

Hatch 1

3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: **G** Dec 31, 2004

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Lube Oil Cooler Failure Results in Emergency Diesel Generator Inoperability

A self-revealing non-cited violation was identified for a failure to take prompt action to correct a condition adverse to quality which resulted in a 1C Emergency Diesel Generator (EDG) Lube Oil Cooler tube failure which rendered the 1C EDG inoperable.

The finding is greater than minor because it adversely affected the Equipment Performance attribute of the Mitigating Systems cornerstone in that the availability of the 1C EDG to respond to Initiating Events was impacted. The finding was determined to be of a very low safety significance because the required redundant equipment trains were operable and the 1C EDG was restored to operable status within the Technical Specification allowed outage time. This finding involved the cross cutting aspect of Problem Identification and Resolution. Inspection Report# : [2004005\(pdf\)](#)

Barrier Integrity

Significance: **G** Jul 29, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Implement Design Control Measures

A non-cited violation of 10 CFR 50, Appendix B, Criterion III, involving the failure to adequately control the configuration of the drywell to torus vacuum breaker actuators was identified. This resulted in the failure to maintain containment integrity requirements because one of two required barriers for containment integrity was inappropriately removed during a design change of the actuators.

This finding is more than minor because it affected the configuration control attribute of the Barrier Integrity cornerstone to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. This finding was determined to be of very low safety significance (Green) because for each of the affected torus vacuum breaker actuators, the outboard containment isolation valve in the associated penetration remained functional. This finding affects the human performance crosscutting area in that licensee staff failed to adequately implement the site process for design controls. Inspection Report# : [2005006\(pdf\)](#)

Emergency Preparedness

Significance: **W** Jun 30, 2005

Identified By: NRC

Item Type: VIO Violation

Failure to Maintain Facilities and Equipment to Support Emergency Response

The NRC identified an apparent violation associated with emergency preparedness planning standard 10 CFR 50.47(b)(8). [The Technical Support Center (TSC) was rendered inoperable for greater than seven days due to planned modification activities.]

This finding is greater than minor because it is associated with the Facilities and Equipment attribute of the Emergency Preparedness (EP) Cornerstone and impacts the objective of the Hatch TSC to maintain facilities and equipment to support emergency response in that the TSC was inoperable during the modification activities and could not be returned to operable within a short period. Based upon IMC 0609, Appendix

B, Emergency Preparedness Significance Determination Process, Sheet 1, and the examples provided in Section 4.8, this finding was [preliminarily] determined to be of low to moderate safety significance (White) because the PS function was lost in that the TSC was inoperable for greater than seven days due to a planned outage in which activities were not scheduled to proceed with high priority for completion.
Inspection Report# : [2005009\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Significance:  Mar 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Appropriate DOT Type A Package Closure Requirements

An NRC-identified non-cited violation of 10 CFR 71.5 was identified for failure to implement current package design specifications for proper closing of Type A shipping packages (CRDM shipment boxes) as required by DOT regulations. Specifically, for Type A packages containing CRDM equipment shipped between January 2003 and February 2005, the licensee failed to prepare the package closures in accordance with vendor package specifications as required by 49 CFR 173.475(e).

This finding is more than minor because it is associated with the public radiation cornerstone program and process attribute and it affected the cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive material released into the public domain. The issue was reviewed using the Public Radiation Safety Significance Determination Process and was determined to be of very low safety significance (Green) because a radiation limit was not exceeded nor was the packaging breached. In addition, previous shipments made by the licensee had arrived at their destination with no identified degradation of the subject packaging and immediate corrective actions assured that on-going CRDM equipment packages were prepared properly prior to shipment.

Inspection Report# : [2005002\(pdf\)](#)

Physical Protection

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

Miscellaneous

Significance: N/A Jul 29, 2005

Identified By: NRC

Item Type: FIN Finding

Biennial Identification and Resolution of Problems Inspection Assessment

The inspectors identified that the licensee was generally effective at identifying problems and entering them into the corrective action program (CAP) for resolution. The licensee maintained a low threshold for identifying problems as evidenced by the continued large number of condition reports (CR) entered annually into the CAP. The inspectors also determined that the licensee was generally prioritizing and evaluating issues properly. The inspectors identified minor problems involving corrective actions for operating experience not being documented within the corrective action program, timeliness of evaluations, and corrective actions which were incomplete. Non-cited violations (NCVs) related to the effectiveness of corrective actions and inadequate evaluation of issues were identified. Audits and self-assessments continued to identify issues related to the corrective action program. On the basis of interviews conducted during the inspection, the inspectors identified that personnel at the site felt free to raise safety concerns to management and to resolve issues via the CAP.

Inspection Report# : [2005006\(pdf\)](#)

Last modified : November 30, 2005