

Palisades

2Q/2006 Plant Inspection Findings

Initiating Events

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Significance: Apr 02, 2006

Identified By: NRC

Item Type: FIN Finding

Moisture Separator Reheater Relief Valve Could Not Be Reseated

The inspectors determined that a finding of very low safety significance (Green) was self-revealed when a Moisture Separator Reheater relief valve failed to reseal during testing. This failure resulted in a slight power rise due to the additional steam demand. Although the operations staff believed a method existed to manually close the valve, a manual method did not exist and a power reduction was needed to reseal the valve. This finding also affected the cross-cutting area of human performance. The licensee stopped use of the procedure and entered the item into their corrective action program.

The inspectors determined that not having adequate planning, contingency plans and procedures in place to reseal the relief valve is more than minor because the failure affected the initiating event cornerstone attribute of procedure quality and increased the likelihood an initiating event due to the increased steam demand of an unseated relief valve. The finding is of very low safety significance since the event did not impact LOCA initiators, mitigation equipment or external event initiators. Corrective action included placing a hold on all relief valve testing until completion of a formal cause evaluation as well as placing this in the CAP system. No violation of NRC requirements occurred.

Inspection Report# : [2006002\(pdf\)](#)G

Significance: Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Spent Fuel Pool Crane Manipulated Outside bounds of Approved Procedures

The inspectors identified one finding of very low safety significance and an associated non-cited violation when plant personnel performed activities outside the scope of the work package used to inspect the spent fuel pool crane. On October 11, 2005, while raising a dry fuel storage (DFS) cask from the spent fuel pool following loading of the cask, the emergency brake on the crane engaged. The engaged emergency brake stopped movement of the load resulting in suspension of the load partially out of the pool. During troubleshooting activities, the workers exceeded the bounds of the approved work package by manipulating the brake release. This finding represented a violation of the license by performing work contrary to requirements specified by NUREG-0612. Corrective actions included reinforcing site standards for procedural adherence as well as successfully lowering the DFS cask. The licensee entered the item in the Corrective Action Program.

The finding was not suitable for evaluation under the SDP. However, because the actions by the worker did not result in any load motion and both crane brakes remained set, NRC management determined the finding to be of very low safety significance (Green). This finding also affected the cross cutting area of human performance.

Inspection Report# : [2005012\(pdf\)](#)

Mitigating Systems

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Significance: Apr 02, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to comply with TS 5.4.1, "Procedures," for an Inadequate Procedure Installing a commercial grade, portable ground detector

The inspectors identified a finding of very low safety significance (Green) when the procedure used to install commercial grade portable ground detection equipment did not provide adequate Class 1E to non-Class 1E separation. During this installation, the licensee did not declare the affected bus inoperable. This finding represented a non-cited violation of Technical Specification (TS) 5.4.1, "Procedures," for an inadequate procedure related to installing a commercial grade, portable ground detector which was not appropriate for the circumstances. The licensee entered the item in the corrective action program and has restricted use of the procedure. The portable ground detection equipment has been removed.

This finding is more than minor because the installation of this temporary equipment impacted the DC bus and made the bus more susceptible to a fault thus degrading a mitigating system function. The finding is of very low safety significance because the improper installation did not result in loss of availability of the bus and only one bus was affected at a time.

Inspection Report# : [2006002\(pdf\)](#)

G**Significance:** Apr 02, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Properly Test the Emergency Diesel Generators Resulting in Preconditioning

The inspectors identified a finding of very low safety significance (Green) when the Emergency Diesel Generators (EDGs) were unacceptably preconditioned prior to testing. This finding represented a non-cited violation of 10 CFR 50 Appendix B, Criterion XI in that the tests were not performed under suitable environmental conditions. The licensee entered the item in the corrective action program.

This finding is more than minor because unacceptable preconditioning can change the as-found condition of the EDG system and therefore mask potential performance issues. The finding is of very low safety significance due to the limited impact that the preconditioning had on the EDG performance. All indications after the testing was performed with an acceptable test is that the machine performance is currently acceptable.

Inspection Report# : [2006002\(pdf\)](#)**G****Significance:** Feb 17, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failed Swagelok Fitting on High Pressure Safety Injection Flow Transmitter FT-0312

A finding of very low safety significance was self-revealed on January 4, 2006, when an incorrectly installed swagelok fitting on high pressure safety injection flow transmitter FT-0312 failed. A Non-Cited Violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures and Drawings," was associated with this finding for the failure to have prescribed instructions when the swagelok fitting was originally installed during field change FC-731 in 1988. Corrective actions included: the swagelok fitting on FT-0312 was repaired and verified to be installed correctly; two other swagelok fittings on high pressure safety injection flow transmitters were disassembled, inspected and repaired as necessary; other swagelok fittings installed in 1988 during field change FC-731 were visually inspected to verify that there was no evidence of leakage. Additional swagelok fittings were scheduled to be disassembled and inspected during the 2006 refueling outage to further address extent of condition.

This finding was more than minor because it was associated with the equipment performance attribute for mitigating systems and the cornerstone objective to ensure the capability of systems that respond to initiating events to prevent undesirable consequences was affected. Specifically, a leak from the failed swagelok fitting on the high pressure safety injection system flow transmitter FT-0312 would have decreased the capability of the high pressure safety injection system to inject water to the reactor core during a small break loss of coolant accident. The finding is of very low safety significance because the high pressure safety injection system's safety function was not lost.

Inspection Report# : [2006003\(pdf\)](#)**G****Significance:** Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Provide Adequate Instruction for Proper Breaker Reassembly

A finding of very low significance (Green) was self-revealed on June 6, 2005, when the licensee discovered that a safety injection valve failed to close as expected. The licensee determined that the procedure used to reassemble the safety-related breaker for the valve was inadequate. This finding represented a Non-Cited Violation of Technical Specifications 5.4, "Procedures," in that procedures were not adequate to ensure the safety related breaker was adequately reassembled after maintenance. Corrective actions included correcting the breaker and looking at other possible breakers with similar failure mechanisms. The licensee entered the item in the Corrective Action Program. The deficiency was also an issue in the cross-cutting area of problem identification and resolution in that a previous event investigation from the same valve failing, and corrective actions from the event, were not effective.

The inspectors determined the issue was more than minor because the issue impacted the cornerstone attributes of equipment performance and procedure quality. The deficiency affected the mitigating system objective to ensure availability and reliability of systems that respond to events to prevent core damage. Specifically, some alternate functions, where the valve was shut in the Emergency Operating Procedures to control charging or ensure adequate hot leg injection, would not be available based on this deficiency.

Inspection Report# : [2005008\(pdf\)](#)

Barrier Integrity

G**Significance:** Dec 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Declare VHX-4 Cooler Inoperable with a Through-wall Piping Leak

The inspectors identified a finding of very low significance (Green) when the licensee failed to declare the containment air cooler, VHX-4, SW piping inoperable and take action in accordance with licensee procedures and technical specifications when a through-wall (pressure boundary) leak existed. This finding represented a non-cited violation of Technical Specifications 5.4, "Procedures," in that procedures were not properly

implemented which would have resulted in declaration of inoperability of component. Corrective actions included conducting repairs to stop the leak. The licensee entered the item in the Corrective Action Program. The deficiency was also an issue in the cross-cutting area of human performance in that personnel did not properly follow the procedure for determining operability.

The inspectors determined that the issue was more than minor because the finding impacted the barrier integrity cornerstone attribute for containment barrier performance. The deficiency affected the barrier integrity objective of providing reasonable assurance that physical design barriers for the containment protect the public from radionuclide releases in that part of the boundary to a closed system for a containment penetration was breached. The finding was of very low safety significance since the breach in the containment boundary was small and would have very little impact on offsite dose evaluations.

Inspection Report# : [2005012\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety



Significance: Apr 19, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Develop Adequate Procedure For Cask And Liner Reuse

The licensee failed to develop an adequate procedure for controlling reuse of a carbon steel liner that was used for storing highly radioactive incore instrument remnants. The liner was subjected to a boric acid environment without properly accounting for its design, material composition and the manufacturers intended use.

Inspection Report# : [2006008\(pdf\)](#)

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : August 25, 2006