

Robinson 2

Initiating Events

G**Significance:** Sep 29, 2001

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

CCW RELIEF VALVE LIFT DURING SHUTDOWN

A non-cited violation for failure to follow a maintenance procedure during a refueling outage as required by Technical Specification 5.0 was identified. This resulted in a component cooling water (CCW) system relief valve not reseating following a relief, causing a partial draindown of the CCW system. The safety significance was very low because of the options available to the operators to mitigate the consequences of the partial draindown to maintain decay heat removal.

Inspection Report# : [2001004\(pdf\)](#)G**Significance:** Jun 30, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE PROCEDURE FOR MAINTAINING REACTOR VESSEL HEAD VENTED DURING REFUELING PREPARATIONS

Green. The inspectors identified a Non-cited Violation of Technical Specification 5.4.1. for failure to provide adequate procedures to maintain the reactor vessel head vented during refueling preparations. This finding was determined to be of very low safety significance because the pressurizer and loops remained vented and the decrease in vessel level was less than two feet (Section 1R20).

Inspection Report# : [2001003\(pdf\)](#)

Mitigating Systems

G**Significance:** Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

REACTOR PROTECTION SYSTEM LOW REACTOR COOLANT SYSTEM FLOW CHANNEL INOPERABLE FOR GREATER THAN TECHNICAL SPECIFICATION ALLOWABLE TIME

GREEN. Reactor protection system low reactor coolant system (RCS) loop 3 flow comparator FC-434 was inoperable for greater than the Technical Specification 3.3.1 allowable time, as described in licensee corrective action report AR 27677. Technical Specification Table 3.3.1-1, item 9 requires three flow channels in each RCS loop to be operable during power operation. One flow channel in RCS loop 3 was found inoperable for greater than the allowed time of six hours. This is being treated as a Non-Cited Violation. This issue was reported as LER 50-261/2001-001-00.

Inspection Report# : [2000006\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

G**Significance:** Jun 30, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO CONTROL ACCESS TO B REACTOR COOLANT PUMP BAY FOLLOWING PLANNED FLUX THIMBLE GUIDE TUBE EXTRACTION.

Licensee TS 5.7 required each high radiation area having radiation intensity greater than 1,000 mRem/hr at 30 centimeters (12 inches) be locked to prevent unauthorized entry into such areas. On April 12, 2001, a radiological survey around the top of the Containment Vessel Sump flapper valves in "B" RCP Bay, detected dose rates of 2,500 mrem/hr. Dose rates increased in the work area following a planned flux thimble guide tube retraction. The licensee failed to meet the TS 5.7 requirements for controlling access to a high radiation area having dose rates greater than 1,000 mrem/hr. The area had been unlocked or controlled. The licensee documented the event in Significant Adverse Condition Investigation report 30704 (Green).

Inspection Report# : [2001003\(pdf\)](#)

Public Radiation Safety

G**Significance:** Dec 30, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO PERFORM SURVEYS, CONTROL DOSE AND MEET SHIPPING REQUIREMENTS RESULTED IN RELEASE OF CONTAMINATED LIFELINE

10 CFR Part 20.1301 requires that licensed operations limit dose to members of the public to allowable limits and 10 CFR Part 20.1501 and Part 1802 requires that licensee's perform adequate surveys to control byproduct material contamination and to evaluate the radiological hazards. 49CFR Part 173 specifies the Department of Transportation (DOT) requirements for shipping radioactive material. The licensee failed to perform adequate surveys, to control dose and to meet DOT shipping requirements resulting in a contaminated lifeline being shipped offsite in June, 2000. Reference Condition Report 0020327.

Inspection Report# : [2000005\(pdf\)](#)

Physical Protection

Miscellaneous

Significance: N/A Mar 02, 2001

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION & RESOLUTION

Based on the results of the inspection, no findings of significance were identified. The implementation of the corrective action program (CAP) was acceptable with concerns noted. Management oversight was evident in all aspects of the program, and trending was extensive and informative with an appropriate focus on human performance. The licensee was generally effective at identifying problems and placing them into the CAP as evidenced by the inspectors' review of problem identification programs/processes, audits and self-assessments, external operating experience, and through plant tours. However, several instances where the licensee had not initiated action requests (ARs) were noted. Licensee audits and assessments were found to be effective. In addition, observations identified by the audits and assessments were consistent with the team's observations. The licensee appropriately evaluated individual problems and established acceptable schedules for implementing corrective actions. Corrective actions were generally implemented in a timely manner. Apparent cause determinations appeared to accurately identify why the equipment problems occurred. The inspectors determined that the licensee properly classified discrepant conditions, but did not have a formal process for use of risk significance when classifying/assigning prioritization of these items. The inspectors concluded that the scope and depth of corrective actions assigned by the licensee were appropriate for the severity and risk significance of the problems identified. However, one AR was assigned an incorrect priority and two ARs were identified with corrective actions that did not match the apparent cause of the problem. Interviews of plant personnel indicated that they felt free to input safety issues and conditions adverse to quality into the CAP. A safety conscious work environment was evident at Robinson.

Inspection Report# : [2001002\(pdf\)](#)

Last modified : April 01, 2002