Crystal River 3 1Q/2003 Plant Inspection Findings

Initiating Events

Significance: Sep 28, 2002 Identified By: Self Disclosing Item Type: FIN Finding Corrective Actions

Green. The licensee's corrective actions for a failed power cable were insufficient to prevent recurrence of a partial loss of offsite power event. The finding was more than minor because it increased the likelihood of a loss of offsite power. The finding was determined to be of very low safety significance by the safety determination process because it did not involve a total loss of offsite power and power remained available for safety equipment. (Section 4OA2)

Inspection Report# : 2002003(pdf)

Significance: Gun 21, 2002

Identified By: NRC Item Type: FIN Finding

Corrective Actions to Address a Feedwater Transient

Green. The inspectors identified that corrective actions to address a feedwater transient which occurred on December 15, 2001, had not been implemented. This issue was more than minor because the feedwater transient required operator intervention in order to stabilize the plant and resulted in cavitation of a feedwater booster pump, which if it had tripped or become damaged, could have resulted in more severe consequences. Therefore, it was important that corrective actions should have been implemented. This finding was determined to be of very low safety significance (Green) by the significance determination process because the impact was limited to a slightly increased likelihood of a plant transient. (Section 4OA2.c)

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Mitigating Systems

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Jun 21, 2002

Identified By: NRC Item Type: FIN Finding

Identification and Resolution of Problems

Based on the results of the inspection, one finding and several negative observations were identified. The licensee was effective at identifying problems at a low threshold and putting them into the corrective action program. Although two issues were identified that the licensee had not entered into the corrective action program, these were considered isolated instances and not indicative of a weakness in this area. Generally, the licensee properly evaluated issues and implemented effective and timely corrective action. Formal root causes for issues classified as significant conditions adverse to quality were especially thorough and detailed. The inspectors identified several examples in which condition reporting evaluations lacked thoroughness or were too narrowly focused, and some corrective actions were not comprehensive or were not implemented as intended. One finding of very low safety significance was identified. The inspectors identified that corrective actions to address a feedwater transient had not been implemented. Licensee audits and self-assessments were effective in identifying deficiencies in the corrective action programs. In addition, audit and assessment findings were consistent with the inspectors' observations. Based on interviews of plant personnel from various departments, personnel indicated that they felt free to input safety issues and conditions adverse to quality into the corrective action and employee concerns programs. A safety conscious work environment was evident at Crystal River

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Last modified: May 30, 2003