

Clinton

Initiating Events

G

Significance: May 13, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

ON MAY 13, 2002 WITH THE REACTOR AT APPROXIMATELY 88 PERCENT RATED THERMAL POWER, THE REACTOR AUTOMATICALLY SHUTDOWN DUE TO A HIGH REACTOR VESSEL WATER LEVEL SIGNAL.

A performance deficiency, associated with this automatic reactor shut down on May 13, 2002, was identified as a failure to establish preventative maintenance or inspections on the "B" turbine driven reactor feed pump (TDRFP) for similar conditions found on the "A" TDRFP (noted in December 2000) before a component failure which led to the automatic reactor shut down. This issue was more than minor because if left uncorrected (i.e. appropriate preventative maintenance not being identified and conducted), it could lead to a more significant safety concern and could cause the increased frequency of an initiating event. Consequently, the inspectors evaluated the significance of the issue using the SDP Appendix A phase 1 worksheet. Since the finding contributed only to the likelihood of a reactor trip and did not affect mitigating system availability, the inspectors determined that the finding was of very low safety significance.

Inspection Report# : [2002006\(pdf\)](#)

G

Significance: Mar 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

NON-CITED VIOLATION OF T.S. 5.4.1. FOR INADEQUATE OPERATING PROCEDURE, RESULTING IN ERAT-SVC BREAKER TRIP.

A Non-Cited Violation of Technical Specification 5.4.1. was identified for an inadequate operating procedure which contributed to an inadvertent emergency reserve auxiliary transformer static-VAR [Volts-Ampere-reactive]-compensator circuit breaker trip. The result of this circuit breaker trip rendered one of the two qualified offsite power sources the transformer inoperable. The finding was of very low safety significance because it could increase the likelihood of an initiating event (reactor trip or a partial loss of offsite power) but did not increase the likelihood that any mitigation equipment would be unavailable.

Inspection Report# : [2002005\(pdf\)](#)

G

Significance: Feb 17, 2002

Identified By: NRC

Item Type: FIN Finding

A TEMPORARY MODIFICATION ON THE "A" RR FCV CONTROL CIRCUITRY.

A finding of very low safety significance was identified associated with a temporary modification installed on the control circuitry for the "A" flow control valve (FCV) of the reactor recirculation system. Problems with the design instructions and other technician knowledge-based deficiencies resulted in an unplanned opening of the "A" flow control valve. Following this unplanned flow control valve movement, operators removed the temporary modification and manually shut down the reactor. The finding was of very low safety significance because unplanned flow control valve movement contributed only to the likelihood of a reactor trip and did not affect mitigating system availability.

Inspection Report# : [2001016\(pdf\)](#)

Mitigating Systems

G

Significance: Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

VIOLATION OF PROCEDURAL REQUIREMENTS CAUSED BY HUMAN PERFORMANCE IN THAT THE LICENSEE FAILED TO CONTROL AND DOCUMENT WORK ON A RISK-SIGNIFICANT, SAFETY-RELATED SYSTEM.

The inspectors identified a finding of very low safety significance while observing maintenance on the Division I Emergency Diesel Generator (EDG). Specifically, the inspectors identified that one of the insulated bearing bracket bolts on the generator was not properly tightened. The performance issue associated with this finding involved workers performing work steps not specified in the work procedure. Compounding the

issue was that once these additional work steps were performed, they were not documented in the work procedure. The finding was more than minor because, if left uncorrected, the EDG could have become inoperable which could impact the Mitigating Systems cornerstone. The finding was of very low safety significance because the condition was found and corrected before the EDG was made operable. This finding was a violation of Technical Specification 5.4.1; however, because the licensee placed the violation into its corrective action program, this was determined to be a NCV.

Inspection Report# : [2002008\(pdf\)](#)

G

Significance: May 29, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

TECHNICAL SPECIFICATION 5.4.1 VIOLATION WAS IDENTIFIED FOR AN INADEQUATE PROCEDURE USED DURING THE PERFORMANCE OF A DIVISION III EDG TEST.

A Non-Cited Violation of Technical Specification 5.4.1 was identified for an inadequate procedure used during the performance of a Division III (Div-III) emergency diesel generator (EDG) test. Errors in the procedure led to the loss of the Div-III safety-related 4160 Volt electrical bus and unplanned unavailability of the high pressure core spray (HPCS) system. The finding was greater than minor because if left uncorrected, the issue has a credible impact on safety. Further, the issue did have an impact on mitigation system operability as the loss of the Div-III electrical bus rendered the HPCS system inoperable. Using Manual Chapter 0609, "Significance Determination Process," (SDP), Appendix A, phase 1 worksheet, the finding screened out as a very low safety significance issue because the event did not result in the actual loss of safety function for the HPCS system.

Inspection Report# : [2002006\(pdf\)](#)

G

Significance: Feb 17, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

NON-CITED VIOLATION T.S. 5.4.1 FOR AN INADEQUATE SURVEILLANCE PROCEDURE.

Procedural inadequacies were determined to be a Non-Cited Violation of Technical Specification 5.4.1. These inadequacies led to the "A" residual heat removal system pump being declared operable without performing the appropriate pump supply breaker functionality checks for the conditions. The finding was of very low safety significance because the licensee subsequently tested the "A" residual heat removal system pump supply breaker with satisfactory results. Therefore, system operability was not impacted.

Inspection Report# : [2001016\(pdf\)](#)

G

Significance: Feb 15, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADAEQUATE CORRECTIVE ACTIONS FOR REPETITIVE FAILURE OF SLC PUMP MOTOR BREAKER.

A Non-Cited Violation (NCV) of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," for inadequate corrective action taken to prevent recurrence of a Standby Liquid Control "A" System (SLC) pump motor breaker failure was identified. This finding was determined to be of very low safety significance due to the low initiating event frequency for Anticipated Transient Without Scram, the availability of the "B" SLC pump, and the high likelihood of successful operator recovery actions.

Inspection Report# : [2002003\(pdf\)](#)

Barrier Integrity

G

Significance: Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

THE LICENSEE FAILED TO ESTABLISH WRITTEN OPERATIONAL TEST PROCEDURES TO DEMONSTRATE THE FUNCTIONAL CAPABILITY OF THE SX MAKEUP TO THE SPENT FUEL POOL.

The inspectors determined that the licensee failed to establish written operational test procedures to verify the functionality of the seismically qualified makeup flow path from the shutdown service water system to the spent fuel pool. The finding was more than minor because, if left uncorrected, silting in the line and pipe wall thinning could result in increased degradation and a more significant safety concern and potentially impacting the Barrier Integrity cornerstone. The finding was of very low safety significance because the as-found conditions, while degraded from original installation, met design requirements. This finding was a violation of 10 CFR 50, Appendix B, Criterion XI "Test Control;" however, because the licensee placed the violation into its corrective action program, this was determined to be a NCV.

Inspection Report# : [2002008\(pdf\)](#)

G**Significance:** Apr 09, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

TECHNICAL SPECIFICATION 5.4.1 WAS IDENTIFIED FOR WORKERS FAILING TO FOLLOW A PROCEDURE WHICH CONTRIBUTED TO THE INADVERTENT LIFTING OF A DOUBLE BLADE GUIDE DURING FUEL MOVEMENT OPERATIONS ON APRIL 9.

A Non-Cited Violation of Technical Specifications (TS) 5.4.1 was identified for workers failing to follow a procedure which contributed to the inadvertent lifting of a double blade guide during fuel movement operations on April 9, 2002. This self-revealing finding was more than minor because if left uncorrected, inadvertent movement of components from the reactor core could lead to a more significant safety concern. Using the fuel barrier column on the SDP Appendix A phase 1 worksheet, the inspectors assessed the finding as a very low safety significance issue. Inspection Report# : [2002006\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

G**Significance:** Dec 12, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO CONDUCT ADEQUATE SURVEY OF AIRBORNE RADIOACTIVE MATERIALS

A finding of very low safety significance was identified through a self-revealing event, when a maintenance mechanic received an unexpected uptake of radioactive material during a valve maintenance procedure resulting in a 115 millirem committed effective dose equivalent (CEDE) dose. This self-revealing finding was caused by inadequate implementation of radiation protection procedures and improper work oversight by the radiation protection staff. The finding is more than minor because it affects the occupational radiation safety cornerstone objective for exposure/contamination control and monitoring. Although an unexpected intake occurred, the radiological conditions associated with the work activity were not of a magnitude sufficient to produce a substantial potential for an exposure in excess of regulatory limits. Therefore, the finding was of very low safety significance (i.e., not an as-low-as-reasonably-achievable finding, not an overexposure or substantial potential for an overexposure, and did not compromise the ability to assess dose). A Non-Cited Violation of 10 CFR 20.1501(a)(1)(ii) was identified for failure to conduct surveys as necessary to assess the radiological conditions and to control exposure to airborne radioactive material.

Inspection Report# : [2002009\(pdf\)](#)

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Feb 15, 2002

Identified By: NRC

Item Type: FIN Finding

WHILE IMPROVEMENTS WERE NOTED IN THE CORRECTIVE ACTION PROGRAM, ONE EXAMPLE OF INADEQUATE CORRECTIVE ACTION WAS IDENTIFIED

Improvements were noted in most areas of the corrective action program that were reviewed. While one example of inadequate corrective action was identified, the licensee generally identified, evaluated, prioritized and implemented corrective actions for identified issues in an effective manner. Improvements in these areas were primarily due to active involvement in the program by program coordinators and the management review committee. The trending program and the interface between the corrective action and maintenance work order programs

were two areas that could be further improved. Continued involvement by the program coordinators and the management review committee is critical to further program improvement.

Inspection Report# : [2002003\(pdf\)](#)

Last modified : March 25, 2003