

## Hatch 2

### 2Q/2015 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:** G Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Maintain HELB Penetrations**

A Green NRC identified non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion III, “Design Control,” was identified for failure to maintain reactor building residual heat removal (RHR) diagonal room penetrations in the designed configuration. The violation was entered into the licensee’s corrective action program as CR 10055943. The licensee issued work orders to seal the affected penetrations in accordance with design documents.

The licensee’s failure to maintain the penetration seals in accordance with design drawings was a performance deficiency. The performance deficiency was more than minor because it was associated with the Design Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective in that the failure to maintain the design basis configuration compromised the capability of the RHR diagonal room wall to restrict a high pressure coolant injection (HPCI) high energy line break to the torus area. The finding was of very low safety significance (Green) because the loss of component function did not significantly affect the function of the train or system. The inspectors determined that the finding had a cross-cutting aspect of “work management” in the human performance area (H.5), because the licensee’s work process did not control work activities such that nuclear safety was the overriding priority. (Section 1R15)

Inspection Report# : [2015002](#) (*pdf*)

**Significance:** G Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Identify Embedded Conduit prior to Core Drill Operations**

A self-revealing non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion V, “Procedures, Instructions, and Drawings,” was identified for failure to identify existing embedded conduit in the vicinity of prescribed core drills location. The violation was entered into the licensee’s corrective action program (CAP) as condition report (CR) 902506.

Failure to provide adequate instructions in Design Change Package (DCP) SNC467474 to perform core drills in the Unit 2 control building to support conduit installations was a performance deficiency. This performance deficiency is more than minor because it affected the Equipment Performance attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective in that 2P41F316A was rendered incapable of performing its’ safety related function of closing in the event of an accident condition. The finding was screened as Green because the inoperability did not last longer than the technical specification (TS) allowed outage time. The inspectors determined the performance deficiency has a cross-cutting aspect of “work management” in the human performance area, because

the licensee's work process did not identify and manage the risk commensurate to the core drill work.

Inspection Report# : [2015001](#) (*pdf*)

**Significance:**  Sep 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to Implement Fire Surveillance Procedure Resulted in Isolation of All Fire Water to the Station**

The NRC identified a NCV of Technical Specification 5.4, "Procedures," for the licensee's failure to properly implement a valve lineup in a surveillance procedure for the fire protection system. The licensee inadvertently isolated all fire suppression water during the performance of a valve lineup. Although this condition was identified by the licensee, the inspectors identified weaknesses in the licensee's apparent cause determination. Therefore, this finding is being treated as an NRC-Identified finding. The violation was entered into the licensee's corrective action program as condition report 841493.

The licensee's failure to implement the correct valve lineup in accordance with procedure 42SV-FPX-015-0, "System Flush Fire Protection Water", was a performance deficiency. This performance deficiency was more than minor because the performance deficiency was associated with the Protection Against External Factors (Fire) attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective in that the failure to implement the correct valve lineup of 42SV-FPX-015-0 resulted in total fire suppression water isolation. The inspectors screened this finding as requiring a Phase 3 analysis, because 1) the duration factor was determined to be 0.01 (< 3 Days), 2) the summation of estimated fire frequency for the fire areas was calculated to 1.24E-01, and 3) the delta CDF calculation was greater than 1E-6 in Table 1.5.4. A Senior Reactor Analyst performed a Phase 3 analysis for the finding using licensee input from their fire PRA. Because of the short exposure time of approximately one hour, the change in risk was below 1E-6. Therefore, this finding is Green. The finding had a cross-cutting aspect of "resources" in the human performance area, because the licensee did not ensure that procedure 42SV-FPX-015-0 was adequate to support nuclear safety. [H.1]

Inspection Report# : [2014004](#) (*pdf*)

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

**Significance:**  Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to perform adequate surveys of air samples for alpha activity**

An NRC-Identified non-cited violation (NCV) of 10 CFR 20.1501(a) was identified for failure to perform an adequate survey. Air samples obtained in the reactor cavity and on the refuel floor during a contamination event indicating

greater than 0.3 beta-gamma Derived Air Concentration (DAC) fraction level were not analyzed for alpha activity as required by the licensee's procedures. Previous characterization of the area had determined the area to be an Alpha Level II area requiring additional assessment and evaluation of air samples. This violation was entered into the licensee's CAP as CR 10033022.

This finding is greater than minor because it was associated with the Occupational Radiation Safety Cornerstone attribute of Program and Process (Monitoring and RP Controls) and adversely affected the cornerstone objective in that failure to identify potentially significant contributors to internal dose could lead to unmonitored occupational exposures. The finding was determined to be of very low safety significance (Green) because it was not related to As Low As Reasonably Achievable (ALARA) Planning and the ability to assess dose was not compromised during these instances. The cause of this finding was directly related to the cross-cutting aspect of leaders ensuring equipment, procedures, and other resources are available and adequate in the Resources component of the Human Performance area. [H.1]

Inspection Report# : [2015001](#) (*pdf*)

**Significance:**  Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

**Failure to perform complete analysis of air samples**

An NRC-Identified non-cited violation (NCV) of TS 5.4.1 was identified for the failure of the licensee to perform complete quantitative analysis of air samples using approved counting equipment as required by the licensee's procedures. NMP-HP-301, Step 5.6, provides guidance for quantitative evaluation of air samples. On February 16, and 25, 2015, air samples for work activities in the Reactor Pressure Vessel head (RPV) and the Reactor Water Cleanup (RWCU) System heat exchanger were not quantitatively analyzed or evaluated for alpha activity even though the areas had been identified as having elevated alpha contamination levels. The licensee entered the issue into their corrective action program (CAP) as CR 10034556.

The finding was more than minor because it was associated with the Occupational Radiation Safety Program attribute of exposure control and affected the cornerstone objective of ensuring adequate protection of worker health and safety from exposure to radiation from airborne radioactive material during routine civilian nuclear reactor operation. Failure to identify potentially significant contributors to internal dose could lead to unmonitored occupational exposures. The finding was determined to be of very low safety significance (Green) because it did not involve: (1) an as low as is reasonably achievable finding, (2) an overexposure, (3) a substantial potential for overexposure, or (4) an impaired ability to assess dose related to As Low As Reasonably Achievable (ALARA) Planning and the ability to assess dose was not compromised during this instance. The cause of this finding was directly related to the cross-cutting aspect of following processes, procedures, and work instructions in the Procedure Adherence component of the Human Performance area.

Inspection Report# : [2015001](#) (*pdf*)

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## Public Radiation Safety

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## Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission

has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

Last modified : August 07, 2015