# Hatch 1
# 3Q/2009 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:** G Jun 30, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to Maintain Fire Brigade Minimum Staffing**
Green. A Green NRC identified NCV of License Conditions 2.C.(3) for Unit-1 and 2.C.(3).(a) for Unit-2 was identified for failure to implement and maintain in effect all provisions of the approved fire protection program. Specifically, the licensee failed to maintain adequate fire brigade staffing by assigning the Unit-1 Operator at the Controls (OATC) the additional responsibility of Fire Brigade Leader. The licensee entered the issue into the corrective action program (CAP) for resolution.

This finding is more than minor because it affected the protection from external factors (fire) attribute of the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance (Green) because the shift staffing compliment was adequate to support the safe shutdown operating functions and independent fire brigade. In addition, the condition existed for only one 12-hour shift. The cause of the finding is related to the cross-cutting element of Human Performance. (Section 4OA2)
Inspection Report# : 2009003 *(pdf)*

**Significance:** W Mar 10, 2009
Identified By: NRC
Item Type: VIO Violation
**1B EDG Coupling Failure**
TBD. A self-revealing apparent violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, was identified for failure to promptly identify and correct a condition adverse to quality. Since 1988, the licensee had observed cracks in the glands of the EDG couplings, but did not identify the cracking was an indication of coupling degradation. Therefore, no condition report was written to identify and correct the condition adverse to quality. Consequently, the 1B coupling developed higher than normal vibration on July 12, 2008, during a routine surveillance which prompted the licensee to declare the 1B EDG inoperable.

The failure to promptly identify and correct a condition adverse to quality for the observed degraded condition of the 1B EDG coupling is a performance deficiency. This finding is more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and adversely affected the objective in that there was no reasonable assurance the 1B EDG could meet its mission time. This finding was assessed using the applicable SDP and preliminarily determined to White because there was a calculated risk increase over the base case between 1E-5 and 1E-6. The dominant sequences included (1) LOOP with loss of emergency power (SBO), success of RCIC, successful depressurization, failure to recover offsite power and the EDGs within 5 hours, and failure of firewater injection due to repressurization caused by inability to operate SRVs without DC power (2) a Transient induced LOOP with failures of PCS and HPCI, successful depressurization and failure of all injection due to inability to recover EDGs or offsite power and (3) LOOP with loss of emergency power, RCIC, and HPCI with failure to recover offsite power and the EDGs. The HPCI system is failed in the model with loss of room cooling due to SBO. The exposure period was a total of 182 days including the 4 day repair interval and the 178 day interval consisting of the individual success periods.

Inspection Report# : 2008009 *(pdf)*
Inspection Report# : 2009008 *(pdf)*

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

**Significance:** G Mar 31, 2009
Identified By: NRC
Item Type: NCV NonCited Violation
**Failure to provide training to users of powered air-purifiying respirators**
The inspectors identified a Green non-cited violation (NCV) of TS 5.4, Procedures, for failure to provide training to users of Powered Air-purifying Respirator (PAPR) type respiratory protection devices as required by procedure 10AC-MGR-026-0, Respiratory Protection Program, revision 1.0. The licensee has entered this issue into the Corrective Action Program as Condition Report 2009102825.

This finding is greater than minor because it is associated with the Occupational Radiation Safety Cornerstone attribute of Human Performance (Training) and adversely affects the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The finding was evaluated using the Occupational Radiation Safety SDP and determined to be of very low safety significance (Green). The finding was not related to ALARA planning, nor did it involve an overexposure or substantial potential for overexposure, and the ability to assess dose was not compromised. This finding involved the cross-cutting aspect of Human Performance, Resources [H.2.b] because there was no formal training program provided to users of PAPR type respiratory protection devices. (Section 2OS3)

Violations of very low safety significance, which were identified by the licensee, have been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. These violations and corrective actions are listed in Section 4OA7 of this report

Inspection Report# : 2009002 *(pdf)*

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## Public Radiation Safety

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## 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.

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# Miscellaneous

Last modified : December 10, 2009