Hatch 2
3Q/2008 Plant Inspection Findings

Initiating Events

Significance: G 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)*

Mitigating Systems

Significance: G Mar 07, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inadequate Response to Water Contaminated Oil Results in HPCI Unavailability
A Green NRC identified non-cited violation of 10 CFR 50 Appendix B, Criterion XVI, Corrective Action, was identified when the licensee failed to thoroughly identify and correct water intrusion into the High Pressure Coolant Injection (HPCI) lubricating oil system (LOS) on two separate occasions. Residual water from these events was not fully removed which resulted in corrosion of the HPCI turbine controls. This violation was entered into the licensee's corrective action program (CAP) as CR 2008100154.

The inspector determined the performance deficiency was the failure to remove all residual water from the HPCI LOS following water intrusion on two separate occasions. The finding was more than minor because it was associated with the equipment performance attribute and adversely affected the objective of the Mitigating Systems cornerstone in that unplanned corrective maintenance of the HPCI pump rendered the system unavailable to respond to initiating events. This finding was determined to be of very low safety significance because the failure did not represent a loss of safety function of a single train. The inspector determined this finding was related to the thoroughness of evaluations aspect of the Problem Identification and Resolution cross cutting area.

Inspection Report# : 2008006 *(pdf)*

Barrier Integrity

Significance: G Sep 19, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Incomplete Mitigating Strategy Required by Facility Operating License (Section 4AO5.2 c)
This B.5.b Pase 2 and 3 Mitigating Strategy Finding has been classified as OUO containing sensitive information classified under 2.390 - see inspection report for details.
Inspection Report# : 2008007 *(pdf)*

Significance: G 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

Last modified : November 26, 2008