Hatch 2

Initiating Events

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
MULTIPLE FAILURES OF MAIN CONTROL ROOM AIR CONDITIONERS
A non-cited violation (NCV) was identified for the licensee's failure to place the main control room air conditioning system in Maintenance Rule (MR) (a)(1) status as required by licensee procedure 40AC-ENG-020-0S and 10 CFR 50.65. The licensee had identified one maintenance preventable functional failure (MPFF) in October 2000 and three MPFFs between December 22, 2000, and January 14, 2001. The performance criteria established for this system was 1 (MPFF) per 36 months. The licensee was aware of the repetitive MPFFs, but had not assessed the system for potential escalation to MR (a)(1) status until identified by the inspectors in March 2001. Following an assessment in March 2001, the licensee concluded that the system should have been placed in MR (a)(1) status on January 1, 2001.
Inspection Report# : 2000006*(pdf)*

Significance: G May 04, 2000
Identified By: NRC
Item Type: FIN Finding
RISK FOR MAINTENANCE ACTIVITIES NOT ADEQUATELY CONSIDERED
The licensee had not adequately considered the effects of removing the Unit 2 condensate pump area cooler from service. However, the operator's quick response to the annunciator and recovery of the system resulted in no challenge to the condensate system or plant operations. Therefore, this issue was evaluated to be of very low significance by the Significance Determination Process and no regulatory requirements were violated.
Inspection Report# : 2000003*(pdf)*

Significance: G Oct 17, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Perform Surveillance Testing on some Reactor Protection System Relays.
Technical Specification Surveillance SR 3.3.1.1.16 requires the relays which actuate the "B" trip system of the reactor protection system upon sensing a turbine stop valve closure be tested for time response every 18 months. On September 9, 2001, two relays were identified that had not been tested for time response since 1995, as described in the licensee corrective action program Reference CR 2001007192 and CR 2001007276.
Inspection Report# : 2001005*(pdf)*

Mitigating Systems

Significance: G Mar 31, 2001
Identified By: Self Disclosing
Item Type: FIN Finding
THE 2C 600 VOLT EMERGENCY BUS TRIPPED DUE TO PERSONNEL PERFORMANCE THAT RESULTED IN AN ELECTRICAL SHORT CIRCUIT DURING A RELAY CALIBRATION
A finding was identified for the loss of the 2C 600 Volt emergency bus due to personnel performance that resulted in an electrical short circuit during a relay calibration. After removing the relay for calibration, a technician inappropriately placed the relay connection paddle back inside the relay case and caused the short. The 2C bus supplies power to multiple risk significant systems in the mitigation systems cornerstone including; safety injection, decay heat removal and long term heat removal systems. Balance-of-plant equipment associated with potential plant transient initiators were also affected. In this case, an automatic power reduction transient began and a loss of condenser vacuum was initiated. However, the event was mitigated by the quick and appropriate response by plant operators so the event was determined to be of very low significance by the Significance Determination Process.
Inspection Report# : 2000006*(pdf)*

Significance: G Oct 17, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Prevent Recurrence of Emergency Bus Undervoltage Relay Setpoint Drift.
A non-cited violation (NCV) of 10 CFR 50, Appendix B, criterion XVI [Corrective Actions] was identified by the inspectors for the licensee's failure to identify repetitive calibration problems and prevent recurrence of a setpoint drift problem associated with 4 kv emergency bus undervoltage relays. The finding was of very low safety significance because the setpoint drift would not result in the failure of the Emergency Diesel Generator (EDG) to provide emergency power to the bus, but would only result in a delay of the automatic start feature of the EDG. Additionally, this problem would have to occur in multiple relays simultaneously before the auto start feature of the EDG would be affected. The inspectors reviewed the past 11 years and did not identify any examples where the problem occurred in multiple relays simultaneously.
Inspection Report# : 2001005*(pdf)*

Significance: G Oct 17, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
The Increase in Risk Associated with Maintenance on the Upstream Traveling Water Screen was not Assessed.
10 CFR 50.65(a)(4) requires, in part, that before maintenance is performed on systems shown to be risk significant, the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activity. On September 13, 2001, the increase in risk associated with maintenance on the upstream traveling water screen was not assessed, as described in the licensee corrective action program Reference CR 2001007635.
Inspection Report# : 2001005*(pdf)*

Significance: G Sep 29, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to Record the as-found Main Steam Isolation Valve Limit Switch Settings as Required by Technical Specification and Sureveillance Procedures.
Technical Specification Surveillance SR 3.3.1.1.13 requires that a channel calibration of Main Steam Isolation Valve (MSIV) limit switches be conducted every 18 months. Procedure 52SV-B21-001-0S, MSIV Limit Switch Inspection, Rev. 4, Ed. 3, implements this requirement, in part, by recording the as found MSIV limit switch settings. It was determined on August 31, 2001, that the as found MSIV limit switch settings were not being recorded as described in the licensee corrective action program Reference CR 2001006969.
Inspection Report# : 2001005*(pdf)*

Significance: G Jun 30, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Separation of Residual Heat Removal Service Water (RHRSW) Cables.
A Non-Cited Violation (NCV) was identified for the licensee's failure to provide separation of redundant Unit 2 RHRSW pump motor cables as required by 10 CFR 50, Appendix R, subsection III.G.2. The cables were located in the same fire area and were needed to achieve and maintain a hot shutdown condition. The finding was of very low safety significance because of the minimal ignition sources and combustible loading in the area and a low initiating event frequency coupled with the remaining fire suppression capability for a fire in this area
Inspection Report# : 2001003*(pdf)*

Significance: G Jun 15, 2001
Identified By: NRC
Item Type: FIN Finding
A change to the intake structure was completed by lifting and bolting maintenance plugs in each side of the common roof structure to provide additional cooling.
A change to the intake structure was completed by lifting and bolting maintenance plugs in each side of the common roof structure to provide additional cooling. This modification performed periodically since 1993, by temporary modification and then by procedure, left the residual heat removal service water pumps susceptible to a tornado-generated missile. Because of the relatively low probability of a tornado-generated missile traversing the gap between the intake structure roof and maintenance plug, this finding was considered of very low safety significance.
Inspection Report# : 2001004*(pdf)*

Significance: N/A Jun 15, 2001

Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform Adequate 50.59 Evaluation for Modification to Intake Structure.
A non-cited violation of 10 CFR 50.59 was identified for an inadequate evaluation associated with the licensee's change to the river intake structure. Specifically, the 10 CFR 50.59 safety analyses associated with lifting and bolting maintenance plugs in the roof of the intake structure, by temporary modification and then by procedure, did not provide an adequate technical basis to support the determination that an unreviewed safety question did not exist. The evaluation failed to address the consequences of a postulated loss of one or two pumps of the residual heat removal service water due to tornado-generated missiles passing through the gap caused by raising the maintenance plug. This condition existed periodically since 1993.
Inspection Report# : 2001004*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: G Oct 17, 2001
Identified By: NRC
Item Type: FIN Finding
Failure to Perform Corrective Maintenance or Implement Compensatory Measures for Degraded Primary Meteorological Tower Atmospheric Temperature Instruments.
The inspectors identified a finding of very low safety significance for the licensee's failure to perform corrective maintenance or implement compensatory measures for degraded primary meteorological tower atmospheric temperature instruments that impaired the ability to assess offsite dose during a plant emergency. The finding has very low safety significance because the secondary meteorological tower instruments were available for use and no release of radioactivity that required a prompt offsite dose assessment occurred. There was no actual public safety consequence.
Inspection Report# : 2001005*(pdf)*

Physical Protection

Significance: G Mar 17, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
Apparent security violation - intrusion detection
The licensee failed to detect an unauthorized penetration into the protected area during testing.
Inspection Report# : 2000007*(pdf)*

Miscellaneous

Significance: N/A Feb 16, 2001
Identified By: NRC
Item Type: FIN Finding
RESULTS OF PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION
The inspectors determined that, in general, problems were properly identified, evaluated, and corrected. A very low threshold for self-identification was demonstrated. Significant problems were adequately addressed. Minor problems were noted involving corrective actions not being documented within the corrective action program, timeliness of evaluations and documentation of repetitive problems, timeliness of corrective actions, corrective actions which were unclear or incomplete, and severity level classification of condition reports.
Inspection Report# : 2001002*(pdf)*

Significance: N/A Nov 30, 2001
Identified By: NRC
Item Type: FIN Finding
Problem Identification and Resolution (PI&R) Inspection Results
The inspectors determined that the licensee's threshold for identifying problems remained sufficiently low and that the licensee was effective at evaluating problems and developing corrective action. No findings of significance were identified. General improvement was noted since the last NRC Problem Identification and Resolution (PI&R) inspection, which was documented in IR 50-321/01-02 and 50-366/01-02, dated March 16, 2001. Since then, the licensee had implemented a new corrective action program (CAP) which strengthened the implementing procedures, increased department management involvement, and established a separate group to manage the CAP as a full-time function. Particularly noteworthy was establishment of a dedicated Trend Coordinator position and a Corrective Action Program Coordinator (CAPCO) position for each department. The Trend Coordinator was responsible for monitoring the CAP and identifying adverse trends. The CAPCO's were responsible for coordinating the resolution of condition reports assigned to their department. Although the new CAP had only been in place since August, 2001, the inspectors also noted improvement with the consistency of the problem evaluation and resolution. However, the inspectors did find that previous issues with identification of repetitive problems and departmental self-assessments continued, and that there were minor deficiencies with the implementing procedures.
Inspection Report# : 2001009*(pdf)*

Significance: 

Jul 23, 2001
Identified By: NRC
Item Type: FIN Finding
Failure to Perform Preventative Maintenance on Traveling Water Screen System Instruments that Affected the Performance of Plant Service Water.
The inspectors identified a finding of very low safety significance for the licensee's failure to perform preventative maintenance on traveling water screen (TWS) system instruments that affected the performance of the Plant Service Water (PSW) system. As a result, the screens became clogged with debris and the intake structure water level decreased causing fluctuations in PSW flow and pressure. Operators reduced power to 85% on Unit 1 and 90% on Unit 2 in response to the problem and dispatched operators to start the TWS locally. Quick response of the operators prevented further degradation of PSW as well as any adverse impact on mitigating systems. The finding has very low safety significance because prompt operator response and performance demonstrated that the procedures in place were satisfactory and the operators were properly trained to perform the evolution.
Inspection Report# : 2001005*(pdf)*

Last modified : March 28, 2002