Initiating Events

Mitigating Systems



Item Type: NCV NonCited Violation

Failure to Demonstrate that the Traveling Water Screen System Was Effectively Controlled per 10 CFR 50.65 (a)(2)

An NRC-identified Non-Cited Violation (NCV) of 10 CFR 50.65 (Maintenance Rule) was identified for failing to demonstrate that the performance of the Traveling Water Screens (TWS) was being effectively controlled through the performance of appropriate preventive maintenance such that the system remained capable performing its intended function to provide adequate water quality to the safety-related Residual Heat Removal Service Water (RHRSW) pumps. As a result, after the Maintenance Rule (a)(2) performance criteria was exceeded, the licensee had neither established goals nor monitored the performance of the TWS per 10 CFR 50.65 (a)(1). The licensee entered their failure to monitor the performance of the TWS into their Corrective Action Program for resolution.

This finding was more than minor because it adversely affected the equipment performance attribute associated with the Mitigating Systems cornerstone objective in that debris were able to bypass the TWS which degraded RHRSW pump flow. This finding was of very low safety significance because redundant RHRSW pumps were operable and the affected RHRSW pumps were returned to operable status within the Technical Specification allowed outage times. This finding directly involved the cross-cutting aspect of Problem Identification and Resolution, in that, the licensee failed to identify that each of the RHRSW pump degraded flow events were maintenance preventable functional failures of the TWS.

Inspection Report# : 2006002(pdf)

Barrier Integrity



Significance: Jul 29, 2005 Identified By: NRC Item Type: NCV NonCited Violation Failure to Adequately Implement Design Control Measures

A non-cited violation of 10 CFR 50, Appendix B, Criterion III, involving the failure to adequately control the configuration of the drywell to torus vacuum breaker actuators was identified. This resulted in the failure to maintain containment integrity requirements because one of two required barriers for containment integrity was inappropriately removed during a design change of the actuators.

This finding is more than minor because it affected the configuration control attribute of the Barrier Integrity cornerstone to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. This finding was determined to be of very low safety significance (Green) because for each of the affected torus vacuum breaker actuators, the outboard containment isolation valve in the associated penetration remained functional. This finding affects the human performance crosscutting area in that licensee staff failed to adequately implement the site process for design controls. Inspection Report# : 2005006(pdf)

Emergency Preparedness

Occupational Radiation Safety

2Q/2006 Inspection Findings - Hatch 1

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Jul 29, 2005 Identified By: NRC Item Type: FIN Finding **Biennial Identification and Resolution of Problems Inspection Assessment**

The inspectors 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 inspectors also determined that the licensee was generally prioritizing and evaluating issues properly. The inspectors identified minor problems involving corrective actions for operating experience not being documented within the corrective action program, timeliness of evaluations, and corrective actions which were incomplete. Non-cited violations (NCVs) related to the effectiveness of corrective actions and inadequate evaluation of issues 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 inspectors identified that personnel at the site felt free to raise safety concerns to management and to resolve issues via the CAP.

Inspection Report# : 2005006(pdf)

Last modified : August 25, 2006