

## Braidwood 2

### 2Q/2003 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Nov 29, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

##### **FEEDWATER OIL DRAIN VALVE INADVERTENTLY LEFT OPEN**

A finding of very low safety significance was identified through a self-revealing event when the main control room received a low oil level alarm for the 2C turbine-driven feedwater pump. The alarm was caused by an oil drain valve being inadvertently left open by a non-licensed operator during planned maintenance occurring on the previous shift. The primary cause of this finding was related to the cross-cutting area of human performance, in that the plant operator did not use adequate self-checking to verify the oil drain valve was closed. This finding was more than minor because it increased the likelihood of a reactor trip event due to low steam generator level, and could have affected the availability of the main feedwater mitigating system due to the potential loss of the 2C turbine-driven feedwater pump from low lube oil pressure. The finding was of very low safety significance because the exposure time was short, all other mitigating systems were available, and the main feedwater system could have been recovered by fairly simple operator actions. The finding was not considered a violation of regulatory requirements.

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

**Significance:**  Sep 30, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

##### **ERRORS DURING MODIFICATION OF ROD CONTROL SYSTEM RESULTS IN INCREASED LIKELIHOOD OF REACTOR TRIP INITIATING EVENT**

A finding of very low safety significance was identified through a self-revealing event when Unit 2 experienced rod control urgent failure alarms and a dropped control rod. The cause of the event was improperly installed insulation on three heat sinks in the rod control power cabinets which caused grounds and reduced voltages to the control rod stationary gripper coils. The heat sinks were not properly insulated from the cabinet chassis during a modification performed in the spring 2002 refueling outage. The primary cause of this finding was related to the cross-cutting area of Human Performance with inadequate work instructions as a contributing factor. The finding was more than minor because it increased the likelihood of a reactor trip initiating event. The finding did not affect the ability to trip the reactor. Since the issue did not affect the likelihood of a loss of coolant, availability of mitigating systems, or the likelihood of a fire or flood, it was of very low safety significance. No violation of regulatory requirements occurred.

Inspection Report# : [2002007\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Sep 30, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO ESTABLISH COMPENSATORY FIREWATCHES FOR TWO REMOVED FIRE RATED BARRIERS**

A finding of very low safety significance was identified by the inspectors for a violation of Technical Specification Fire Protection Program requirements. The licensee removed two fire rated barriers (floor plugs) in the auxiliary building, and left them off for over five months, without establishing the required compensatory fire watches. The primary cause of this violation was related to the cross-cutting area of Human Performance. The licensee Fire Marshall failed to identify that the floor plugs were rated fire barriers, despite labels indicating that the 10 CFR 50, Appendix R, program applied to them, before authorizing their removal. This issue was more than minor because a fire in one elevation of the auxiliary building could have spread to other elevations and therefore affected redundant trains of mitigating systems. The issue was of very low safety significance because the inspectors could not develop realistic fire scenarios in one elevation that could reasonably propagate to the elevations above. The issue was a Non-Cited Violation of Technical Specification 5.4.1 which required the implementation of written procedures covering the Fire Protection Program. Inspection Report# : [2002007\(pdf\)](#)



**Significance:** Aug 14, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

### **MAINTENANCE ERROR ON 2A DG RESULTS IN UNPLANNED UNAVAILABILITY OF MITIGATING SYSTEM**

A finding of very low safety significance was identified through a self-revealing event after the 2A diesel generator tripped during routine Technical Specification surveillance testing. The cause of the trip was an improperly installed thrust bearing wear detector during routine maintenance about a month before the trip. The primary cause of this finding was related to the cross-cutting area of Human Performance. The issue was more than minor because the trip resulted in the unplanned unavailability of the generator in order to troubleshoot and repair the problem. The finding was of very low safety significance because the safety function of the 2A diesel generator was unaffected. No violation of regulatory requirements occurred.

Inspection Report# : [2002007\(pdf\)](#)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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## **Public Radiation Safety**

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## Physical Protection

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## Miscellaneous

Last modified : September 04, 2003