

Robinson 2

2Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 14, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Implement a Safety Injection and Containment Vessel Spray System Operating Procedure

Green. A failure to adequately implement an operating procedure resulted in the mispositioning of a vent valve in the safety injection (SI) system. A non-cited violation of Technical Specification 5.4.1 was identified. This finding is greater than minor and had credible impact on safety. The finding had the potential for affecting the mitigating systems cornerstone equipment, including, loss of reactor water storage tank level, flooding of the SI pump room and subsequent loss of SI and containment spray pumps due to flooding. The finding is of very low safety significance (Green) because any significant leakage would have caused the auxiliary building sump level to increase, alerting the control room. Further, the pipe cap downstream of the mispositioned valve had not exhibited any leakage.

Inspection Report# : [2003004\(pdf\)](#)

Significance:  Jun 14, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Load Rejection Abnormal Operating Procedure

Green. A failure to follow an abnormal operating procedure resulted in an improper increase in turbine load for the purpose of temperature control. A non-cited violation of Technical Specification (TS) 5.4.1 was identified for failure to follow Abnormal Operating Procedure (AOP)-15, Secondary Load Rejection. The procedure requires, under specific conditions, the operators to either insert control rods or borate the reactor coolant system for the purposes of temperature control. However, subsequent to receipt of a turbine runback, increasing turbine load was used for temperature control. This finding affected mitigating systems cornerstone equipment. The finding had a credible impact on safety and is greater than minor because the turbine load action was non-conservative. The finding was determined to be of very low safety significance (Green) because TS limits were not exceeded and the power increase from the turbine load increase following the runbacks was very small and did not approach reactor protection system setpoints.

Inspection Report# : [2003004\(pdf\)](#)

Significance:  Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to adequately implement procedure OPS-NGGC-1301, Equipment Clearances

Green. A failure to adequately implement an equipment clearance procedure resulted in an extended unavailability and inoperability of the B motor driven auxiliary feedwater (MDAFW) pump. A non-cited violation of Technical Specification (TS) 5.4.1 was identified. This finding is greater than minor as the clearance error extended the total unavailability and inoperability of the B MDAFW pump beyond that originally planned. The finding is of very low safety significance as the total inoperability of the B MDAFW pump did not exceed TS allowed outage time and both the A MDAFW train and the steam driven auxiliary feedwater pump were operable.

Inspection Report# : [2002004\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Aug 30, 2002

Identified By: NRC

Item Type: FIN Finding

PROBLEM IDENTIFICATION AND RESOLUTION

The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution as evidenced by the inspectors' review of maintenance records, site programs, audits, assessments, external operating experience, and through plant tours. No deficiencies were identified which were not contained within the CAP. Oversight of the CAP was effective with the self evaluation group tracking program completion activities, grading action requests (ARs) to monitor quality, and using performance indicators to track CAP performance. CAP rollup meetings were good at identifying the causes of deficiencies and examining the potential for common causes and trends. Three examples were noted where ARs were rejected to resolve deficiencies outside of the CAP which were subsequently not initiated. The inspectors determined that the licensee generally classified discrepant conditions correctly, but had not yet implemented its plan to incorporate a formal process for using risk significance in classifying / prioritizing ARs. Two examples of incorrect AR classification were noted which were corrected by the licensee. Root cause investigations were generally thorough and corrective actions were appropriate to the root and contributing causes. One case was noted where the root cause was not comprehensive which was identified during the

licensee's AR effectiveness review. One example was identified where a corrective action assignment was signed off before it had been completed. Licensee audits and assessments were determined to be effective with all identified deficiencies noted to have been included within the CAP. Employee concerns reviewed were properly substantiated and entered into the CAP for resolution. All personnel interviewed felt free to input safety findings into the CAP for problem resolution. The team noted corrective action program ownership at every level and in all plant departments observed.

Inspection Report# : [2002005\(pdf\)](#)

Last modified : September 04, 2003