Calvert Cliffs 2
3Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2005
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish Adequate Clearance Order Boundaries
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 implemented while performing maintenance on the Unit 2, 21A reactor coolant pump (RCP) drain line valve replacement activity during reduced inventory. Specifically, on March 7, 2005, while in reduced Reactor Coolant System (RCS) inventory, the 21A RCP drain line was opened to support a maintenance activity which inadvertently drained the reactor coolant system (RCS) into the normal containment sump. The RCS level dropped one-half inch before operators diagnosed the draindown and closed the drain valve. A lack of knowledge and understanding regarding the height of the drain line penetrating into the RCS piping, as compared to the reduced inventory level of the RCS, resulted in the inadvertent draindown and loss of RCS inventory.

This finding is greater than minor because it was associated with the Initiating Events Cornerstone configuration control attribute and affected the cornerstone's objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown operations. This finding did not involve an actual loss of shutdown cooling (SDC). As a result, this finding was determined to be of very low safety significance (Green) in accordance with a Phase 2 risk assessment performed using the NRC Inspection Manual, Chapter 0609, "Significance Determination Process," Appendix G, "Shutdown Operations 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 licensed operators did not follow plant procedures and determine if boundaries specified in the clearance order were adequate for the maintenance activity. (Section 1R04)

Inspection Report# : 2005002*(pdf)*

Significance: G Jun 28, 2003
Identified By: Self-Revealing
Item Type: FIN Finding
Troubleshooting Human Performance Error Results in a Reactor Trip
The inspectors identified a finding because the work practices during a turbine governor valve control circuit troubleshooting activity were inadequate and resulted in a reactor trip.

This finding is greater than minor because it affected an attribute and the objective of the Initiating Events Cornerstone in that the work practices inadequacies resulted in a perturbation in plant stability by causing a reactor trip. The finding is of very low safety significant in accordance with Phase 1 of the reactor safety SDP because, although it caused a reactor trip, it did not increase the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to a combination of a reactor trip and loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flood.
Inspection Report# : 2003003*(pdf)*

Mitigating Systems

Significance: G 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 4OA2)

Inspection Report# : 2005004*(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