

Hatch 2

3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: **G** Jul 29, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Prompt Corrective Actions for an NCV

A non-cited violation of 10 CFR 50, Appendix B, Criteria XVI, involving the failure to take prompt corrective actions for a previously identified NCV was identified. This resulted in the failure to evaluate and restore compliance with 10 CFR 50 Appendix R.

This finding is greater than minor because it affected the reliability objective and the equipment performance attribute of the Mitigating Systems cornerstone. Although emergency lighting units with at least an 8-hour battery power supply were not provided as required by 10 CFR 50, Appendix R, Section III.J, the inspectors determined that operators would be able to accomplish the actions with the use of flashlights. The inspectors determined that the finding affected the "Post-fire SSD" category in that it affected the ability to complete post-fire actions. Because the operators had a high probability of completing the task using flashlights, a low degradation rating was assigned due to minimal impact on the effectiveness of post-fire actions. Therefore, this finding was determined to have very low safety significance (Green). This finding affects the corrective action attribute of the Problem Identification and Resolution crosscutting area.

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

Significance: **G** Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Untimely and Unapproved Manual Operators Actions for Post-Fire SSD

The inspectors identified a non-cited violation of Technical Specification 5.4.1.a because Abnormal Operating procedure 34AB-X43-001-2, "Fire Procedure," was not adequate to preclude spurious opening of all eleven safety relief valves (SRVs) during plant fires. In lieu of protecting the cables, a local manual operator action was directed to preclude spurious opening of the SRVs as a result of fire damage to cables in the SRV control circuitry. The inspectors determined that the local manual operator action would not be performed in sufficient time to be effective.

The finding is greater than minor because it affects the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, spurious operation of all SRVs during certain fire scenarios could complicate post-fire recovery actions. The finding is associated with the protection against external factors attribute. The finding was evaluated using the Fire Protection SDP and was determined to be a finding of very low safety significance because the likelihood of starting a fire in Fire Area 2104 was very low and equipment needed to mitigate the transient caused by all SRVs opening would be unaffected by the fire. In addition, the inspectors verified the systems and equipment required to achieve and maintain hot shutdown conditions would remain free of fire damage and that safe shutdown capability could be achieved even with all SRVs open.

Inspection Report# : [2005003\(pdf\)](#)

Barrier Integrity

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