

Calvert Cliffs 2

2Q/2004 Plant Inspection Findings

Initiating Events

Significance:  Jun 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to properly implement station emergency operating procedures. (Section 3.1)

The inspectors identified a non-cited violation of CCNPP Technical Specification 5.4.1.b because the operating crew did not properly implement station emergency operating procedures during the Unit 2 reactor trip reactor shutdown on January 23, 2004.

The finding was more than minor because it affected the Initiating Events Cornerstone in that the failures to follow station procedures complicated the plant's post-trip response and the ability of the operators to restore normal plant conditions. This finding had 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.

A contributing cause of the finding was related to the Human Performance cross-cutting area because licensed operators did not properly implement station emergency operating procedures. (Section 3.1)

Inspection Report# : [2004008\(pdf\)](#)

Significance:  May 28, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Combustible Material Control in Unit 1 69' West Electrical Room

The team identified a non-cited violation of License Condition 3.E, because Calvert Cliffs Nuclear Power Plant was not maintaining control of combustible materials in the Unit 1 69' West Electrical Room as described and approved in the safety evaluation report issued September 14, 1979.

Since the finding affected the initiating events cornerstone objective the finding is more than minor. The finding is of very low safety significance because the material was not located below cable trays carrying safety related cables and the material had been evaluated in the combustible loading calculations. (Section 1RO5.4)

Inspection Report# : [2004003\(pdf\)](#)

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 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:  Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate corrective actions for 480v breaker testing deficiency. (Section 40A2)

The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI. The licensee failed to promptly correct a testing deficiency identified during a CX relay failure in 1998. When action was taken in October of 2001, it was not sufficient to prevent further CX relay failures in December 2003 and February 2004.

This finding is more than minor because it affects the Mitigating Systems Cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and affects the availability and reliability of the 480 volt (v) electrical distribution system. The finding is of very low safety significance because the finding did not represent an actual loss of safety function and did not screen as potentially risk significant due to a seismic, fire, flooding or severe weather initiating event. The inspectors identified that a contributing cause of this finding was related to the cross-cutting area of Problem Identification and Resolution. (Section 40A2)

Inspection Report# : [2004005\(pdf\)](#)

Significance: TBD Jun 18, 2004

Identified By: Self Disclosing

Item Type: FIN Finding

Failure to adequately implement modification design review of the reactor regulating system quick open circuit. (Section 2.1.b.1)

A self-revealing event identified a finding of low to moderate safety significance, because Calvert Cliffs Nuclear Power Plant (CCNPP) did not perform a modification design review, as required by station procedures. Following a Unit 2 reactor trip on January 23, 2004, the atmospheric dump valves and turbine bypass valves automatically Quick Opened, as designed. However, the Quick Open signal did not clear when the reactor coolant temperature dropped below the Quick Open setpoint, because of a reactor regulating system relay failure. As a result, an uncontrolled cooldown of the reactor coolant system occurred, which in turn caused a loss of the normal heat removal system.

This finding was more than minor because it was considered to be a precursor to a more significant event. A Significance Determination Process Phase-3 risk analysis determined that this finding was of low to moderate safety significance, based on the change in core damage frequency. (Section 2.1.b.1)

Inspection Report# : [2004008\(pdf\)](#)

Significance:  Jun 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Test records for safety related work not retained by document control. (Section 2.3)

The inspectors identified a non-cited violation of very low safety significance of 10 CFR 50 Appendix B, Criterion XVII, "Quality Assurance Records," because CCNPP did not retain records of test results. From 1999 to March 2004, CCNPP did not retain wiring verification point-to-point test records for modifications of safety-related circuits. As a result, after the records are transferred to Records Management, verification of the work performed cannot be done.

This finding was more than minor because the failure to retain the required records was not an isolated example, and the records were irretrievably lost, similar to example 1.b in NRC Inspection Manual 0612 Appendix E. This finding was not suitable for a Significance Determination Process evaluation, but was reviewed by NRC management and determined to be of very low safety significance.

A contributing cause of this finding was related to the Human Performance cross-cutting area because station personnel did not adequately implement written instructions in a safety-related procedure. (Section 2.3)

Inspection Report# : [2004008\(pdf\)](#)

Significance:  Jun 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to have procedures required by regulatory guide 1.33. (Section 3.2)

The inspectors identified a non-cited violation of CCNPP Technical Specification 5.4.1.a because CCNPP did not have a procedure (off-normal) for the failure of the reactor regulating system (RRS) as required by Regulatory Guide 1.33.

This finding was more than minor because if the operators had switched to the alternate channel of RRS, after the failure of the RRS relay in the X channel, the atmospheric dump valves (ADV) and turbine bypass valves (TBVs) would have properly controlled reactor temperature and terminated the uncontrolled cooldown. This finding had 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 3.2)

Inspection Report# : [2004008\(pdf\)](#)

Significance:  Jun 18, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Failure to adequately implement modification work instructions for wiring terminations. (Section 2.2.b.1)

A self-revealing event identified a non-cited violation of very low safety significance of Technical Specification 5.4.1, because CCNPP did not adequately implement modification work instructions. As a result, during a plant event, recovery actions were delayed because operators were unable to reset the "B" channel of the safety injection actuation signal (SIAS) system from the control room.

This finding was more than minor because the SIAS system was returned to service, following modification work, and subsequently became unable to

perform its function, similar to example 5.b in NRC Inspection Manual 0612 Appendix E. This finding had very low safety significance because the finding did not represent an actual loss of a safety function.

A contributing cause of this finding was related to the Human Performance cross-cutting area because maintenance technicians did not adequately implement written work instructions. (Section 2.2.b.1)

Inspection Report# : [2004008\(pdf\)](#)

Significance:  May 28, 2004

Identified By: NRC

Item Type: FIN Finding

Inadequate Breaker Coordination

The team identified a finding in that protective relay settings for the bustie circuit breakers for the 1A and OC emergency diesel generators were not adequately coordinated with the feeder breakers for the 4kV/480V service transformers supplying the 480VAC load centers.

Because the finding affected the design control attribute of the mitigating systems cornerstone, it was more than minor. Since the issue did not result in an actual loss of a safety function of a single train of equipment, the issue was determined to be of very low safety significance.

Inspection Report# : [2004003\(pdf\)](#)

Significance:  May 28, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to provide protection in accordance with 10 CFR Part 50, Appendix R, Section III.G.2

The team identified a non-cited violation of 10 CFR Part 50, Appendix R, Section III.G.2, because Calvert Cliffs Nuclear Power Plant utilized manual actions to operate equipment necessary for achieving and maintaining hot shutdown in lieu of providing protection to the cables associated with that equipment, as required by the regulation.

In accordance with the guidance provided in inspection procedure 71111.05, "Fire Protection", (revision dated 3/6/03) this finding is greater than minor. The finding is of very low safety significance because the manual actions are reasonable and are expected to meet the criteria outlined in the Enclosure 2 of inspection procedure 71111.05. (Section 1RO5.5)

Inspection Report# : [2004003\(pdf\)](#)

Significance:  Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Prevent Recurrence of a Degraded Bearing Condition

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 significant conditions adverse to quality are promptly identified and corrected. Specifically the licensee failed to promptly identify a significant condition adverse to quality associated with the #10 upper crankcase bearing on the 2A Emergency Diesel Generator (EDG). This condition if left uncorrected could have resulted in the failure of the EDG. This degraded condition occurred in 1995 and again in October 2003, on the 2A EDG. As a result of the October 2003 degraded condition, the licensee requested an Notice of Enforcement Discretion (NOED) since repair activities would exceed the allowable outage times as specified in Technical Specification (T.S.) 3.8.1, "A.C. Sources - Operating". The NRC granted a NOED to the licensee on October 10, 2003.

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. If left uncorrected, this condition could have led to the failure of the 2A EDG.

This finding was of very low safety significance because the degraded condition did not result in an actual failure of the EDG to perform its safety function. The inspectors identified that a contributing cause of this finding was related to the cross-cutting area of Problem Identification and Resolution. (Section 1R12)

Inspection Report# : [2004004\(pdf\)](#)

Significance:  Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Effective Corrective Actions Associated with Component Mispositioning Events

The inspector selected seven issues identified in the Corrective Action Program (CAP) for detailed review (Issue Report Nos. IR4-008-987 and -988, IR4-009-607, -608, -642, and -680, and IR4-023-854). The issues were associated with site dose reduction, inadvertent release of radioactive material from the RCA, position qualifications,

completion and documentation of required training, negative trends in written communications identified by self-assessment review, and documentation of radioactive material storage locations. On February 5, the inspector met with the Health Physics Support Supervisor to discuss these Issue Reports.

The documented reports for the issues were reviewed to ensure that the full extent of the issues was identified, an appropriate evaluation was performed,

and appropriate corrective actions were specified and prioritized.

Inspection Report# : [2004004\(pdf\)](#)

G

Significance: Jan 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

HPSI Design Support/Seismic Structural Records not Retrievable (Section 1R21.b.1)

The team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVII, Quality Assurance Records, related to the licensee's inability to retrieve records required to furnish evidence of the adequate performance of activities affecting the quality of the high pressure safety injection (hPSI) system. Specifically, quality records, identifiable with both the design change details for a Unit 2 HPSI pipe support snubber installation and the design calculations for the seismic adequacy for structural platforms in the refueling water tank (RWT) rooms in Units 1 & 2, were not retrievable.

The finding was evaluated using Manual Chapter 0612, Appendix E, example 1.b and determined to be more than minor because the records were irretrievable lost. The finding was associated with the attribute of design control (initial design, plant modifications). This issue is considered a very low safety significance finding because, while the required records were not retrievable, an as-built design review was conducted by the licensee which demonstrated the structural adequacy of the existing field configurations (Section 1R21.b.1)

Inspection Report# : [2004002\(pdf\)](#)

G

Significance: Jan 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

High Pressure Safety Injection System Operation Outside of Design Basis (Section 1R21.b.2)

The team identified a non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, Design Control, for Constellation Energy Group's (CEG) failure to correctly translate the emergency core cooling system (ECCS) design basis into the HPSI system operating instructions and procedures. Specifically, for shot durations during surveillance test activities, the HPSI loop isolation valve was placed in a condition that could impact core cooling if the redundant train of HPSI were to fail.

The finding was more than minor because it affected the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events (i.e., loss of coolant accidents) to prevent undesirable consequences (core damage). The finding was associated with the attribute of configuration control (operating equipment lineup). The finding was of very low safety significance because it represented the loss of single train of HPSI for less than the TS 3.5.2.A allowed outage time (72 hours) during each occurrence. (Section 1R21.b.2)

Inspection Report# : [2004002\(pdf\)](#)

G

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\(pdf\)](#)

G

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\(pdf\)](#)

G

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\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Significance:  Jun 18, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to recognize an unusual event during the Unit 2 reactor trip. (Section 4.1)

The inspectors identified a non-cited violation of 10CFR50.54(q) because the operating crew did not properly recognize plant conditions commensurate with an Unusual Event in accordance with the emergency plan and implementing procedures during the Unit 2 reactor trip on January 23, 2004.

This finding was more than minor because it effected the response organization performance attribute of the Emergency Preparedness Cornerstone in that failure to properly recognize plant conditions commensurate with an Unusual Event classification. This finding was of very low safety significance, because it involved an implementation problem during an actual event and the CCNPP staff failed to identify the Unusual Event in the post trip review.

This finding is related to the Human Performance cross-cutting area because the operating crew did not properly recognize plant conditions commensurate with an Unusual Event in accordance with the emergency plan during a Unit 2 excessive steam demand event on January 23, 2004. (Section 4.1)

Inspection Report# : [2004008\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Significance: N/A Nov 07, 2003

Identified By: NRC

Item Type: FIN Finding

Problem Identification & Resolution Team Assessment

The team determined that the licensee was generally effective at identifying discrepant conditions at an appropriate threshold and entering them into the corrective action program. Once entered into the system, issues were usually prioritized appropriately and in a timely fashion, and were evaluated in adequate detail commensurate with the safety significance. Overall, the evaluations reasonably identified the causes of the problem, the extent of the condition, and provided for corrective actions to address the causes. However, in some cases, the corrective action program was not being used effectively and consistently to resolve and prevent problems. There were some instances where issue reports were characterized at a lower category than prescribed by the corrective action program. Further, the team identified some instances where issue evaluations, as well as the associated corrective

actions, were not effective in resolving problems. On the basis of interviews conducted during the inspection, workers at the station felt free to input safety findings into the corrective action program.

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

Last modified : September 08, 2004