

Calvert Cliffs 1

3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedures for Offsite Power Availability

The inspectors identified an NCV of Technical Specification 5.4.1.a. "..., written procedures shall be established, implemented,.." for the failure to provide an adequate procedure for the operation of the electrical system. Specifically, Operating Procedure OI-27-B, 13.8kV System, provides steps for placing voltage regulators under manual control which makes the associated offsite source to the affected 4 kV busses inoperable. The procedure did not state this, and as a result, when the voltage regulators were placed in manual the associated offsite source was not declared inoperable when it should have been.

This finding is greater than minor because it is associated with the cornerstone attribute Procedure Quality and affects the objective of the Mitigating Systems Cornerstone to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This finding was determined to be a finding of very low safety significance because the finding did not represent an actual loss of a safety function and was not potentially risk significant due to an external initiating event. (Section 40A2)

Inspection Report# : [2005004\(pdf\)](#)

Significance:  Mar 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Change SRW Operating Procedure During Sequencer Modification

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a. "..., written procedures shall be established, implemented,.." because plant procedural requirements were not included in all appropriate sections of the Unit 1 Operating Instruction, OI-15, "Service Water System." Specifically, certain procedural sections in OI -15 did not adhere to OI-15 precaution L, which prohibited the system to be in a configuration where two service water pumps could have loaded simultaneously onto a single emergency diesel generator (EDG). An engineering evaluation performed by the licensee, associated with the two pumps simultaneously loading onto an EDG, determined that this system alignment could have adversely affected the reliability of the safety-related Fairbanks Morse EDG following a loss of offsite power (LOOP) event concurrent with a loss of coolant accident (LOCA).

This finding is greater than minor because it was associated with the Mitigating System Cornerstone human performance attribute and affected the cornerstone's objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. This finding did not involve the actual loss or degradation of equipment specifically designed to mitigate a seismic event or the loss of any safety function. As a result, this finding was determined to be of very low safety significance (Green) in accordance with a Phase 1 risk assessment performed in accordance with Inspection Manual Chapter - 0609, "Significance Determination Process." The inspectors identified that a contributing cause of this finding was related to the cross-cutting area of human performance. The relevant causal factor was personnel because the Unit 1 service water procedures were not appropriately changed by operations procedure writers although a procedure revision was noted in the modification package as being required. (Section 1R15)

Inspection Report# : [2005002\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : November 30, 2005