperature loop channel calibration is determined to have greater than minor significance because the licensee's failure to report the condition impacted the NRC's ability to perform its regulatory function. Therefore, this finding was considered applicable to traditional enforcement. Although the significance determination process is not designed to assess the significance of violations that potentially impact or impede the regulatory process, the finding can be assessed using the significance determination process. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," this finding is determined to be of very low safety significance because it only affected the mitigating system cornerstone and the resistance temperature detectors were found to be within calibration.

Inspection Report# : [2004003\(pdf\)](#)

G

Significance: Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM MONTHLY REVIEWS TO ENSURE EXCESS HOURS HAVE NOT BEEN ASSIGNED

The inspectors identified a noncited violation of Technical Specification 5.2.2.d for the failure of authorized individuals to review monthly overtime reports to ensure that excessive hours have not been assigned. Specifically, following the implementation of an electronic reporting system in 2001, the licensee did not ensure that all managers continued to receive and approve the Excess Hours Report.

The finding is greater than minor because if left uncorrected it could become a more significant safety concern in that exceeding the NRC Generic Letter 82-02, "Nuclear Power Plant Staff Working Hours," guidelines for overtime limits is a contributor to worker fatigue. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," this finding is determined to be of very low safety significance because there were no known actual adverse plant or equipment conditions that could be attributed to worker fatigue.

Inspection Report# : [2004003\(pdf\)](#)

G

Significance: Jun 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CORRECTLY TRANSLATE DESIGN INFORMATION INTO THE AS-BUILT CONFIGURATION

The team identified a noncited violation for the failure to comply with 10 CFR Part 50, Appendix B, Criterion III, "Design Control." The licensee failed to correctly translate design information into the as-built configuration of the auxiliary feedwater system, in that, 28 feet of exposed auxiliary feedwater minimum flow recirculation line was not protected from a tornado-generated missile for both trains as described in Design Basis Manual, Table 2-1 and Section 10.4.9.1, "Design Basis," of the Final Safety Analysis Report. This issue was entered into the licensee's corrective action program as Condition Report/Deficiency Request 2721947.

In accordance with NRC Inspection Manual 0612, Appendix B, "Issue Screening," this finding is greater than minor because it is associated with the design control attribute of the mitigating systems cornerstone, and affected the cornerstone objective to ensure the capability of systems to respond to initiating events. The inspectors evaluated the issue using the Phase 1 Screening Worksheet for the Initiating Events, Mitigating Systems, and Barriers Cornerstones provided in Manual Chapter 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." The finding was determined to be of very low safety significance because: the finding did not represent an actual loss of safety function and because the analyst determined that the system would continue to meet its risk-significant function following a postulated tornado initiating event.

Inspection Report# : [2004007\(pdf\)](#)

G

Significance: Apr 08, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CORRECTLY IMPLEMENT THE VENTING REQUIREMENTS OF PROCEDURE 40OP-9SI01

A noncited violation of Technical Specification 5.4.1a. was identified for the failure to correctly implement the venting requirements of Procedure 40OP-9SI01, Appendix D. Specifically, when venting the shutdown cooling system while in reduced inventory, the operators failed to attain a steady stream of air free water from Valve V019 and vented from a location not specified in the procedure.

This finding was more than minor because the failure to properly vent the shutdown cooling system while in reduced inventory could, if left uncorrected, become a more significant safety concern. The inadequate venting was associated with the operability, availability, and function of the shutdown cooling system while in reduced inventory (i.e., potential loss of long term decay heat removal).

This performance issue was found to be of very low safety significance (GREEN), because none of the plant conditions met the threshold for performing a Phase 2 analysis. This finding has cross-cutting implications in the human performance area. That is, this violation was the direct result of operators not correctly implementing a procedure.

The licensee entered this issue into its corrective action program as Condition Report/Discrepancy Request 2686273.

Inspection Report# : [2004009\(pdf\)](#)

Barrier Integrity

Significance:  Nov 23, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

CORE ALTERATIONS WITH LESS THAN TWO OPERABLE SRMs

A self-revealing violation of Technical Specification 3.9.2 was identified for performing core alterations with less than the required number of startup range monitors. The licensee did not identify that startup monitor Channel 2 was failed low through troubleshooting activities prior to commencing core reload. The licensee only determined that startup monitor Channel 2 was inoperable after core alterations had commenced. The issue was entered into the licensee's corrective action program as Condition Report/Disposition Requests 2654704 and 2654642.

The finding is greater than minor because it is associated with the configuration control attribute of the barrier integrity cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radio nuclide releases caused by accidents or events. Using Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process," this finding is determined to have very low safety significance because the event did not constitute a loss of control and did not represent a finding requiring quantitative assessment. The finding did not increase the likelihood of loss or cause a degradation in the ability to restore decay heat removal, reactor coolant system inventory, offsite power, alternate core cooling, or containment.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Nov 09, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO INCLUDE VENTS AND DRAINS INTO LOCKED VALVE PROGRAM

A noncited violation of Technical Specification Surveillance Requirement 3.6.3.3 was identified for failure to perform the required position verification for vent and drain valves associated with eight safety injection system penetrations per unit. The issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2753335.

This finding is greater than minor since it is associated with the configuration control attribute of the barrier integrity cornerstone and affects the cornerstone objective to provide reasonable assurance that the containment physical design barrier is preserved to protect the public from radio nuclide releases caused by accidents or events. Using the Phase 1 Worksheet in Manual Chapter 0609, "Significance Determination Process," the finding is determined to have very low safety significance because it only affected the barrier integrity cornerstone, all the valves were found closed, and did not result in an actual open pathway out of the reactor containment.

Inspection Report# : [2004005\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE MAIN GENERATOR EXCITATION LIMITER CIRCUIT PROBLEMS

A noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Procedures," was identified because the licensee failed to follow the procedure for dispositioning a degraded condition for continued use. Specifically, the licensee failed to place a degraded main generator excitation limiter circuit into the work control process via the appropriate procedure to ensure that it was appropriately evaluated and processed.

The finding was greater than minor because it was associated with the human performance attribute of the barrier integrity cornerstone and impacted the cornerstone objective to provide reasonable assurance that physical design barriers, in this case the fuel cladding, protect the public from radio nuclide releases caused by accidents or events.

Inspection Report# : [2004013\(pdf\)](#)

Significance: SL-IV Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

CONTAINMENT PURGE PENETRATION NONCONFORMANCE

A Severity Level IV noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the failure to correct a nonconforming condition in a timely manner. Specifically, since June 2001, the licensee discontinued implementation of required Technical Specification surveillance testing for the containment purge valves by declaring the valves inoperable and installing blind flanges. This issue was entered into the corrective action program as CRDR 2711167.

The finding is greater than minor because the licensee's failure to submit a license amendment to correct the nonconforming condition impacted the NRC's ability to perform its regulatory function. Therefore, this finding was considered applicable to traditional enforcement. Although the significance determination process is not designed to assess the significance of violations that potentially impact or impede the regulatory process, the finding can be assessed using the significance determination process. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," the finding is determined to have very low safety significance because it only affected the barrier integrity cornerstone and the installation of blind flanges adequately maintained containment integrity.

Inspection Report# : [2004003\(pdf\)](#)

G

Significance: Jun 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

MISSING BOLTS ON SUPPORT FOR MAIN STEAM LINE WHIP RESTRAINT

A self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion V, was identified for the failure to secure a main steam line pipe whip restraint inside the Unit 2 containment in accordance with design drawings. Specifically, the pipe whip restraint was missing four ½-inch diameter nuts from the embedded anchor bolts. This issue was entered into the corrective action program as CRDR 2643347.

The finding is greater than minor since it is associated with the equipment performance attribute of the barrier integrity cornerstone and affects the cornerstone objective of protecting the containment barrier from radionuclide releases caused by accidents or events. Using the Phase 1 worksheet in Manual Chapter 0609, "Significance Determination Process," this finding is determined to have very low safety significance because it did not represent an actual open pathway in the physical integrity of the reactor containment and did not represent an actual reduction of the atmospheric pressure control function of the reactor containment.

Inspection Report# : [2004003\(pdf\)](#)

Significance: SL-IV May 21, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROVIDE AN EVALUATION OF A CHANGE TO THE FACILITY AS DESCRIBED IN THE UFSAR, UNDER 10 CFR 50.59 REQUIREMENTS

The team identified a Severity Level IV violation of 10 CFR 50.59 requirements for failing to evaluate a modification to spent fuel storage in the spent fuel pools. The team reviewed CRDR 2524176, regarding the lack of a criticality analysis to support the use of rod capture tubes, which hold individual harvested fuel pins, in the spent fuel rack. The team reviewed the licensee's process of storing individual fuel pins, removed from a parent fuel assembly, and placed in rod capture tubes to be located in guide tubes of another host assembly. This resulted in a component that had nuclear fuel pins, of varying enrichment and depletion, stored as a regular fuel assembly in the spent fuel pools. The team noted that Section 9.1 of the UFSAR specifically described the storage of spent fuel in regions based upon fuel assembly initial enrichment, actual burnup, and actual decay time. The UFSAR does not describe the storage of individual pins in these regions. The licensee previously interpreted this as meaning the UFSAR did not prohibit such storage, and would not require consideration of enrichment, burnup, and decay of individual pins. The licensee failed to provide an evaluation of a change to the facility as described in the UFSAR, under 10 CFR 50.59 requirements. The licensee subsequently performed an evaluation of the criticality under station procedure 72DP-9NF01, "Control of SNM Transfer and Inventory," which was found acceptable.

The issue was determined to be more than minor, through Inspection Manual Chapter 0612, Appendix B, in that it affected the barrier integrity cornerstone attribute of human performance, and could have represented a more significant issue if left uncorrected. In accordance with the NRC Enforcement Manual, violations of 10 CFR 50.59 are not processed through the significance determination process. Therefore, this issue was considered applicable to traditional enforcement. Although the significance determination process is not designed to assess significance of violations that potentially impact or impede the regulatory process, the result of a 10 CFR 50.59 violation can be assessed significance through the significance determination process. The team leader and the Region IV senior reactor analyst discussed the significance of this finding. An SDP Phase 1 screening was performed and the finding was determined to have very low safety significance because there was no actual loss of the barrier integrity function. The licensee entered this issue into its corrective action program as CRDR 2711241.

Inspection Report# : [2004006\(pdf\)](#)

G

Significance: Apr 08, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENTER A NONCONFORMITY REPORT FROM THE STEAM GENERATOR FABRICATOR INTO THE PALO VERDE CORRECTIVE ACTION PROGRAM

A noncited violation of Criterion XVI, Corrective Action, of Appendix B to 10 CFR Part 50, was identified for the failure of the measures

established to assure conditions adverse to quality are promptly identified and corrected. Specifically, although a fabricator informed licensee representatives of a tube with damage from a packing crate screw, the licensee representative did not enter the issue into the corrective action program to assure that the adverse condition (i.e., inadequate packing of tubes) was promptly corrected. Additionally, the corrective action program was deficient in that there was no mechanism to ensure that adverse conditions identified by the fabricator were made known to the appropriate licensee personnel. As a result, the potential for a similarly damaged tube to exist in the steam generators installed in the plant was not assessed, nor were actions taken to support detecting such a damaged tube during the pre-service examination by the licensee's eddy current examiners.

This finding is more than minor because it had actual safety consequences (i.e., a steam generator tube leak). This finding affects the barrier integrity cornerstone because of the potential to release radionuclides through the leaking tube. Reactor coolant system barrier performance was the affected attribute. This finding has cross-cutting implications in the problem identification and resolution area. That is, this finding was the direct result of the engineering staff's failure to properly address and correct a condition adverse to quality. The licensee entered this issue into its corrective action program as Condition Report/Discrepancy Request 2685303.

This finding was found to be of very low safety significance after a Phase 3 evaluation using the Manual Chapter 0609, Significance Determination Process.

Inspection Report# : [2004009\(pdf\)](#)

Emergency Preparedness

Significance: TBD Mar 20, 2005

Identified By: NRC

Item Type: AV Apparent Violation

CHANGE TO RADIOLOGICAL EMERGENCY ACTION LEVELS WHICH DECREASED THE EFFECTIVENESS OF THE EMERGENCY PLAN

The inspector identified an apparent violation of 10 CFR 50.54(q) for implementing a change to emergency action levels, which decreased the effectiveness of the emergency plan. Emergency Plan Implementing Procedure 99, "EPIP Standard Appendices," Revision 2, removed from two emergency action levels site boundary exposure rate as measured in the environment as a classifiable condition.

Implementation of changes to emergency action levels, which decreased the effectiveness of the emergency plan was a performance deficiency. The finding is more than minor because removal of a classifiable condition from licensee emergency action levels has the potential to impact safety, and licensee implementation of a change to their emergency plan, which decreases the effectiveness of the plan without prior NRC approval, impacts the regulatory process. This finding is an apparent violation of 10 CFR 50.54(q). The licensee has entered this issue into their corrective action system as Condition Report/Disposition Request 2774185.

Inspection Report# : [2005011\(pdf\)](#)

G

Significance: Mar 18, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CORRECT THE DEVELOPMENT OF PROTECTIVE ACTION RECOMENDATIONS NOT IN ACCORDANCE WITH FEDERAL GUIDANCE

The inspectors identified a noncited violation of 10 CFR 50.54(q). The licensee failed to correct a practice which could result in an evacuation protective action recommendation for segments of the population that would not benefit from evacuation, contrary to federal guidance.

This finding is more than minor because it was associated with a cornerstone attribute and affected the emergency preparedness cornerstone objective to ensure the adequate protection of the public health and safety. This finding is of very low safety significance because this practice could result in an increased dose to the evacuating public by evacuating some areas unnecessarily, but would not prevent the notification of appropriate protective action recommendations to those members of the public who did require evacuation.

Inspection Report# : [2005002\(pdf\)](#)

G

Significance: Dec 15, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE PROCEDURES FOR IMPLEMENTATION OF AN EMERGENCY ACTION LEVEL

The examiners identified a noncited violation of 10 CFR Part 50, Appendix E, IV.B, for inadequate procedures for implementation of an emergency action level. Emergency Action Level 3-13 requires that an Alert be declared if "major damage to irradiated fuel" is accompanied by a "valid high radiation alarm on the associated radiation monitor." However, the phrase "major damage to irradiated fuel" is not defined in any site procedure, nor is it defined, clarified, or addressed through operator training such that operators would know when conditions meet the

threshold for declaring an Alert as a result of damage to irradiated fuel. This deficiency was evidenced during the examination by the fact that the examination authors, examination reviewers, and five of the seven license applicants taking the examination did not recognize conditions that warranted declaring an Alert using Emergency Action Level 3-13. The licensee was evaluating a clarifying change to Emergency Action Level 3-13 and its bases documents and has documented this issue in Condition Report/Disposition Request 2761670.

The finding is a performance deficiency in that the licensee failed to identify that Emergency Action Level 3-13 would not be properly implemented without objectively defining the phrase "major damage to irradiated fuel" in either plant procedures or operator training. The finding is more than minor because it affects the Emergency Preparedness Cornerstone of procedural quality in that it could result in a failure to declare an Alert emergency classification when conditions warrant. The finding is of very low safety significance since it was a failure to comply with a regulatory requirement associated with a Risk-Significant Planning Standard that did not result in the loss or degradation of that Risk-Significant Planning Standard function.

Inspection Report# : [2004301\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

TECHNICAL SUPPORT CENTER UNAVAILABLE

A noncited violation of 10 CFR 50.49(q) was identified because the licensee failed to follow the emergency plan when they did not adequately maintain facilities required for emergency response. Specifically, the Technical Support Center (TSC) EDG failed because a test switch was not returned to its proper position following maintenance 6 days prior to the event. As a result, the emergency response organization assembled in the alternate TSC. This resulted in some confusion and posed some unique challenges to the emergency response organization.

The finding was evaluated using Inspection Manual Chapter 0609, "Significance Determination Process," Appendix B, Sheet 2 - Actual Event Implementation Problem. Failure to implement the requirements of the Emergency plan associated with emergency planning standard 8 is considered a failure to comply with planning standard 8 during an actual event implementation. The event was a declared Alert, but was not a failure to implement a risk significant planning standard, as defined in Inspection Manual Chapter MC 0609 Appendix B, §2.0. Therefore, the finding is of very low safety significance.

Inspection Report# : [2004013\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY IMPLEMENT EMERGENCY PLAN

A noncited violation of 10 CFR 50.49(q) was identified because the licensee failed to follow the emergency plan when they did not ensure that adequate command and control was established during the event. Specifically, the licensee did not follow Emergency Plan Implementing Procedure 1, "Satellite Technical Support Center Actions," which requires that for multiple unit events, the Unit 1 shift manager is responsible for initially classifying and declaring the emergency and assuming the position of the on-shift emergency coordinator. As a result, each of the units' respective shift managers initially assumed the role of emergency coordinator and resulted in notification irregularities to state and local officials.

The finding is more than minor because it is related to the emergency preparedness cornerstone attribute of Response organization performance, and affects the cornerstone objective in that command and control challenges resulting in inaccurate communications to the offsite officials could potentially affect the ability to ensure that adequate measures would be taken to protect the public health and safety.

Inspection Report# : [2004013\(pdf\)](#)

Significance:  Sep 24, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

UNTILMELY AUGMENTATION OF ERGENCY PERSONNEL

A noncited violation of 10 CFR 50.54(q) was identified because the licensee failed to follow the emergency plan. Specifically, the licensee failed to meet minimum staffing goals of Table 1, "Minimum Staffing Requirements for PVNGS for Nuclear Power Plant Emergencies" following the Alert declaration on June 14, 2004.

This finding was evaluated using Inspection Manual Chapter 0609, "Significance Determination Process," Appendix B, Sheet 2 - Actual Event Implementation Problem. Failure to implement the requirements of the Emergency plan associated with emergency planning standard 2 is considered a failure to comply with planning standard 2 during an actual event implementation. The event was a declared Alert, but was not a failure to implement a risk significant planning standard, as defined in Inspection Manual Chapter MC 0609 Appendix B, §2.0. Therefore, the finding is of very low safety significance.

Inspection Report# : [2004013\(pdf\)](#)

Occupational Radiation Safety

Significance:  Oct 05, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH HIGH RADIATION AREA TECHNICAL SPECIFICATION REQUIREMENT

The inspector reviewed a self revealing non-cited violation of Technical Specification 5.7.1.b because a radiation worker could not hear the electronic dosimeter alarm. Specifically, on September 30, 2003, a radiation worker, in a high radiation area, could not hear the electronic dosimeter alarm for approximately thirty minutes. The individual did not respond to the alarm until after entering another area with lower ambient noise. The licensee determined that the individual had a hearing deficiency. This occurrence was entered into the licensee's Corrective Action Program as Condition Report/Disposition Request 2689876.

The failure to provide an effective alarming dosimeter to a worker entering a high radiation area is a performance deficiency. This finding is greater than minor because it is associated with the Occupational Radiation Safety Program and Process attribute and affected the cornerstone objective because the failure to hear an electronic dosimeter alarm could increase personnel dose. Using the Occupational Radiation Safety Significance Determination Process, the inspector determined that the finding was of very low safety significance because it did not involve: (1) ALARA planning and controls, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose .

Inspection Report# : [2004005\(pdf\)](#)

Public Radiation Safety

Significance:  Feb 04, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO SHIP RADIOACTIVE MATERIAL CORRECTLY

The team reviewed a self-revealing, non-cited violation of 10 CFR 71.5, which occurred when the licensee failed to ship radioactive material correctly. A radioactive shipment classified as an "excepted package-limited quantity" exceeded the external dose rate limitation of 0.5 millirem per hour because licensee personnel failed to ensure that the package contents could not shift during transportation. The package recipient identified dose rates of 0.8 millirems per hour on the exterior surface of the package and notified the licensee of the problem.

The finding is greater than minor because it was associated with a Public Radiation Safety cornerstone attribute (human performance) and it affected the associated cornerstone objective because the failure to correctly ship radioactive material decreases the licensee's assurance that the public will not receive unnecessary dose. However, this finding cannot be evaluated by the Public Radiation Safety Significance Determination Process because it does not involve radioactive shipments classified as Schedule 5 through 11, as described in NUREG-1660, and it does not fit traditional enforcement. Therefore, the finding was reviewed by NRC management and determined to be of very low safety significance. Additionally, this finding had cross-cutting aspects associated with human performance (personnel). The individual directly contributed to the finding when the licensee's shipper failed to ensure that the package contents could not shift. The finding was placed into the licensee's corrective action program.

Inspection Report# : [2005009\(pdf\)](#)

Significance:  Feb 04, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONTROL RADIOACTIVE MATERIAL

The team reviewed a self-revealing, non-cited violation of Technical Specification 5.4.1, which occurred when the licensee failed to prevent radioactive material from leaving the radiological controlled area and the protected area. A tape measure worn on the lanyard of a radiation protection technician was not evaluated for the presence of radioactive material before its release from the radiological controlled area. The licensee discovered the radioactive material when the individual was whole body counted; however, the discovery was fortuitous because the licensee's procedural guidance did not specify that items, such as the lanyard, be worn consistently during the whole body counting process. The quantity of radioactive material on the tape measure would have been identified by the licensee's cabinet radiation detectors had the radiation protection technician used one as required.

The finding is greater than minor because it was associated with a Public Radiation Safety cornerstone attribute (human performance) and it affected the associated cornerstone objective because the failure to control radioactive material decreases the licensee's assurance that the public will not receive unnecessary dose. Using the Public Radiation Safety Significance Determination Process, the team determined that the finding had very low safety significance because: (1) it was a radioactive material control finding, (2) it was not a transportation finding, (3) it did not result in public dose greater than 0.005 rem, and (4) the number of occurrences was not greater than five. Additionally, this finding had cross-cutting aspects associated with human performance (personnel). The individual directly contributed to the finding when the

radiation protection technician failed to use the established process to evaluate the tool for radioactive contamination. The finding was placed into the licensee's corrective action program.

Inspection Report# : [2005009\(pdf\)](#)

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A May 21, 2004

Identified By: NRC

Item Type: FIN Finding

IDENTIFICATION AND RESOLUTION OF PROBLEMS

The team concluded that the licensee was generally effective at identifying problems and processing them through the corrective action program. The licensee effectively prioritized and evaluated issues with a few exceptions. The team identified examples where the licensee had not evaluated identified issues for proper compliance with 10 CFR 50.59 requirements. Additionally, in some cases, corrective actions were not timely or fully documented. Licensee audits and assessments were found to be effective except for one example involving maintenance rule application to radiation monitors. On the basis of interviews conducted during this inspection, workers at the site felt free to input safety findings into the corrective action program.

Inspection Report# : [2004006\(pdf\)](#)

Last modified : June 17, 2005