

Hatch 2

1Q/2008 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2007

Identified By: Self-Revealing

Item Type: FIN Finding

Improper Test Lead Construction Results in Plant Transient

A self-revealing finding was identified for the licensee's failure to follow proper work practices during construction of two test leads in accordance with skill of the craft training. The failure of the test leads resulted in an abrupt speed decrease in the Unit 2 'B' Recirculation Pump and a reactor power reduction.

The inspectors determined that a performance deficiency existed because work practices were not followed in accordance with skill-of-the-craft training. This finding is greater than minor because it is associated with the human performance attribute of the Initiating Event Cornerstone and affected the objective in that it resulted in a rapid 2B recirculation pump speed reduction and reactor power transient. This finding was determined to be of very low safety significance because there were no complications associated with this transient and all mitigation systems remained available. The inspectors did not identify a specific cross-cutting aspect associated with this issue.

Inspection Report# : [2007005](#) (*pdf*)

Significance:  Sep 30, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Maintenance Instructions Results in Reactor Scram during Generator Recorder Calibration

A self-revealing non-cited violation (NCV) of 10CFR50 Appendix B, Criterion V, Instructions, Procedures, and Drawings, was identified for inadequate work instructions provided to workers for the calibration of a main generator output recorder. The calibration was performed with the main generator on-line which caused a sensed power load unbalance (PLU) resulting in a reactor scram.

This finding is greater than minor because it is associated with Equipment Performance attribute and adversely affected the Initiating Events cornerstone objective in that it resulted in a challenge to safety functions at power. The finding was determined to be of a very low safety significance because no other mitigating equipment or functions were adversely affected. The inspectors determined this finding was related to the complete and accurate procedures aspect of the human performance cross-cutting area (H.2c). The licensee has entered this issue their corrective action program (CAP) as Condition Report (CR) 2006104201. (Section 4OA3.3)

Inspection Report# : [2007004](#) (*pdf*)

Mitigating Systems

Significance:  Aug 17, 2007

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Update Parts Specifications Following a Design Modification

A self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion III was identified for failure to control the design aspects of a plant modification. The licensee failed to incorporate vendor parts and specifications for a modification to the Unit 1 residual heat removal (RHR) pump discharge check valves.

The team determined this finding is more than minor because it was related to the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective in that the repeat failures resulted

in unplanned unavailability of one train of RHR. This finding is of very low safety significance because it did not result in loss of safety function for a single train greater than allowed Technical Specification outage time. The team determined this finding was of very low safety significance because it did not result in loss of safety function for a single train greater than allowed Technical Specification outage time. The team determined this finding involved a Human Performance cross-cutting aspect of complete, accurate and up-to-date design documentation, procedures, and work packages in that the vendor part number for the non-counterweighted valve disk hanger was not reflected in current station documents. The licensee has entered this violation into their corrective action program as CR 2007107101.

Inspection Report# : [2007006 \(pdf\)](#)

Significance:  Aug 17, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Required ASME Code, Section XI Testing

An NRC-identified Green non-cited violation of 10 CFR 50.55a(g)(4) for the failure to perform periodic leakage testing of buried piping sections of the High Pressure Coolant Injection (HPCI) and Standby Diesel Service Water (SBDSW) systems as required by Section XI of the ASME Code for the third 10-year In-service Inspection (ISI) interval.

This finding is more than minor because it affects the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective in that if a significant leak or rupture should occur as a result of undetected piping degradation, water could not be delivered to mitigating system components preventing these systems from fulfilling their intended safety functions. This finding is of very low safety significance (Green) because it does not represent an actual loss of a system's safety function. Further, the licensee performed the required testing on the SBDSW piping on May 22, 2007, and performed HPCI piping inspections in 2005 and found no significant degradation. This finding was reviewed for any cross-cutting aspects and none were identified. The licensee has entered the violation into their corrective action program as CRs 2007102265 and 2007104138.

Inspection Report# : [2007006 \(pdf\)](#)

Barrier Integrity

Significance:  Mar 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Equipment Clearance Procedures Results in Control Room Ventilation Inoperability

A self revealing non-cited violation of 10 CFR 50 Appendix B, Criterion V was identified for the failure to recognize the impact of a clearance activity on the Main Control Room Environmental Control (MCREC) system. The licensee entered this violation into their Corrective Action Program (CAP) as Condition Report (CR) 2008102274.

Failure to recognize the impact of a clearance activity on the MCREC system is a performance deficiency. This finding is more than minor because it is associated with the structure, system, component and barrier performance attribute as it relates to the radiological barrier functionality of the control room of the Barrier Integrity cornerstone. The inspectors determined the finding was of very low safety significance because the loss of the air handling units represents a degradation of the radiological barrier function (control room pressurization) only. This finding is related to the work practices aspect of the human performance cross-cutting area in that the full impact of the clearance was not properly identified and assessed in accordance with the equipment clearance procedure. (H.4(a))

Inspection Report# : [2008002 \(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Aug 17, 2007

Identified By: NRC

Item Type: FIN Finding

Biennial Identification and Resolution of Problems Inspection Summary

Two Green non-cited violations (NCVs) were identified. The team 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 (CRs) entered annually into the CAP. The team also determined the licensee was generally prioritizing and evaluating issues properly. The team 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. NCVs related to the effectiveness of corrective actions and inadequate evaluation of issues were identified. Audits and selfassessments continued to identify issues related to the corrective action program. On the basis of interviews conducted during the inspection, the team identified that personnel at the site felt free to raise safety concerns to management and to resolve issues via the CAP.

Inspection Report# : [2007006](#) (*pdf*)

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