

## Hatch 2

### 3Q/2003 Plant Inspection Findings

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#### Initiating Events

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#### Mitigating Systems

**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 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:**  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:**  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\(pdf\)](#)

**Significance:**  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\(pdf\)](#)

**Significance:**  Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**Inadequate Corrective Action for Missing Penetration Seals**

The licensee had not taken prompt corrective action for missing RHR Service Water (RHRSW) piping penetration seals at the intake structure.

A non-cited violation of 10CFR50 Appendix B, Criterion XVI was identified. This finding is more than minor because the lack of penetration seals could have permitted the Plant Service Water (PSW) valve pit to flood and effected the mitigating systems cornerstone. Because flooding of the PSW valve pit had not occurred nor were flooding conditions present, this failure to promptly correct a condition adverse to quality is of very low safety significance.

Inspection Report# : [2002005\(pdf\)](#)

**Significance:**  Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

**Calculation Error Results in Incorrect Steam Line High Flow Setpoints**

An incorrect calculation constant resulted in a non-conservative setpoint for the Unit 1 main steam line flow - high isolation setpoint.

A self-revealing non-cited violation of Technical Specification (TS) table 3.3.6.1-1 was identified. This finding is greater than minor because the actual setpoint exceeded the TS allowable value and the analytical limit, as a result of the error. However, the violation is of very low significance because the increased steam released due to the higher

setpoint would not significantly impact offsite radiological dose during a main steam line break accident.

Inspection Report# : [2002005\(pdf\)](#)



**Significance:** Dec 31, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate Operability Assessment of Main Steam Safety Relief Valve**

The licensee did not promptly identify the cause of a failed safety relief valve (SRV). An operability evaluation written in response to the failure was not timely and did not adequately support a determination that the remaining SRV's were operable. Consequently, this significant condition adverse to quality was not promptly corrected and adequate measures were not taken to preclude repetition.

A non-cited violation of 10CFR50 Appendix B, Criterion XVI was identified. This finding is greater than minor because the licensee's operability assessment was not timely and relied primarily on unsupported engineering judgement for a determination of operable for the remaining SRV's. It also required multiple revisions when inconsistencies were identified by the inspectors. This finding was of very low significance because no loss of SRV function occurred.

Inspection Report# : [2002005\(pdf\)](#)



**Significance:** Oct 24, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Consider Vortexing in the Calculation for CST Level for Automatic Switchover of the HPCI Pump Suction**

Green. A non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control, was identified for inadequate design control of the high pressure coolant injection (HPCI) system suction source from the condensate storage tank (CST). Vortexing in the CST was not accounted for when the licensee calculated the CST level setpoint specified in the Technical Specifications (TS) for automatic HPCI system suction switchover from the CST to the suppression pool. Vortexing could cause air ingestion into the HPCI system suction from the CST and the air could then damage the HPCI pump.

This finding was of very low safety significance because licensee use of the non-safety CST as a HPCI pump suction source with the CST at low levels was unlikely since the reactor vessel or suppression pool would generally reach a high level first, where the HPCI pump would be automatically stopped or its suction would be automatically switched to the safety-related suppression pool. In addition, alternate core cooling methods would normally be available, including reactor core isolation cooling (RCIC) as well as automatic depressurization system (ADS) and low pressure coolant injection (LPCI).

Inspection Report# : [2002006\(pdf\)](#)



**Significance:** Oct 24, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

### **Inadequate RCIC System Operating Procedure**

Green. A non-cited violation of TS 5.4.1, Procedures, was identified for an inadequate RCIC system operating procedure. The section of the procedure for local manual operation of RCIC, if followed exactly as written, would have resulted in overspeeding the RCIC pump with no water flow through the pump and with no cooling water to the pump.

This finding was of very low safety significance because the likelihood of losing Division I direct current (DC) power was low; consequently the potential need for local manual operation of RCIC was low. In addition, other core cooling methods would normally be available, including HPCI as well as ADS and LPCI.

Inspection Report# : [2002006\(pdf\)](#)

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

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## 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 : December 01, 2003