# Crystal River 3

## Initiating Events

**Significance:** G 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:** G Jun 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)
Inspection Report# : 2002006*(pdf)*

## Mitigating Systems

**Significance:** G Jun 29, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
**Failure to complete an accurate risk assessment per 10 CFR 50.65(a)(4)**
10 CFR 50.65 (a)(4) requires, in part, that before performing maintenance activities (including but not limited to surveillances, post-maintenance testing, and corrective and preventive maintenance), the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activities. Contrary to the above, the licensee failed to assess the maintenance risk for all plant maintenance to be performed during the week of February 11, 2002. Specifically, the completed assessment failed to account for raw water pumps within licensee-established risk assessment scope that were concurrently out of service. This is being treated as a Non-Cited Violation. The violation is in the licensee corrective action program as Nuclear Condition Report 58911.
Inspection Report# : 2002002*(pdf)*

**Significance:** G Jun 29, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
**Failure to properly position a component during clearance (tagging) activities**
Technical Specification 5.6.1, Procedures, states that written procedures shall be implemented covering the activities recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. The regulatory guide list in Appendix A, includes procedures for equipment control (tagging). Licensee procedure OPS-NGGC-1301, Equipment Clearance implements this requirement and states, in step 4.10, that the "Tag Hanger positions components as specified on the Clearance Checklist." Contrary to the above, the tag hanger for Clearance Checklist 35216, on April 4, 2002, failed to position the emergency feedwater pump (EFP-3) fuel rack, in the "tripped" position prior to placing a "Diesel Engine Tripped" tag on the fuel rack. The rack was in the Normal, not tripped position and this was not identified by the independent second-checker. This is being treated as a Non-Cited Violation. The violation is in the licensee corrective action program as Nuclear Condition Report

58819.
Inspection Report# : 2002002*(pdf)*

## 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.
Inspection Report# : 2002006*(pdf)*

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