Hatch 2 1Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: Mar 27, 2004 Identified By: Self Disclosing Item Type: NCV NonCited Violation

Inadequate Maintenance Instructions Results in Emergency Diesel Generator Start and Inoperability

A self-revealing non-cited violation (NCV) was identified for inadequate work instructions provided to workers to remove a section of Plant Service Water (PSW) piping. This resulted in spilling water on to the 2C Emergency Diesel Generator (EDG) relay panel causing an auto-start of the 2C EDG and subsequent inoperability.

This finding is more than minor because it adversely affected the equipment performance attribute of the Mitigating Systems cornerstone in that the water spillage affected EDG operability. The finding was determined to be of a very low safety significance because the required redundant equipment trains were operable and the 2C EDG was restored to operable status within the Technical Specification (TS) allowed outage time.

Inspection Report#: 2004002(pdf)

Significance:

Aug 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Actions For A Previous Violation

A Green NCV of 10 CFR 50, Appendix B, Criteria XVI, involving inadequate corrective actions for a previously identified NCV was identified. This resulted in the failure to perform a Technical Specification surveillance requirement within the specified frequency.

This finding is more than minor because if left uncorrected TS required surveillances would not be performed due to procedural inadequacies. Specifically, this finding involved the failure to determine the extent of condition with regard to procedural deficiencies following initial identification of deficiencies in September 2001. In this instance, the individual channel response times could have become greater than the maximum values assumed in the safety analysis associated with the Minimum Critical Power Ratio (MCPR) Safety Limit. This missed surveillance requirement was determined to be of very low safety significance (Green) because the subsequent successful performance of the response time test demonstrated the relays were operable at all times.

Inspection Report#: 2003007(pdf)

Significance: Aug 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate Pressure Transients on Safety Related System

A Green NCV of 10 CFR 50, Appendix B, Criteria XVI, was identified for failure to identify that recurring pressure transients during Residual Heat Removal Service Water (RHRSW) pump startup required evaluation.

This finding is is more than minor because on multiple occasions the piping design pressure was exceeded yet the licensee failed to evaluate the effect of the pressure transient on the system. This issue is of very low safety significance (Green) because it did not actually result in the safety related system being inoperable for greater than the time allowed by plant TS.

Inspection Report# : 2003007(pdf)

Significance:

Jul 25, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Unapproved Manual Operator Actions for Post-Fire Safe Shutdown

Green. The team identified a non-cited violation of 10 CFR 50, Appendix R, Section III.G.2 in that the licensee relied on some manual operator actions to operate safe shutdown equipment, instead of providing the required physical protection of cables from fire damage without NRC approval.

The finding is greater than minor because it affected the availability and reliability objectives and the equipment performance attribute of the mitigating systems cornerstone. Since the actions could reasonably be accomplished by operators in a timely manner, this finding did not have potential safety significance greater than very low safety significance.

Inspection Report# : 2003006(pdf)



Jul 25, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Emergency Lighting for Operation of Post-Fire SSD Equipment

Green. The team identified a non-cited violation 10 CFR 50, Appendix R, Section III.J because emergency lighting was not adequate for some manual operator actions that were needed to support post-fire operation of safe shutdown equipment.

The finding is greater than minor because it affected the reliability objective and the equipment performance attribute of the mitigating systems cornerstone. Since operators would be able to accomplish the actions with the use of flashlights, this finding did not have potential safety significance greater than very low safety significance.

Inspection Report# : 2003006(pdf)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Aug 29, 2003

Identified By: NRC Item Type: FIN Finding

Biennial Problem Identification and Resolution Inspection Results

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 (CR) entered annually into the CAP. The team also determined that the licensee was generally prioritizing and evaluating issues properly. The team concluded however, that deficiencies exist in the implementation of effective corrective actions to prevent recurrence. Numerous repetitive equipment problems had not been resolved in a timely manner. Two NCVs involving 10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, were identified. Audits and self-assessments 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# : 2003007(pdf)

Last modified: May 05, 2004