

Hatch 2

3Q/2009 Plant Inspection Findings

Initiating Events

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: **G** Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Preconditioning of the turbine building plant service water isolation valves

An NRC-identified NCV of 10 CFR Part 50 Appendix B, Criterion XI, Test Control was identified for preconditioning of the Turbine Building Plant Service Water (PSW) Isolation Valves. A maintenance work order stoked the valves several times prior to performing the documented stroke time testing.

This finding is more than minor because if left uncorrected the finding had the potential to lead to a more significant safety concern in that other safety-related valve performance deficiencies could have been masked. In accordance with NRC Inspection Manual Chapter 0609, Significant Determination Process, the inspectors performed a Phase 1 analysis and determined the finding was of very low safety significance (Green) because the finding did not result in a loss of safety function. The finding has an associated cross-cutting aspect in the area of Problem Identification & Resolution. Specifically as it relates to implementation of Operating Experience (OE) because the licensee has reviewed prior OE describing unacceptable preconditioning, but failed to recognize preconditioning and prevent it prior to performing work associated with the maintenance work order [P.2.b]. (Section 1R22)

Inspection Report# : [2009002](#) (*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*)

Significance: SL-IV Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Report A Reportable Condition

A NRC-identified violation of 10 CFR 50.72, Immediate Notification Requirements for Operating Nuclear Power Reactors, and 10 CFR 50.73, Licensee Event Report System, was identified when the licensee did not recognize the loss of all three main control room (MCR) air handling units (AHUs) was a reportable condition. Consequently, the licensee failed to make an eight hour report as required by 10 CFR 50.72 and submit a licensee event report (LER) within 60 days as required by 10 CFR 50.73. This violation does not apply to Unit 1 because it was in a refueling outage and the AHUs were not required to be operating. This violation has been entered into the licensee's CAP as CR 2008111957.

Failure to recognize the loss of the MCREC system safety function was reportable is a performance deficiency. This finding was evaluated using traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function of event assessment. The inspectors determined this finding was a SL IV violation because the failure to report this condition did not substantively impact the Agency's regulatory responsibilities and the Agency would not have responded in a significantly different manner had the information been properly reported. This finding had the cross-cutting aspect of evaluating for reportability in the area of Problem Identification and Resolution (P.1(c)) because the licensee evaluated reportability only for the entry into TS LCO 3.0.3.

Inspection Report# : [2008005](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Improper core drill location results in secondary containment inoperability

A self-revealing NCV of 10 CFR Part 50 Appendix B, Criterion V, Instructions, Procedures, and Drawings, was identified because workers did not properly follow the work instructions during a core drilling activity which resulted in a breach of secondary containment. A maintenance worker missed the containment box designed to maintain secondary containment integrity during core drilling to support a plant modification.

The finding is more than minor because it adversely impacted the Configuration Control Attribute of the Barrier Integrity Cornerstone. The improper core drill caused secondary containment to become inoperable. In accordance with NRC Inspection Manual Chapter 0609, Significant Determination Process, the inspectors performed a Phase 1 analysis and determined the finding was of very low safety significance (Green) because the finding only affected secondary containment. The finding has an associated cross-cutting aspect in the area of Human Performance. Specifically, work practices as it relates to use of human error prevention techniques commensurate with the risk of the assigned task. The workers mistakenly measured the drill location from two different reference points above and below the floor [H.4.a]. (Section 1R18)
Inspection Report# : [2009002](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to provide training to users of powered air-purifying 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*)

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

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