

## Calvert Cliffs 2

### 4Q/2003 Plant Inspection Findings

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#### Initiating Events

**Significance:**  Jun 28, 2003

Identified By: Self Disclosing

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 significance 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\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Failure to adequately evaluate suction stabilizer failures and perform repairs in a timely manner**

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, which requires that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Specifically, the licensee failed to promptly correct a condition adverse to quality associated with suction stabilizer failures, which if left uncorrected could have resulted in the failure of a charging pump. These failures occurred on the Unit 1, 13 charging pump in October, 2002, and on the Unit 2, 23 charging pump in September, 2002. The associated repairs were not timely and did not occur until October, 2003, and December 2003, respectively.

This finding is greater than minor because it affects the Reactor Safety, Mitigating Systems attribute of equipment performance, and the availability, reliability, and capability objective of the mitigating systems cornerstone because if left uncorrected, this condition could have led to the failure of a charging pump. The issue was of very low safety significance because the finding was not a design or qualification deficiency, the finding did not represent an actual loss of safety function, and the finding did not screen as potentially risk significant due to a seismic, fire flooding, or severe weather initiating event. Additionally, the failure of a charging pump did not occur while its suction stabilizer was in a failed condition. The inspectors identified that a contributing cause of this finding was related to the cross-cutting area of Problem Identification and Resolution.

Inspection Report# : [2003006\(pdf\)](#)

**Significance:**  Nov 07, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to prevent the recurrence of a significant condition adverse to quality involving mispositioning events**

A significant condition adverse to quality involving several component mispositioning events associated with several safety-related systems occurred between January 2002 and October 2003 and effective measures were not implemented to determine the cause of the problem and to preclude recurrence.

Inspection Report# : [2003009\(pdf\)](#)

**Significance:**  Nov 07, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to identify and correct repeated failures of CCWHX saltwater flow verification.**

The licensee failed to take appropriate corrective actions in a timely manner to address and correct repeat component cooling water heat exchanger (CCWHX) saltwater system test failures.

Inspection Report# : [2003009\(pdf\)](#)

**Significance:**  Mar 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

**Untimely & inadequate corr. actions to prevent 4kV breaker auxiliary switch failure. The condition review for SBM switches used in other applications have been inadequate and incompl. since 1996.**

A self-revealing NCV was documented regarding CCNP's inadequate and untimely corrective actions to prevent recurrence of SBM-type auxiliary switch failure as required by 10 CFR 50, Appendix B, Criteria XVI, "Corrective Action". The finding is considered a PI&R cross-cutting issue due to the failure to prevent recurrent SBM-type switch failures and due to inadequate and incomplete extent of condition reviews since CCNPP's review of industry operating experience regarding degraded and defective GE SBM switches in 1996.

The inspectors determined that this event was more than minor because the finding represented an actual loss of the safety function, for 28 days, for the 1B EDG to be capable of providing emergency electrical power to the 14 4kV vital emergency bus. The safety significance of this finding was very low because of a plant design feature that allows the Unit 2 motor driven auxiliary feedwater pump to supply the Unit 1 steam generators during a station blackout (no AC power) at Unit 1. (Section 40A3).

Inspection Report# : [2003002\(pdf\)](#)

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## Barrier Integrity

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## Emergency Preparedness



**Significance:** Mar 29, 2003

Identified By: NRC

Item Type: FIN Finding

**EAL initiating conditions caused delays in declar. approp. emerg. classifi. during simulator as a drill. The EALS & Oper. procedures in lieu of plant conditions alone contributed to this issue.**

The inspectors identified a finding that the CCNPP emergency action level (EAL) initiating conditions, as written, caused delays and an incorrect emergency classification declaration during a simulator scenario evaluated as a drill. A contributing cause of this finding was that the content of CCNPP's EALs incorporated plant conditions and operator implementation of procedures as initiating conditions in lieu of using plant conditions alone as the EAL initiating conditions.

This issue was determined to be more than minor because if left uncorrected it could become a more significant safety concern regarding the potential untimely public notification of an emergency. This finding was classified as Green (of very low safety significance) after NRC management review since the Emergency Preparedness (EP) Significance Determination Process (SDP) did not apply. (Section 1EP6)

Inspection Report# : [2003002\(pdf\)](#)

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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

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