

## Palo Verde 1

### 3Q/2005 Plant Inspection Findings

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## Initiating Events

**G****Significance:** Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**FAILURE TO MONITOR TELLTALE DRAINS RESULTED IN SPENT FUEL POOL LEAKAGE TO THE ENVIRONMENT**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified as a result of the licensee's failure to properly monitor leakage using the spent fuel pool (SFP) leak detection surveillance as required by Procedure 40DP-9OPA3, "Area 3 Operator Logs, Modes 1-4." This resulted in leakage of SFP water through two adjacent concrete walls. Specifically, operations personnel did not monitor the SFP telltale drains for evidence of leakage for a period of five and a half months, and failed to take the necessary action to reschedule the task. This issue involved human performance crosscutting aspects associated with operations personnel following procedures and questioning attitude. This issue also involved problem identification and resolution crosscutting aspects associated with operations and engineering personnel implementing timely corrective actions. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2814209.

The finding is greater than minor because it affects the equipment performance and human performance attributes of the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. 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 SFP. This finding is determined to be of very low safety significance by NRC management review because radiation shielding was provided by the SFP water level, the SFP cooling and fuel building ventilation systems were available, and there were multiple sources of makeup water (Section 1R14)

Inspection Report# : [2005004\(pdf\)](#)

**G****Significance:** Sep 30, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**IMPROPER CONTROL OF STEAM GENERATOR FEEDWATER SYSTEM RESULTED IN A REACTOR TRIP AND MAIN STEAM ISOLATION**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified as a result of the licensee's failure to follow Procedure 40OP-9ZZ04, "Plant Startup Mode 2 to Mode 1," and Procedure 40OP-9FT01, "Feedwater Pump Turbine A," which resulted in an automatic reactor trip and main steam isolation signal due to a high steam generator water level. Specifically, the secondary reactor operator failed to: (1) ensure downcomer feed flow to both steam generators, (2) properly set-up the controller, and (3) establish a stable steam generator level between 30 to 40 percent prior to placing the feedwater controller in automatic. Additionally, the secondary reactor operator failed to inform the control room supervisor and other control room personnel when he made numerous transfers into and out of automatic valve control to make manual feedwater adjustments when attempting to recover steam generator water level. This issue involved human performance crosscutting aspects associated with operations personnel following procedures and attention to detail. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2814209.

The finding is greater than minor because it affects the human performance attribute of the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. A Phase 2 analysis was required because the Phase 1 Worksheet in Manual Chapter 0609, "Significance Determination Process," determined that the finding affected the initiating events cornerstone and contributed to the likelihood that mitigation equipment or functions would not be available. Using the Phase 2 worksheets associated with transients and transients without the power conversion system, the finding is determined to have very low safety significance since all remaining mitigation capability was available or recoverable (Section 1R14).

Inspection Report# : [2005004\(pdf\)](#)

**G****Significance:** Apr 23, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**FAILURE TO FOLLOW PROCEDURES RESULTING IN SPENT FUEL POOL DRAINDOWN**

A self-revealing noncited violation of Technical Specification 5.4.1.a was identified for the failure to follow procedures which resulted in an inadvertent reduction of spent fuel pool water level. Specifically, approximately 1800 gallons of water was unknowingly directed to the transfer canal when operations personnel failed to follow Procedure 40OP-9PC06, "Fuel Pool Clean Up and Transfer." The initial auxiliary operator opened a valve when the step required the valve to be closed and did not open another valve as required by the procedure. A second auxiliary

operator performed an inadequate independent verification of the position of the valves. This issue involved human performance crosscutting aspects associated with procedure implementation and operator attention to detail. This issue was entered into the corrective action program as Condition Report/Disposition Request 2793816.

The finding is greater than minor because it affects the configuration control and human performance attributes of the initiating events cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. 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 NRC 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# : [2005003\(pdf\)](#)

## Mitigating Systems

**Significance:**  Sep 30, 2005

Identified By: NRC

Item Type: FIN Finding

### COMMUNICATION DEFICIENCIES BETWEEN ORGANIZATIONS

The inspectors identified a finding involving ineffective and inaccurate technical communications between organizations to support equipment operability decision making during maintenance on the Unit 1 high pressure safety injection long-term recirculation check Valve SIAV522. Specifically, (1) the licensee did not verify the accuracy of an engineer's statement regarding 10 CFR 50.59 documents, and consequently, did not ensure that all documents used to support the work activity existed, (2) maintenance personnel changed the freeze seal location without consulting operations or engineering, even though the location was a key assumption that formed the basis for several conclusions in the operability evaluation, and (3) engineering personnel incorrectly informed operations personnel that only 5 to 10 gpm was needed to full stroke Valve SIAV522 when approximately 100 gpm was needed. The issue involved human performance crosscutting aspects associated with inadequate communications between the engineering, maintenance, and operations organizations. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Requests 2822343 and 2831411.

The finding is greater than minor since it could become a more significant safety concern in that the failure to provide accurate information to support operational decision making could result in improper operability determinations. Using the 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 did not result in the loss of safety function of a single train or system for greater than the Technical Specification allowed outage time (Section 1R15).

Inspection Report# : [2005004\(pdf\)](#)

**Significance:**  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### FAILURE TO PERFORM LICENSING DOCUMENT CHANGE REQUEST AND 10 CFR 50.59 SCREENING FOR ABANDONMENT OF THE BORONOMETER

The inspectors identified a noncited violation of 10 CFR Part50, AppendixB, CriterionXVI, "Corrective Action," for the failure to correct a discrepancy between the current condition of the boronometer and the required configuration described in the Updated Final Safety Analysis Report. Specifically, in April 2003 the licensee identified the need to perform a Licensing Document Change Request and a corresponding 10 CFR 50.59 screening due to the abandonment of the Updated Final Safety Analysis Report required boronometer, but failed to implement corrective actions to ensure that the Licensing Document Change Request and 10CFR 50.59 screening were performed. This issue involved problem identification and resolution crosscutting aspects associated with engineering personnel implementing timely corrective actions. This issue was entered into the licensee's corrective action program as Condition Report/Disposition Request 2823704.

The finding is greater than minor because it was associated with the design control performance attribute of the mitigating systems cornerstone and affects the cornerstone objective to ensure the reliability and availability of systems that respond to initiating events. Using the Manual Chapter0609, "Significance Determination Process," Phase1 Worksheet, the finding is determined to have very low safety significance because there was no actual loss of safety function (Section 4OA2).

Inspection Report# : [2005004\(pdf\)](#)

**Significance:**  May 17, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### FAILURE TO CORRECT A CONDITION ADVERSE TO QUALITY

The inspectors identified a noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to identify and correct a deficiency in the method of testing the auxiliary feedwater pump discharge check valves. Specifically, in 1998 the licensee identified the need to test the auxiliary feedwater pump Train B discharge check valve for leak tightness, but failed to implement the appropriate corrective actions to incorporate testing into Procedure 73ST-9XI38, "AF Pumps Discharge Check Valves - Inservice Test." This issue involved problem identification and resolution crosscutting aspects associated with the failure to implement timely corrective actions. This issue was entered into the corrective action program as Condition Report/Disposition Request 2800972.

The finding is greater than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective to ensure the reliability and availability of systems that respond to initiating events. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding is determined to have very low safety significance because there was no actual loss of safety function  
Inspection Report# : [2005003\(pdf\)](#)

**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:**  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\(pdf\)](#)

**G**

**Significance:** Feb 09, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **FAILURE TO CORRECT A CONDITION ADVERSE TO QUALITY**

A self-revealing noncited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," was identified as a result of the licensee's failure to correct a condition adverse to quality following the loss of a charging pump during the July 14, 2004 reactor trip event. Specifically, the licensee failed to correct the basis for operating charging pumps and the boric acid makeup pump from the refueling water tank. Consequently, on February 9, 2005, operators aligned the charging pumps in a similar configuration to the July 14, 2004, event and Charging Pumps B and E tripped. This issue involved problem identification and resolution crosscutting aspects associated with the failure to implement timely corrective actions. This issue was entered into the corrective action program as Condition Report/Disposition Request 2776236.

The finding is greater than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and affects the cornerstone objective of ensuring the reliability and availability of systems that respond to initiating events. Using Manual Chapter 0609, "Significance Determination Process," Phase 1 Worksheet, the finding was determined to have very low safety significance because the third charging pump and both boric acid makeup pumps were available to perform the emergency borate safety function.

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

**Y**

**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 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 will be inspected within the scope of a supplemental 95002 inspection in August - September, 2005.

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

**G**

**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\(pdf\)](#)

## Barrier Integrity

**G**

**Significance:** Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**MAINTENANCE PERFORMED ON FUEL HANDLING EQUIPMENT WITHOUT PROPER QUALIFICATIONS**

The inspectors identified a noncited violation of Technical Specification 5.4.1.a for failing to ensure maintenance on safety-related fuel handling equipment was performed by personnel with the correct qualifications. Specifically, the licensee failed to follow the requirements of Procedure 30DP-9MP01, "Conduct of Maintenance," which required that Task Qualified Independent Workers (qualified workers) be assigned to perform work or direct work by Dependent Workers (unqualified workers). Consequently, maintenance on refueling equipment by unqualified workers had not been properly supervised on at least five work orders in 2003 and 2004. This issue was entered into the corrective action program as Condition Report/Disposition Request 2797536.

The finding is determined to be greater than minor because if left uncorrected it could become a more significant safety concern in that improperly performed maintenance on fuel handling equipment could impact the safe movement of nuclear fuel and increase the probability of a fuel handling accident. 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 affects the barrier integrity cornerstone and is determined to be of very low safety significance by NRC management review because it was a deficiency that did not result in the actual degradation of spent fuel.

Inspection Report# : [2005003\(pdf\)](#)

**G**

**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\(pdf\)](#)

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## Emergency Preparedness

**Significance:** SL-III 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\(pdf\)](#)

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## Occupational Radiation Safety

## 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\(pdf\)](#)

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## Physical Protection

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

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## Miscellaneous

Last modified : November 30, 2005