Palo Verde 2
1Q/2009 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Evaluate Design Changes Leads to a Manual Reactor Trip
A self revealing finding of Procedure 81DP-0DC13, "Deficiency Work Order," Revision 13, was identified for the failure of engineering personnel to ensure modifications do not inadvertently affect design basis plant conditions. Specifically, between January 23, 2001 and October 6, 2007, engineering personnel failed to ensure material compatibility of the condenser air removal system seal water cooler tube plugs to prevent corrosion. This resulted in sodium ingress into the condenser hotwell and steam generators due to a corroded tube plug that failed in the condenser air removal system D seal water cooler, and consequently a manual reactor scram. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 3074272.

The finding is greater than minor because it is associated with the design control attribute of the initiating events cornerstone and affects the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown and power operations. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding is determined to have very low safety significance because the finding did not result in exceeding the technical specification limit for identified reactor coolant system leakage, did not affect other mitigation systems, did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available; and did not increase the likelihood of a fire or internal/external flood. This finding was evaluated as not having a crosscutting aspect because the performance deficiency is not indicative of current performance.

Inspection Report# : 2008003 *(pdf)*

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Fire in Pressurizer Cubicle due to Poor Work Practices
A self-revealing noncited violation of License NPF-51, Condition 2.C. (6), was identified involving the failure to follow procedures for proper control of ignition sources. Specifically, contract welding personnel failed to deenergize welding equipment and properly secure the welding rod electrodes, resulting in a fire in the Unit 2 pressurizer cubicle inside containment. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 3170965.

The finding is greater than minor because it is associated with the external factors attributes of the initiating events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Manual Chapter 0609, "Significance Determination Process," Appendix M, "Significance Determination Process Using Qualitative Criteria," was used since the Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process," does not address the potential risk significance of fire protection findings during shutdown conditions. The finding was determined to be of very low safety significance by NRC management review because the finding occurred while the unit was already in a cold shutdown condition and the finding did not affect equipment necessary to maintain safe shutdown. This finding has a crosscutting aspect in the area of human performance associated with work practices because the licensee did not ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported [H.4(c)].

Inspection Report# : 2008003 *(pdf)*

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Resolve Discrepancies Between Installed Equipment and Work Instructions Results in Mis-positioning Event
A self-revealing finding was identified for the failure of operations and maintenance personnel to follow Procedure 01DP-9ZZ01, "Systematic Troubleshooting," and resolve a discrepancy with a work instruction prior to proceeding with troubleshooting. Specifically, maintenance and operations personnel did not resolve an error in Work Order 3174332 when troubleshooting Breaker NBN-S01A that failed to trip, resulting in a loss of the non-vital electrical bus that supplied power to the nuclear cooling water and normal chilled water systems. This issue was entered into the licensee's corrective action program as Palo Verde Action Request 3174647.

The finding is greater than minor because it is associated with the initiating events cornerstone attribute of configuration control and affects the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown and power operations. Using the Manual Chapter 0609 Appendix G, "Shutdown Operations Significance Determination Process," the finding is determined to have very low safety significance because the finding did not result in a loss of shutdown safety functions. This finding has a crosscutting aspect in the area of human performance associated with work practices because maintenance and operations personnel proceeded in the face of uncertainty or unexpected circumstances [H.4(a)].

Inspection Report# : 2008003 *(pdf)*

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadvertent Decrease in Reactor Water Level Due to Personnel Error
A self-revealing noncited violation of Technical Specification 5.4.1, "Procedures," was identified for the failure of operations personnel to adequately implement Procedure 40DP-9OP19, "Locked Valve, Breaker, and Component Tracking." Specifically, on May 14, 2008, Valve SIA-V421 was found out of its locked closed position one and one-half turns open resulting in approximately 930 gallons of water being inadvertently transferred from the reactor coolant system to the refueling storage water tank. This issue has been entered into the licensee's corrective action program as Palo Verde Action Request 3174527.

The failure to ensure the valve was properly closed resulted in an inadvertent reactor vessel level decrease. The finding is more than minor because it is associated with the configuration control attribute of the initiating events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. A Phase 2 analysis was required because using Manual Chapter 0609, Appendix G, "Shutdown Operations Significance Determination Process," Attachment 1, the inspectors determined that the finding actually resulted in a loss of reactor coolant system inventory. Using the Phase 2 worksheets in Attachment 2, this was determined to be a loss of level control precursor event. The initiating event likelihood for this finding was determined from Table 1 of the worksheet and the resultant core damage frequency was determined to be 1E-8, therefore the finding screened as having very low safety significance. The finding has a crosscutting aspect in the area of human performance associated with work practices because the licensee failed to use human error prevention techniques such as self-checking [H.4(a)].
Inspection Report# : 2008003 *(pdf)*

Mitigating Systems

Significance: G Mar 31, 2009

Identified By: NRC
Item Type: FIN Finding
Failure to Correct Deficient Condition for the Essential Spray Pond Chemical Addition System Valves High Failure Rate
The inspectors identified a finding for the failure of engineering and maintenance personnel to adequately implement timely corrective actions for deficiencies associated with the essential spray pond sodium hypochlorite chemical addition system. Specifically, between May 2006 and March 2009, corrective actions to replace degraded sodium hypochlorite valves with a more reliable chemical addition system were not taken resulting in the Unit 2 spray pond Train A chemistry pH level being out of specification high on two occasions. This issue was entered into the licensee's corrective action program as Palo Verde Action Request 3277070.

The finding is more than minor because it 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 to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have a very low safety significance because the finding did not result in a loss of system safety function, an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time, or screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance associated with decision making because the licensee did not communicate bases for decisions to personnel with a need to know such that work is performed safely in a timely manner [H.1(c)].

Inspection Report# : 2009002 *(pdf)*

Significance: G Mar 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform an Adequate Operability Determination for High Chlorine in the Essential Spray Pond
The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of operations personnel to follow procedures to declare the essential spray pond inoperable. Specifically, on November 13, 2008, operations personnel failed to follow procedures to declare Unit 2 essential spray Pond A inoperable and perform a 10 CFR 50.59 screening when a compensatory measure, such as acid addition, was required to restore operability of the spray pond. This resulted in the performance of a calculation and an evaporative test to verify operability of essential spray Pond A for the mission time without taking credit for compensatory measures. This issue was entered into the licensee's corrective action program as Palo Verde Action Request 3258988.

The finding is more than minor because it 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 to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have a very low safety significance because the finding did not result in a loss of system safety function, an actual loss of safety function of a single train for greater than its technical specification allowed outage time, or screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance associated with decision-making because safety-significant decisions were not verified to validate underlying assumptions and identify unintended consequences [H.1(b)]
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Inspection Report# : 2009002 *(pdf)*

Significance: G Mar 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Periodically Inspect or Test, and Repair Fire Penetration Seals
The inspectors identified 5 examples of a non-cited violation of License Condition 2.C.(7), 2.C.(6), and 2.F for Unit 1,

Unit 2, and Unit 3, respectively, for the failure of engineering and maintenance personnel follow procedures to adequately inspect and repair fire penetration seals. Specifically, between 2004 and August 2008, engineering and maintenance personnel failed to inspect and repair fire penetration seals, which provide protection to safety-related equipment during fire events, resulting in the licensee declaring 4 fire penetration seals degraded and 1 non-functional. This issue was entered into the licensee's corrective action program as Palo Verde Action Request 3295124.

The finding is more than minor because it was associated with the external factors attribute (i.e. fire) of the mitigating systems cornerstone and affected the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to require additional evaluation under Inspection Manual Chapter 0609, Appendix F, "Fire Protection Significance Determination Process." Based on the analysis performed, the inspector concluded that the degradation of the fire barrier penetration seals represented a low degradation of the fire confinement element of the fire protection program, the degraded fire barrier penetration seals had no credible fire damage state, and that the fire ignition sources present could not damage the post fire safe shutdown equipment, and therefore determined the finding to have very low safety significance. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because the licensee failed to implement the corrective action program with a low threshold for identifying issues [P.1 (a)]

Inspection Report# : 2009002 *(pdf)*

Significance: G Feb 27, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Identify and Correct Related Degradation of Safety-Related Inverters
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” for the licensee’s failure to promptly identify and correct a condition adverse to quality. Specifically, the licensee failed to incorporate industry and vendor recommended preventative maintenance requirements to prevent the age related degradation of safety-related inverter components. This finding was entered into the licensees corrective action program as Palo Verde Action Request 3291971.

The inspectors determined that the failure to identify the necessary maintenance practices and take corrective actions prior to the 2008 inverter failures was a performance deficiency. This finding is more than minor because it affects the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Using Inspection Manual Chapter 0609, "Significance Determination Process," Phase 1 worksheets, the team determined that a Phase 2 analysis was required because the finding represented a loss of system safety function. A Phase 2/Phase 3 significance determination was performed by an NRC senior reactor analyst. Based on a bounding analysis, the analyst determined that the delta core damage frequency result was less than 1.0E-7/yr. This noncited violation was therefore determined to be of very low safety significance. This finding has a crosscutting aspect in the problem identification and resolution component of operating experience, in that the licensee failed to implement operating experience through changes to station procedures.

Inspection Report# : 2009006 *(pdf)*

Significance: G Feb 27, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Properly Implement Corrective Action Process for Potential Operability Issues with the Safety Related Systems and Systems Important to Safety
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of operations personnel to follow the corrective action program to ensure that degraded and nonconforming conditions associated with safety related systems and systems important to safety were properly

reviewed for operability. Specifically, between December 21, 2006, and January 30, 2009, operations personnel failed to perform adequate operability determinations of Palo Verde Action Requests associated with the component design basis review project and other site projects, resulting in 97 Palo Verde Action Requests that either needed an immediate operability determination or a functional assessment, or needed more information to provide reasonable assurance of operability. Of the 97 examples 20 occurred following implementation of corrective actions associated with the Confirmatory Action Letter to improve this process and therefore are reflective of current performance. This issue was entered into the licensee's corrective action program as Palo Verde Action Request 3281099.

The finding is greater than minor because it 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 to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have a very low safety significance because the finding did not result in a loss of system safety function, an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time, or screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of problem identification and resolution associated with the corrective action program because 9 of the 20 examples, reflective of current performance, were not thoroughly evaluated such that the resolutions address causes and extent of conditions, as necessary, including properly evaluating for operability conditions adverse to quality.

Inspection Report# : 2009006 *(pdf)*

Significance: G Feb 27, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedures for Performing Operability Determinations
The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure of operations personnel to follow the corrective action program to ensure that degraded and nonconforming conditions associated with safety related systems and systems important to safety were reviewed for operability. Specifically, between December 21, 2006 and January 30, 2009, operations personnel failed to perform adequate operability determinations of Palo Verde Action Requests associated with the component design basis review project and other site projects, resulting in 97 Palo Verde Action Requests that either needed an immediate operability determination or a functional assessment, or needed more information to provide reasonable assurance of operability. Of the 97 examples 20 occurred following implementation of corrective actions to improve this process and therefore are reflective of current performance. This issue was entered into the licensee's corrective action program as Palo Verde Action Request 3281099.

The finding is greater than minor because it 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 to prevent undesirable consequences. Using Manual Chapter 0609.04, “Phase 1 – Initial Screening and Characterization of Findings,” the finding was determined to have a very low safety significance because the finding did not result in a loss of system safety function, an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time, or screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance associated with resources because 11 of the 20 examples, reflective of current performance, were the result of inadequate procedural guidance governing the conduct of operability determinations to ensure that conditions adverse to quality are properly evaluated for their potential operability impacts.

Inspection Report# : 2009006 *(pdf)*

Significance: G Dec 31, 2008
Identified By: NRC
Item Type: FIN Finding
Failure to Promptly Identify and Correct Degraded Hydrostatic Penetration Seals
The inspectors identified a finding of Palo Verde Nuclear Generating Station Procedure 01DP 0AP10, "Corrective

Action Program," Revision 1, for the failure of operations and engineering personnel to promptly identify and correct a condition adverse to quality. Specifically, between February 13, 2007 and July 18, 2008, operations and engineering personnel failed to identify and correct degraded hydrostatic flood penetration seals which provide protection to safety-related equipment during internal flooding events. This resulted in over 100 hydrostatic penetration seals in the control, diesel, and main steam support structure buildings being left degraded for greater than 12 months. This issue was entered into the licensee's corrective action program as Palo Verde Action Request 3264501.

The finding is greater than minor because it is associated with the protection against external factors (i.e. flood hazard) attribute of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have a very low safety significance because the finding did not result in a loss of system safety function, an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time, or screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of problem identification and resolution associated with operating experience because operations and engineering personnel failed to implement and institutionalize operating experience through changes to station processes, procedures, equipment, and training programs [P.2(b)].

Inspection Report# : 2008005 *(pdf)*

Significance: G Sep 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform an Operability Determination for High Chlorine in the Essential Spray Pond
The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure of operations and chemistry personnel to follow the corrective action program to ensure that potentially nonconforming conditions associated with the essential spray pond system were reviewed for operability. Specifically, between July 10, 2008 and July 11, 2008, operations and chemistry personnel failed to ensure all relevant information was reviewed for operability when the Unit 2 essential spray Pond A hypochloride addition Valve 2-SPN-V494 was found open. This resulted in the essential spray pond chemistry pH and chlorine samples being delayed to the extent that the sample results were not reliable to assess operability. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 3206115.

The finding is greater than minor because it 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 to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have a very low safety significance because the finding did not result in a loss of system safety function, an actual loss of safety function of a single train for greater than its technical specification allowed outage time, or screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance associated with decision-making because safety-significant decisions were not verified to validate underlying assumptions and identify unintended consequences [H.1(b)].

Inspection Report# : 2008004 *(pdf)*

Significance: G Jun 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Work Instructions for Reinstallation of Constant Support Hanger
The inspectors identified a noncited violation of Technical Specification 5.4.1.a, "Procedures," for the failure to establish and implement adequate maintenance procedures. These inadequate instructions resulted in the failure to install required washers during installation of a constant support spring hanger for a main steam line on May 14, 2008. This issue was entered into the licensee corrective action program as Condition Report/Disposition Request 3177622.

The finding is greater than minor because it is associated with the procedure quality attribute of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have a very low safety significance because the finding did not result in a loss of system safety function, an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time, or screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. This finding has a crosscutting aspect in the area of human performance associated with resources because the licensee failed to ensure work packages were complete, accurate and included up-to-date design documentation to assure nuclear safety [H.2(c)].

Inspection Report# : 2008003 *(pdf)*

Significance: G Jun 30, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Prevent Recurrence of a Significant Condition Adverse to Quality for the Feedwater Isolation Valves
A self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," was identified for the failure of engineering personnel to implement adequate corrective actions to preclude recurrence of a significant condition adverse to quality. Specifically, between June 28, 1998 and July 17, 2006, on several occasions, the four way 'N' valve for an economizer main feedwater isolation valve became lodged in the center blocked position, preventing fast closure of the main feedwater isolation valve upon receipt of a main steam isolation signal. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2915450.

This finding is greater than minor because it is associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences. A Phase 2 analysis was required because using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," there was a loss of main feedwater isolation of a single train to Steam Generator 1 for greater than the Technical Specification allowed outage time. Using the Phase 2 worksheets associated with a steam generator tube rupture without steam generator isolation, the finding is determined to have very low safety significance since all remaining mitigation capability was available or recoverable. This finding was evaluated as not having a crosscutting aspect because the performance deficiency is not indicative of current performance.

Inspection Report# : 2008003 *(pdf)*

Significance: Y 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.
{Note: Finding remains open - IP 95002 results pending 12/16/2005}

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 NRC assessed this finding through Phase 3 of the Significance Determination Process and made a preliminary determination that the issue had substantial safety significance (Yellow). After considering the information developed during the inspection and the results of testing

sponsored by the licensee, the NRC has concluded that this inspection finding is appropriately characterized as Yellow. The final Significance Determination Process letter was issued on April 8, 2005. This issue was inspected within the scope of a Supplemental 95002 Inspection in August - September 2005.

{NOTE: Yellow finding remains open because the corrective actions taken in response to the root causes and related programmatic concerns involving questioning attitude, technical rigor, and operability determinations have not been fully effective. - IP 95002 Supplemental Inspection completed December 2005, IR 05000528/20050112, 05000529/20050112 and 05000530/2005012, IP 95002 Followup Supplemental Inspection completed August 2006, IR 05000528/2006010, 05000529/2006010 and 05000530/2006010}
Inspection Report# : 2004014 *(pdf)*
Inspection Report# : 2009006 *(pdf)*

Barrier Integrity

Significance: G Sep 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedural Requirements to Implement Technical Specification 5.5.2.b
The inspectors identified a non-cited violation of Technical Specification 5.5.2.b, "Primary Coolant Sources Outside Containment," for the failure of engineering and maintenance personnel to implement a program to verify integrated leak test requirements for abandoned valves still connected to an active system. Specifically, between January 8, 1993 and September 30, 2008, engineering personnel failed to ensure portions of the containment spray system, which could be in contact with radioactive fluids outside containment, were included in the integrated leak test requirements. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 3170965.

The performance deficiency associated with this finding was the failure of engineering and maintenance personnel to implement a program to verify integrated leak test requirements for abandoned valves still connected to an active system. The finding is greater than minor because it is associated with the design control and procedural quality attribute associated with maintaining radiological barrier functionality for the auxiliary building of the barrier integrity cornerstone and affects the cornerstone objective to provide reasonable assurance that the physical design barriers protect the public from radio nuclide releases caused by accidents or events. Using Manual Chapter 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding is determined to have very low safety significance because it only represented a degradation of the radiological barrier function of the auxiliary building. This finding was evaluated as not having a crosscutting aspect because the performance deficiency is not indicative of current performance.

Inspection Report# : 2008004 *(pdf)*

Emergency Preparedness

Significance: G Jun 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Correct a Risk Significant Planning Standard
The inspectors identified a noncited violation (NCV) of 10 CFR 50.54(q) and 10 CFR Part 50, Appendix E.IV.F.2.g, for the licensee’s failure to correct an identified risk significant planning standard weakness between May 2, 2007 and October 28, 2007. Specifically, the licensee failed to implement adequate corrective actions for identified weaknesses in the ability to correctly make a Site Area Emergency declaration for a steam generator tube rupture event. This issue

was entered into the licensee's correction action program as Palo Verde Action Request 3083911.

The NRC determined that the inability to consistently implement an Emergency Action Level was a performance deficiency within the licensee's control. This finding is more than minor because it was associated with the Emergency Preparedness attribute of emergency response organization performance and affected the cornerstone objective to implement adequate measures to protect the health and safety of the public because the inability to properly recognize and classify an emergency condition affects the licensee's ability to implement adequate protective measures. This finding was preliminarily determined to be of low to moderate safety significance. After consideration of information provided during and after a Regulatory Conference held on March 25, 2008, the NRC has concluded that the knowledge deficiency identified among senior operators would not likely result in an incorrect emergency classification during a steam generator tube rupture event, and the NRC has concluded the significance of the inspection finding is appropriately characterized as Green (i.e., a finding of very low safety significance). This violation is being treated as an NCV, consistent with Section VI of the NRC Enforcement Policy. The cause of this finding has crosscutting aspects associated with the corrective action aspect of the problem identification and resolution area in that the licensee failed to thoroughly evaluate problems such that resolutions ensured correcting problems [P.1.(c)]. The cause of this finding was also related to the safety culture component of accountability in that the licensee failed to demonstrate a proper safety focus and reinforce safety principles [O.1.(c)].

Inspection Report# : 2008003 *(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : May 29, 2009