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Home > Electronic Reading Room > Document Collections > Reports Associated with Events > Event Notification Reports > 2011 > December 16

Event Notification Report for December 16, 2011

U.S. Nuclear Regulatory Commission
Operations Center

Event Reports For
12/15/2011 - 12/16/2011

** EVENT NUMBERS **

47459 47499 **47518** 47519 47524 47525 47529

TOP

!!!! THIS EVENT HAS BEEN RETRACTED. THIS EVENT HAS BEEN RETRACTED !!!!!

Power Reactor

Event Number: 47459

Facility: PALO VERDE

Notification Date: 11/19/2011

Region: 4 State: AZ

Notification Time: 16:48 [ET]

Unit: [1] [] []

Event Date: 11/19/2011

RX Type: [1] CE,[2] CE,[3] CE

Event Time: 08:28 [MST]

NRC Notified By: AMADO FERNANDEZ

Last Update Date: 12/15/2011

HQ OPS Officer: BILL HUFFMAN

Person (Organization):

Emergency Class: NON EMERGENCY

BLAIR SPITZBERG (R4DO)

10 CFR Section:

50.72(b)(3)(ii)(B) - UNANALYZED CONDITION

50.72(b)(3)(v)(D) - ACCIDENT MITIGATION

Unit	SCRAM Code	RX CRIT	Initial PWR	Initial RX Mode	Current PWR	Current RX Mode
1	N	N	0	Hot Standby	0	Hot Standby

Event Text

THE LOW PRESSURE SAFETY INJECTION SYSTEM WAS SUBJECTED TO HIGH PRESSURE RESULTING IN BOTH TRAINS BEING DECLARED INOPERABLE

"On November 19, 2011, Unit 1 was in Mode 3. Boration of the four reactor coolant system (RCS) cold leg injection lines was in progress using High Pressure Safety Injection pump 'A'.

"During this activity, 'SI CHK VLV Leak Pressure Hi' alarms were received at 0828 [MST]. The 'A' and 'B' Low Pressure Safety Injection (LPSI) subsystems were declared inoperable because the pressure downstream of the motor operated LPSI injection valves was above 1525 psia. This elevated pressure potentially impacts the ability of the LPSI RCS loop injection valves to open. The high differential pressure may exceed the capability of the motor operator. All four injection line pressures were found above 1525 psia and LCO 3.0.3 was entered due to both trains of LPSI being inoperable. At 0839 [MST], pressure in the 'A' train injection lines was lowered below 1525 psia and 'A' LPSI subsystem was declared operable and LCO 3.0.3 was exited. At 0842 [MST], pressure was reduced below 1525 psia on the 'B' train injection lines and the 'B' LPSI subsystem was declared operable and LCO 3.5.3 condition A was exited.

"This call is being made to report a condition that could have prevented the fulfillment of a safety function required to mitigate the consequences of an accident and unanalyzed condition that existed for 11 minutes while both LPSI subsystems were inoperable.

"The NRC Resident Inspector has been notified."

*** RETRACTION RECEIVED FROM DANIEL HAUTALA TO CHARLES TEAL AT 1546 EST ON 12/15/11 ***

"The following event description is based on information currently available. If through subsequent reviews of this event, additional information is identified that is pertinent to this event or alters the information being provided at this time, a follow-up notification will be made via ENS or under the reporting requirements of 10CFR50.73.

"This notification is a retraction of ENS 47459 which was made by Arizona Public Service to report a condition that could have prevented the fulfillment of a safety function required to mitigate the consequences of an accident and an unanalyzed condition that existed for 11 minutes while both LPSI subsystems were declared inoperable when pressure downstream of the motor operated injection valves for safety injection subsystem were declared inoperable. An engineering review of the motor operated valves thrust and torque calculations determined that the affected valves would have been fully capable of performing their intended safety function at the time of the pressure excursion.

"The NRC Resident Inspector has been notified of this retraction."

TOP

Power Reactor	Event Number: 47499
Facility: TURKEY POINT	Notification Date: 12/06/2011
Region: 2 State: FL	Notification Time: 09:51 [ET]
Unit: [3] [4] []	Event Date: 12/06/2011
RX Type: [3] W-3-LP,[4] W-3-LP	Event Time: 09:30 [EST]
NRC Notified By: ROBERT STRUSINSKI	Last Update Date: 12/15/2011
HQ OPS Officer: MARK ABRAMOVITZ	
Emergency Class: NON EMERGENCY	Person (Organization):
10 CFR Section:	BINOY DESAI (R2DO)
50.72(b)(3)(xiii) - LOSS COMM/ASMT/RESPONSE	

Unit	SCRAM Code	RX CRIT	Initial PWR	Initial RX Mode	Current PWR	Current RX Mode
3	N	Y	100	Power Operation	100	Power Operation
4	N	Y	100	Power Operation	100	Power Operation

Event Text

TECHNICAL SUPPORT CENTER NON-FUNCTIONAL DUE TO PLANNED MAINTENANCE

"Between December 6, 2011 and January 13, 2012, a sequence of activities are planned that will render the Technical Support Center (TSC) non-functional at times by removing the emergency ventilation system from service. These activities are being performed in support of planned preventive maintenance and extended power uprate facility upgrades. In preparation for these emergency ventilation system outages, the TSC emergency responders were notified that if an emergency occurred during these outages the Emergency Coordinator and the TSC staff involved with classification, notification and PARS should report to the control room. All other TSC personnel should report to the Operational Support Center. The duration for each of these TSC outages is expected to be less than 24 hours. The NRC Operations Center will be provided an update to this notification when the TSC emergency ventilation has been removed from service and following restoration for each time period. This 8 hour notification in accordance with 10 CFR 50.72(b)(3)(xiii)."

The licensee notified the NRC Resident Inspector, and State and local governments.

* * * UPDATE FROM CHRISTOPHER TRENT TO JOE O'HARA AT 1900 EST ON 12/7/11 * * *

The TSC is functional at this time.

The NRC Resident Inspector will be notified.

* * * UPDATE FROM BILL BURROWS TO CHARLES TEAL AT 0313 EST ON 12/14/11 * * *

The TSC has been removed from operation to continue planned maintenance.

The NRC Resident Inspector has been notified. Notified R2DO (Bartley).

* * * UPDATE FROM ROBERT STRUSINSKI TO JOHN KNOKE AT 0330 EST ON 12/15/11 * * *

The TSC is functional at this time.

The NRC Resident Inspector will be notified. Notified R2DO (Scott Freeman) via email.

TOP

Agreement State	Event Number: 47518
Rep Org: NV DIV OF RAD HEALTH	Notification Date: 12/12/2011
Licensee: RENOWN SOUTH MEADOWS MEDICAL CENTER	Notification Time: 12:31 [ET]
Region: 4	Event Date: 12/08/2011
City: RENO State: NV	Event Time: 14:30 [PST]
County:	Last Update Date: 12/12/2011
License #: 16-12-0566-01	
Agreement: Y	Person (Organization):
Docket:	
NRC Notified By: SNEHA RAVIKUMAR	
HQ OPS Officer: VINCE KLCO	
Emergency Class: NON EMERGENCY	

Event Text

AGREEMENT STATE REPORT- LINEN TRANSPORT TRUCK DETAINED AFTER SETTING OFF RADIATION ALARM

The following information was provided via email:

"On 12/8/11 at 1430 PST, the Nevada Radiation Control Program (NRCP) received a call from the Alternate Radiation Safety Officer (ARSO) for Renown South Meadows Medical Center, that a truck carrying linen had been detained by the California Highway Patrol (CHP) at the Truckee inspection station after setting off a radiation alarm. The ARSO explained that the truck was not carrying any materials from the Nuclear Medicine Department or decay room and she knew of no reason that it would be radioactive. She provided the name and number for the CHP at Truckee.

"The NRCP contacted the CHP and were told that they had surveyed the truck with a Ludlum meter and measured .400 millirem per hour (or 400 microR/hour) outside the trailer. The CHP said that their protocols dictate that anything above three times background is treated as a hazmat incident and must have proper packaging and manifest. They had not run an identification spectrum on the truck. They had no capability to unload a trailer on site for further investigation. They were holding the vehicle pending instructions from their departmental radiation specialist and agreed to call [the NRCP] when they had a decision.

"The Aramark (linen service) representative confirmed that the vehicle in question was a tractor trailer and was carrying only linen from Renown.

"At approximately 1545 PST, the CHP called and indicated that they had released the trailer with orders to return to Renown Medical Center. They were unable to identify the radioisotope present and the dose rate reading was now .100 millirem per hour (100 micro R/hr).

"The NRCP Incident Response Supervisor arrived at Renown Medical center at approximately 1645 PST, shortly after the truck, and met with Renown staff. After conducting a radiation survey on the outside of the truck, he determined the general location of the high radiation and identified Technetium-99m (Tc-99m) as a suspected isotope. Linens are transported in large plastic bins, which were removed with a pallet jack, by the staff at Renown. When the radioactive bin was identified, it was segregated, a thorough survey was done and the radioisotope was positively identified as Tc-99m. The bin was placed in Renown's decay room where it will remain for 2 to 10 days until the Tc-99m decays.

"The most likely cause of this contamination was that a recently treated patient soiled the sheets and the possibility of radioactive contamination was not recognized by floor staff. Linens are not routinely screened for radiation. Aramark recently began transporting linens to Sacramento, rather than processing locally, so they are now subject to inspection upon entering California. The RCP will assist Renown with some procedure changes that will minimize the chances of this happening in the future.

"Dose rate readings were one order of magnitude lower than what CHP reported. It is unknown why CHP was unable to obtain an accurate identification of the isotope.

"Radiation readings: RadEye - Background 6 uR/hr; at bin 48 uR/hr; Ortec MicroDetective - Background 65 counts per second; at bin 1800 counts per second; Renown 451P Ion Chamber - Background 6 uR/hr; at bin 52 uR/hr; Ludlum 14c with pancake G-M detector - at bin 1800 counts per minute."

Nevada Report Number: NV110024



Agreement State

Rep Org: TEXAS DEPARTMENT OF HEALTH
Licensee: PASADENA REFINING SYSTEM, INC
Region: 4
City: PASADENA State: TX
County:
License #: 01344
Agreement: Y
Docket:
NRC Notified By: KAREN BLANCHARD
HQ OPS Officer: JOHN KNOKE

Emergency Class: NON EMERGENCY
10 CFR Section:
AGREEMENT STATE

Event Number: 47519

Notification Date: 12/12/2011
Notification Time: 14:38 [ET]
Event Date: 12/10/2011
Event Time: 19:00 [CST]
Last Update Date: 12/12/2011

Person (Organization):
WAYNE WALKER (R4DO)
MICHELE BURGESS (FSME)

Event Text

AGREEMENT STATE REPORT - NUCLEAR GAUGES DAMAGED DUE TO FIRE

The following information was provided from the state via email:

"On December 12, 2011, the Agency was notified by a licensee that on Saturday, December 10, 2011, at approximately 1900 CST, there was a fire in the coker unit at their facility in Pasadena, TX. The RSO reported there were 4 fixed nuclear gauges on drums in the area of the fire. The gauges were Ohmart-Vega Model SH1G-1 and each contained a 300 milliCurie Cesium-137 source. Two gauges were directly in the fire and were damaged. The other two gauges were shielded from the fire by the drum they were mounted on and it has not yet been determined if they sustained any damage. The area was barricaded to prevent entry due to unsafe conditions caused by the fire (i.e. structural damage that has to be assessed, heat, ash/hydrocarbons). There were no radiation levels above background found during initial surveys from the barricade line and subsequent surveys conducted under the drums on the ground level and second level (areas where people will begin working). Higher levels will be surveyed prior to entry. The licensee has made arrangements with Ohmart-Vega for service

to remove all 4 gauges once the area is safe.

"Gauge and Source Information:

Gauges: All Ohmart-Vega Model SH1G-1
Serial numbers:13543162, 13543163, 13543164 (in fire), 13543165 (in fire)
Sources: Cesium-137, 300 milliCuries each, SN same as gauge
Gauges installed March, 2010.

"More information will be provided as it is obtained."

Texas Incident #: I-8909

TOP

Power Reactor

Facility: SAINT LUCIE
Region: 2 State: FL
Unit: [1] [] []
RX Type: [1] CE,[2] CE
NRC Notified By: TIMOTHY MILLER
HQ OPS Officer: JOE O'HARA

Emergency Class: NON EMERGENCY
10 CFR Section:
50.72(b)(3)(xiii) - LOSS COMM/ASMT/RESPONSE

Event Number: 47524

Notification Date: 12/15/2011
Notification Time: 07:30 [ET]
Event Date: 12/15/2011
Event Time: 09:00 [EST]
Last Update Date: 12/15/2011

Person (Organization):
SCOTT FREEMAN (R2DO)

Unit	SCRAM Code	RX CRIT	Initial PWR	Initial RX Mode	Current PWR	Current RX Mode
1	N	N	0	Refueling	0	Refueling

Event Text

ERDADS OUT OF SERVICE FOR PLANNED MAINTENANCE

"The St. Lucie Unit 1 Emergency Response Data Acquisition and Display System (ERDADS) will be removed from service for system modification following completion of core offload for the current cycle 24 refueling outage, currently scheduled for 12/15/2011 at 0900. The ERDADS system will be functional prior to core reload (Mode 6) and fully operational prior to the plant startup. This is an informational notification of a planned loss of emergency assessment capability. Control room indications including annunciators are available as alternate means to monitor critical data. An update to this notification will be provided when the system is restored to service."

The NRC Resident Inspector has been notified.

TOP

Power Reactor

Facility: CATAWBA
Region: 2 State: SC
Unit: [1] [2] []
RX Type: [1] W-4-LP,[2] W-4-LP
NRC Notified By: STEVE CHRISTOPHER
HQ OPS Officer: JOE O'HARA

Emergency Class: NON EMERGENCY
10 CFR Section:
50.72(b)(2)(i) - PLANT S/D REQD BY TS

Event Number: 47525

Notification Date: 12/15/2011
Notification Time: 10:41 [ET]
Event Date: 12/15/2011
Event Time: 07:39 [EST]
Last Update Date: 12/15/2011

Person (Organization):
SCOTT FREEMAN (R2DO)

Unit	SCRAM Code	RX CRIT	Initial PWR	Initial RX Mode	Current PWR	Current RX Mode
1	N	Y	100	Power Operation	99	Power Operation
2	N	Y	100	Power Operation	100	Power Operation

Event Text

DUAL UNIT TECHNICAL SPECIFICATION 3.0.3 REQUIRED SHUTDOWN DUE TO LOSS OF CONTROL ROOM CHILLERS

"Control room area chilled water system 'B' train tripped while control room area chilled water system 'A' train was isolated for maintenance. Unit 1 and Unit 2 entered technical specification 3.0.3 at 0739 EST. Unit 1 shutdown commenced at 1030 EST. Unit 2 shutdown is scheduled to commence at 1100 EST. This plant condition also requires a notification under 10CFR50.72(b)(3)(v)."

The licensee is investigating the cause of the trip on the 'B' train and is taking actions to restore the 'A' train to service and exit the shutdown. The electrical lineup is normal and all safety systems are operable.

The NRC Resident Inspector has been notified. The states of North Carolina and South Carolina will be notified. Local county governments of

York, Gaston, and Mecklenberg counties will also be notified.

TOP

Non-Agreement State

Rep Org: DEPT OF NAVY RADIATION SAFETY CMTE
Licensee: DEPT OF NAVY RADIATION SAFETY CMTE
Region: 1
City: ARLINGTON State: VA
County:
License #: 45-23645-01NA
Agreement: Y
Docket:
NRC Notified By: DONNA DAVIS-URGO
HQ OPS Officer: PETE SNYDER

Emergency Class: NON EMERGENCY
10 CFR Section:
20.2201(a)(1)(ii) - LOST/STOLEN LNM>10X

Event Number: 47529

Notification Date: 12/15/2011
Notification Time: 18:27 [ET]
Event Date: 12/13/2011
Event Time: 19:00 [EST]
Last Update Date: 12/15/2011

Person (Organization):
HAROLD GRAY (R1DO)
KEVIN O'SULLIVAN (FSME)

This material event contains a "Less than Cat 3" level of radioactive material.

Event Text

HELICOPTER INTEGRATED BLADE INSPECTION SYSTEM SOURCE LOST

On 12/13/11, after a Marine Corps CH53 Helicopter training flight at 1900 PST it was determined during a post flight inspection that the 500 micro-Curie Sr-90 integrated blade inspection system (IBIS) source was missing. The flight originated on Marine Corps Air Station Miramar. During the flight the helicopter flew over the pacific ocean then to and over Camp Pendleton before returning to Miramar.

An investigation into the event is ongoing. The results of the investigation will determine what actions are taken to recover the source.

THIS MATERIAL EVENT CONTAINS A "LESS THAN CAT 3" LEVEL OF RADIOACTIVE MATERIAL

Sources that are "Less than IAEA Category 3 sources," are either sources that are very unlikely to cause permanent injury to individuals or contain a very small amount of radioactive material that would not cause any permanent injury. Some of these sources, such as moisture density gauges or thickness gauges that are Category 4, the amount of unshielded radioactive material, if not safely managed or securely protected, could possibly - although it is unlikely - temporarily injure someone who handled it or were otherwise in contact with it, or who were close to it for a period of many weeks. For additional information go to http://www-pub.iaea.org/MTCD/publications/PDF/Pub1227_web.pdf

This source is not amongst those sources or devices identified by the IAEA Code of Conduct for the Safety & Security of Radioactive Sources to be of concern from a radiological standpoint. Therefore is it being categorized as a less than Category 3 source

Page Last Reviewed/Updated Thursday, March 29, 2012



HOME

NEWS RELEASES

EVENT REPORTS

ADAMS

OPEN GOV

DIGITAL GOVERNMENT

STUDENTS & TEACHERS

PHOTOS & VIDEO

FOR DEVELOPERS

ABOUT US

STRATEGIC PLAN

BUDGET & PERFORMANCE

PERF & ACCOUNTABILITY REPT

HISTORY OF THE NRC

EMPLOYMENT

NRC ETHICS

AGENCY STATUS

CONTACT US

POPULAR DOCUMENTS

INFO DIGEST

FACTSHEETS & BROCHURES

FORMS

ELECTRONIC SUBMITTALS
APPLICATION

NRC REPORTS - NUREG

NRC REGULATIONS - 10-CFR

INSPECTION REPORTS

PLAIN WRITING

ENFORCEMENT ACTIONS

RULEMAKING

STAY CONNECTED

BLOG

CHAT

TWITTER

YOUTUBE

FLICKR

GOVDELIVERY

RSS