UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

January 27, 2014

Mr. David R. Vineyard
Vice President
Southern Nuclear Operating Company, Inc.
Edwin I. Hatch Nuclear Plant
11028 Hatch Parkway North
Baxley, GA 31513

SUBJECT: EDWIN I. HATCH NUCLEAR PLANT - NRC INTEGRATED INSPECTION REPORT 05000321/2013005, 05000366/2013005, 05000321/2013502, AND 05000366/2013502

Dear Mr. Vineyard:

On December 31, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Edwin I. Hatch Nuclear Plant Units 1 and 2. On January 24, 2014, the NRC inspectors discussed the results of this inspection with Mr. Richard Spring and other members of your staff. Inspectors documented the results of this inspection in the enclosed inspection report.

NRC inspectors documented three findings of very low safety significance (Green) in this report. Each of these findings involved a violation of NRC requirements. Further, inspectors documented a licensee-identified violation which was determined to be of very low safety significance in this report. The NRC is treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2.a of the Enforcement Policy.

If you contest the violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region II; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC resident inspector at the Edwin I. Hatch Nuclear Plant.

If you disagree with a cross-cutting aspect assignment in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region II; and the NRC resident inspector at the Edwin I. Hatch Nuclear Plant.

As a result of the Safety Culture Common Language Initiative, the terminology and coding of cross-cutting aspects were revised beginning in calendar year 2014. New cross-cutting aspects identified in calendar year 2014 will be coded under the latest revision to Inspection Manual Chapter (IMC) 0310. Cross-cutting aspects identified in the last six months of 2013 using the previous terminology will be converted to the latest revision in accordance with the cross-reference in IMC 0310. The revised cross-cutting aspects will be evaluated for cross-cutting themes and potential substantive cross-cutting issues in accordance with IMC 0305 starting with the calendar year 2014 mid-cycle assessment review.

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, “Public Inspections, Exemptions, Requests for Withholding,” of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC’s Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Frank Ehrhardt, Chief
Reactor Projects Branch 2
Division of Reactor Projects

Docket Nos.: 50-321, 50-366
License Nos.: DPR-57 and NPF-5

Enclosures: Inspection Report 05000321/2013005, 05000366/2013005,
05000321/2013502, and 05000366/2013502
w/Attachment: Supplemental Information

cc distribution via ListServ

As a result of the Safety Culture Common Language Initiative, the terminology and coding of cross-cutting aspects were revised beginning in calendar year 2014. New cross-cutting aspects identified in calendar year 2014 will be coded under the latest revision to Inspection Manual Chapter (IMC) 0310. Cross-cutting aspects identified in the last six months of 2013 using the previous terminology will be converted to the latest revision in accordance with the cross-reference in IMC 0310. The revised cross-cutting aspects will be evaluated for cross-cutting themes and potential substantive cross-cutting issues in accordance with IMC 0305 starting with the calendar year 2014 mid-cycle assessment review.

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding," of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Frank Ehrhardt, Chief
Reactor Projects Branch 2
Division of Reactor Projects

Docket Nos.: 50-321, 50-366
License Nos.: DPR-57 and NPF-5

Enclosures: Inspection Report 05000321/2013005, 05000366/2013005,
05000321/2013502, and 05000366/2013502
w/Attachment: Supplemental Information

cc distribution via ListServ

☒ PUBLICLY AVAILABLE ☐ NON-PUBLICLY AVAILABLE ☐ SENSITIVE ☒ NON-SENSITIVE
ADAMS: ☒ Yes ACCESSION NUMBER:_____ ☒ SUNSI REVIEW COMPLETE ☐ FORM 665 ATTACHED

OFFICE	RII:DRP	RII:DRP	RII:DRP	RII:DRS	RII:DRS	RII:DRP	RII:DRP
SIGNATURE	Via email	Via email	Via email	Via email	Via email	JGW /RA/	FJE /RA/
NAME	EMorris	DHardage	PNiebaum	BCaballero	JLaughlin	JWorosilo	FEhrhardt
DATE	01/21/2014	01/22/2014	01/21/2014	01/21/2014	01/21/2014	01/21/2014	01/27/2014
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: G:\DRPII\RPB2\HATCH\REPORTS\2013 IRS\13-05\HATCH IR 2013-005.DOC

Letter to David R. Vineyard from Frank Ehrhardt dated January 27, 2014

SUBJECT: EDWIN I. HATCH NUCLEAR PLANT - NRC INTEGRATED INSPECTION REPORT 05000321/2013005, 05000366/2013005, 05000321/2013502, AND 05000366/2013502

DISTRIBUTION:
C. Evans, RII
L. Douglas, RII
OE Mail
RIDSNRRDIRS
PUBLIC
RidsNrrPMHatch Resource

U. S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.:	50-321, 50-366
License Nos.:	DPR-57 and NPF-5
Report Nos.:	05000321/2013005, 05000366/2013005, 05000321/2013502, and 05000366/2013502
Licensee:	Southern Nuclear Operating Company, Inc.
Facility:	Edwin I. Hatch Nuclear Plant
Location:	Baxley, Georgia 31513
Dates:	October 1 – December 31, 2013
Inspectors:	E. Morris, Senior Resident Inspector D. Hardage, Resident Inspector P. Niebaum, Senior Resident Inspector (Farley) B. Caballero, Senior Operations Engineer (1R11.3) J. Laughlin, Emergency Preparedness Inspector (1EP4)
Approved by:	Frank Ehrhardt, Chief Reactor Projects Branch 2 Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000321/2013005, 05000366/2013005, 05000321/2013502, 05000366/3013502; 10/01/2013-12/31/2013; Edwin I. Hatch Nuclear Plant, Units 1 and 2, Maintenance Effectiveness , Refueling and Other Outage Activities, Problem Identification and Resolution

The report covered a three-month period of inspection by the Hatch resident inspectors, the Farley senior resident inspector, a senior operations engineer, and an emergency preparedness inspector. There were two NRC identified findings, and one self-revealing finding identified and documented in this report. The significance of inspection findings are indicated by their color (i.e. greater than Green, or Green, White, Yellow, Red) and determined using IMC 0609, "Significance Determination Process" (SDP) dated June 2, 2011. Cross-cutting aspects are determined using IMC 0310, "Components Within The Cross-Cutting Areas" dated October 28, 2011. All violations of NRC requirements are dispositioned in accordance with the NRC's Enforcement Policy dated July 9, 2013. The NRC's program for overseeing the safe operations of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process" revision 4.

Cornerstone: Initiating Events

- Green. NRC inspectors identified a non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to promptly identify the source of leakage under Unit 1 reactor vessel on February 26, 2013. On October 25, 2013, the licensee identified the source of under vessel leakage to be from two bolts on a control rod drive mechanism to restore compliance. This violation was entered into the licensee's corrective action program as condition report (CR) 723942.

  The failure to promptly identify leakage from control rod drive mechanism 06-35 on February 26, 2013, as required by 10 CFR 50 Appendix B, Criterion XVI, "Corrective Actions," was a performance deficiency. This performance deficiency affected the initiating events cornerstone and was determined to be more-than-minor because, if left uncorrected, failure to identify the location of leakage sources within the drywell has the potential to lead to a worse leak and a more significant safety concern. The inspectors screened this finding utilizing IMC 0609 Attachment 4, "Initial Characterization of Findings," dated June 19, 2012. The finding screened as Green using the initiating events loss of coolant accident initiator screening questions because the finding degradation assessment did not result in exceeding the reactor coolant system leak rate for a small loss of coolant accident and did not affect the functions of other systems used to mitigate a loss of coolant accident. The inspectors determined this performance deficiency had a cross cutting aspect in the human performance area decision-making attribute because the licensee did not use conservative assumptions in decision making by demonstrating that a condition adverse to quality was identified or did not exist in order to proceed with plant startup. [H.1(b)] (Section 1R20.2)

Cornerstone: Mitigating Systems

- Green. The NRC inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to implement existing procedural guidance for the control of clearances between installed scaffolding and safety-related plant equipment. The licensee corrected each scaffold identified to restore compliance. This violation has been entered into the licensee's corrective action program as CR 721564.

  Failure to maintain the required clearance of two inches between scaffolding and safety related equipment in accordance with 50AC-MNT-003-0, "Scaffold Control," was a performance deficiency. The performance deficiency was more-than minor because it adversely affected the protection against external factors attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, this issue is similar to IMC 0612 Appendix E, Section 4 Example (a) of a more-than-minor issue because the licensee routinely failed to perform engineering evaluations on scaffolding erected with clearances less than procedural requirements. The inspectors screened this finding utilizing IMC 0609 Attachment 4, "Initial Characterization of Findings," dated June 19, 2012, and IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings at Power" dated June 19, 2012. The finding screened as Green using Exhibit 2, Section A. "Mitigating Structures, Systems, Components and Functionality" screening question 1, because the finding was a qualification (seismic) deficiency of a mitigating structure, system, or component which maintained its operability or functionality. The inspectors determined this performance deficiency had a cross cutting aspect in the work practices component of the human performance area because the licensee did not ensure supervisory and management oversight of work activities, including contractors, such that nuclear safety is supported. [H.4(c)] (Section 1R12)

- Green. A self-revealing NCV of Hatch Unit 1 and Unit 2 Technical Specification 5.4., "Procedures," was identified on October 5, 2013, when the licensee failed to implement an administrative procedure for equipment control which caused the "A" main control room air conditioning unit to trip. The licensee properly realigned the system and restarted the "A" main control room air conditioning unit to restore compliance. This violation has been entered into the licensee's corrective action program as CR 713629.

  Failure to ensure the use of the personal danger tags (PDTs) will have no adverse effects on the continued operation of the plant as required by procedure NMP-AD-003-005, "PDT Tags/Maintenance Locks Use With Operating Permit Tags or PDT Documentation Sheets," was a performance deficiency. This performance deficiency was more-than-minor because it adversely affected the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, a PDT clearance sheet was performed on in-service equipment and resulted in the tripping of the "A" main control room air conditioner. The inspectors evaluated the finding in accordance with IMC 0609,

Attachment 4, “Initial Characterization of Findings,” dated June 19, 2012. Using Table 2, “Cornerstones Affected by Degradation Condition or Programmatic Weakness,” the finding affected the mitigating systems cornerstone and required further evaluation using IMC 0609 Appendix A, “The Significance Determination Process (SDP) for Findings At-Power,” dated June 19, 2012. Based on Appendix A, Exhibit 2 – Mitigating Systems Screening Questions, the finding screened as Green because all the questions were answered no. The inspectors determined this finding has a cross-cutting aspect in the work control aspect of the human performance area, because the licensee did not coordinate work activities by incorporating actions to address the need to keep personnel apprised of work status, the operational impact of work activities, or plant conditions that may affect work activities. [H.3(b)] (Section 4OA2.3)

A violation of very low safety significance or severity level IV that was identified by the licensee has been reviewed by the NRC. Corrective actions taken or planned by the licensee have been entered into the licensee’s corrective action program. This violation and corrective action tracking number is listed in Section 4OA7 of this report.

REPORT DETAILS

Summary of Plant Status

Unit 1 began the inspection period at or near 100 percent rated thermal power (RTP). On October 21, 2013, operators performed a unit shutdown to Mode 4 due to a condensate steam leak from the long cycle recirculation line isolation valve. The unit was restarted on October 24, 2013, and returned to RTP on October 29, 2013. On November 29, 2013, operators reduced power to 20 percent RTP to repair gland seal steam supply valves. The unit returned to 100 percent RTP on December 3, 2013. On December 23, 2013, the unit entered end-of-cycle coastdown and remained in coastdown throughout the remainder of the inspection period.

Unit 2 began the inspection period at or near 100 percent RTP. On November 23, 2013, operators reduced unit power to 65 percent RTP due to high turbine building temperatures. The unit returned to 100 percent RTP on November 24, 2013. The unit operated throughout the remainder of the inspection period at or near 100 percent RTP.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R01 Adverse Weather Protection (71111.01)

a. Inspection Scope

Seasonal Extreme Weather Conditions

The inspectors conducted a detailed review of the station's adverse weather procedures written for extreme low temperatures. The inspectors verified that weather related equipment deficiencies identified during the previous year had been corrected prior to the onset of seasonal extremes. The inspectors evaluated the licensee's implementation of adverse weather preparation procedures and compensatory measures before the onset of seasonal extreme weather conditions. Documents reviewed are listed in the Attachment. The inspectors evaluated the following risk-significant systems:

- Plant service water
- High pressure coolant injection

b. Findings

No findings were identified.

1R04 Equipment Alignment (71111.04)

a. Inspection Scope

Partial Walkdowns

The inspectors verified that critical portions of the selected systems were correctly aligned by performing partial walkdowns. The inspectors selected systems for assessment because they were a redundant or backup system/train, were important for mitigating risk for the current plant conditions, had been recently realigned, or were a single-train system. The inspectors determined the correct system lineup by reviewing plant procedures and drawings. Documents reviewed are listed in the Attachment. The inspectors selected the following three systems/trains to inspect:

- Unit 1 “B” train of residual heat removal service water system while “C” residual heat removal service water pump was out of service for maintenance, October 1
- Unit 2 “A” train of residual heat removal system while “B” train was out of service for maintenance, October 17
- Unit 1 “B” train of core spray system while “A” train was out of service for maintenance, November 4

b. Findings

No findings were identified.

1R05 Fire Protection (71111.05AQ)

a. Inspection Scope

Quarterly Inspection

The inspectors evaluated the adequacy of selected fire plans by comparing the fire plans to the defined hazards and defense-in-depth features specified in the fire protection program. In evaluating the fire plans, the inspectors assessed the following items: 1) control of transient combustibles and ignition sources; 2) fire detection systems; 3) water-based fire suppression systems; 4) gaseous fire suppression systems; 5) manual firefighting equipment and capability; 6) passive fire protection features; 7) compensatory measures and fire watches; and 8) issues related to fire protection contained in the licensee’s corrective action program. The inspectors toured the following five fire areas to assess material condition and operational status of fire protection equipment. Documents reviewed are listed in the Attachment.

- Unit 1 diesel generator building; diesel generator rooms “1A”, “1B”, and “1C”, oil storage rooms “1A”, “1B”, and “1C”, and battery rooms “1A”, “1B”, and “1C”, fire zones 1401, 1402, 1403, 1405, 1406,1407, 1409, 1410, and 1411

- Unit 2 diesel generator building; diesel generator rooms “2A” and “2C”, oil storage rooms “2A” and “2C”, and battery rooms “2A” and “2C”, fire zones 2401, 2402, 2403, 2405, 2406, and 2407
- Unit 1 & 2, intake structure, fire zone 0501
- Unit 1 & 2, condensate storage tank, fire zones 1603 and 2603
- Unit 1 & 2, service water valve pit, fire zones 1602, 1602, 2601, and 2602

b. Findings

No findings were identified.

1R06 Flood Protection Measures (71111.06)

a. Inspection Scope

Underground Cables

The inspectors reviewed related flood analysis documents and inspected the areas listed below that contain cables whose failure could disable risk significant equipment. The inspector directly observed the condition of cables and cable support structures and, as applicable, verified that dewatering devices and drainage systems were functioning properly. In addition, the inspectors verified the licensee was identifying and properly addressing issues using their corrective action program. Documents reviewed are listed in the Attachment.

- PB1-X, pull box located north of auxiliary boiler
- PB1-Y, pull box located east of emergency diesel generator building

b. Findings

No findings were identified.

1R11 Licensed Operator Requalification Program and Licensed Operator Performance (71111.11)

a. Inspection Scope

.1 Resident Inspector Quarterly Review of Licensed Operator Requalification

The inspectors observed two simulator scenarios conducted for training of an operating crew for requalification. The inspectors assessed licensed operator performance, the ability of the licensee to administer the scenario, the quality of the post-scenario critique, and the performance of the simulator. Documents reviewed are listed in the Attachment.

.2 Resident Inspector Quarterly Review (Licensed Operator Performance)

The inspectors observed licensed operator performance in the main control room during Unit 1 shutdown from 100 percent rated thermal power on October 21. Inspectors observed licensed operator performance to assess the following:

- Use of plant procedures
- Control board manipulations
- Communications between crew members
- Use and interpretation of instruments, indications, and alarms
- Use of human error prevention techniques
- Documentation of activities
- Management and supervision

Documents reviewed are listed in the Attachment.

.3 Annual Review of Licensee Requalification Examination Results

On December 19, 2013, the licensee completed the comprehensive biennial requalification written examinations and the annual requalification operating examinations required to be administered to all licensed operators in accordance with 10 CFR 55.59(a)(2). The inspectors performed an in-office review of the overall pass/fail results of the individual operating examinations and the crew simulator operating examinations in accordance with Inspection Procedure (IP) 71111.11, "Licensed Operator Requalification Program."

b. Findings

No findings were identified.

1R12 Maintenance Effectiveness (71111.12)

a. Inspection Scope

The inspectors assessed the licensee's treatment of the two issues listed below in order to verify the licensee appropriately addressed equipment problems within the scope of the Maintenance Rule (10 CFR 50.65). The inspectors reviewed procedures and records in order to evaluate the licensee's identification, assessment, and characterization of the problems as well as their corrective actions for returning the equipment to a satisfactory condition. Documents reviewed are listed in the Attachment. The inspectors also interviewed system engineers and the maintenance rule coordinator to assess the accuracy of performance deficiencies and extent of condition.

- Unit 1 and 2, turbine building heating ventilation and air conditioning system U41
- Unit 1, control room air handling unit "C", 1Z41B003C, tripped due to a low flow alarm

b. Findings

Introduction: An NRC-identified Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when the licensee failed to implement existing procedural guidance for the control of clearances between installed scaffolding and safety-related plant equipment.

Description: Procedure 50AC-MNT-003-0, "Scaffold Control," requires in part that scaffolding erected in the vicinity of safety-related structures, systems, or components shall be greater than two inches from the safety-related structure, systems, or components; or an engineering evaluation must be performed; or the component must be declared inoperable. The NRC identified the following three examples where the licensee failed to construct scaffolding erected within the vicinity of safety-related structures, systems, or components, in accordance with procedure, 50AC-MNT-003-0.

- Scaffold was in direct contact with standby gas train on February 28, 2013. The licensee subsequently declared the standby gas train inoperable and entered this issue into their CAP as CR 598568.
- Scaffold was in direct contact with all three trains of the main control room air handling units on October 18, 2013. The licensee subsequently removed the scaffolding and entered this issue into their CAP as CR 720390.
- Scaffold was less than two inches from plant service water components on November 7, 2013. The licensee subsequently relocated the scaffold and entered this issue into their CAP as CR 730131.

In each of these three examples scaffolding was erected less than two inches from the safety-related structure, system, or component; no engineering evaluation had been performed; and the equipment had not been previously declared inoperable.

Analysis: Failure to maintain the required clearance of two inches between scaffolding and safety related equipment in accordance with 50AC-MNT-003-0, "Scaffold Control," was a performance deficiency. The performance deficiency was more-than minor because it adversely affected the protection against external factors attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events. Specifically, this issue is similar to IMC 0612 Appendix E, Section 4 Example (a) of a more-than-minor issue, because the licensee routinely failed to perform engineering evaluations on scaffolding erected with clearances less than procedural requirements. The inspectors screened this finding utilizing IMC 0609 Attachment 4, "Initial Characterization of Findings," dated June 19, 2012, and IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings at Power" dated June 19, 2012. The finding screened as Green using Exhibit 2, Section A. "Mitigating Structures, Systems, Components and Functionality" screening question 1, because the finding was a qualification (seismic) deficiency of a mitigating structure, system, or component which maintained its operability or functionality. The inspectors determined this performance deficiency had a cross cutting aspect in the work practices component of the human performance area because the licensee did not ensure supervisory and management oversight or work activities, including contractors, such that nuclear safety is supported. [H.4(c)]

Enforcement: 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires in part that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Licensee procedure 50AC-MNT-003-0, "Scaffold Control," Ver. 9.0, requires in part that scaffolding built in the vicinity of safety-related equipment maintain a two inch minimum clearance from safety-related equipment, or an engineering evaluation must be performed, or the component be declared inoperable. Contrary to the above, from February 28, 2013, to November 7, 2013, the licensee had constructed scaffolding in the vicinity of safety-related equipment which was not erected in accordance with the procedural requirements. Specifically, scaffolding was erected with less than two inch minimum clearance from the safety-related equipment, no engineering evaluation had been performed, and the equipment had not been previously declared inoperable. The licensee corrected each scaffold identified to restore compliance. This violation is being treated as an NCV, consistent with Section 2.3.2 of the Enforcement Policy. The violation was entered into the licensee's corrective action program as CR 721564. (NCV 05000321,366/2013005-01, "Scaffolding Installed in Safety Related Areas Failed to Meet Procedural Requirements")

1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13)

a. Inspection Scope

The inspectors reviewed the three maintenance activities listed below to verify the licensee assessed and managed plant risk as required by 10 CFR 50.65(a)(4) and licensee procedures. The inspectors assessed the adequacy of the licensee's risk assessments and implementation of risk management actions. The inspectors also verified that the licensee was identifying and resolving problems with assessing and managing maintenance-related risk using the corrective action program. Additionally, for maintenance resulting from unforeseen situations, the inspectors assessed the effectiveness of the licensee's planning and control of emergent work activities. Documents reviewed are listed in the Attachment.

- Week of October 1 – October 4, including planned maintenance on Unit 1 "C" residual heat removal service water pump, and Unit 1 reactor protection system "A" motor generator.
- Week of November 2 – November 8, including planned maintenance on Unit 1 "A" core spray pump, unit 1 "C" plant service water pump, and the "A" main control room air conditioner.
- Week of November 16 – November 22, including planned maintenance on Unit 2 "C" emergency diesel generator.

b. Findings

No findings were identified.

1R15 Operability Evaluations and Functionality Assessments (71111.15)

a. Inspection Scope

The inspectors selected the four operability determinations or functionality evaluations listed below for review based on the risk-significance of the associated components and systems. The inspectors reviewed the technical adequacy of the determinations to ensure that technical specification operability was properly justified and the components or systems remained capable of performing their design functions. To verify whether components or systems were operable, the inspectors compared the operability and design criteria in the appropriate sections of the technical specification and updated final safety analysis report to the licensee's evaluations. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled. Additionally, the inspectors reviewed a sample of corrective action documents to verify the licensee was identifying and correcting any deficiencies associated with operability evaluations. Documents reviewed are listed in the attachment.

- Control rod drive 06-35 bottom flange leak, CR 723942
- "1A" emergency diesel generator fuel tank volume low, CR 724340
- Main steam isolation valve 2B21F022A internal tolerances less than design, CR 739565
- Diesel fire pump "FP3" radiator hose degradation (bulging/bubbled), CR 741181

b. Findings

No findings were identified.

1R18 Plant Modifications (71111.18)

a. Inspection Scope

The inspectors verified that the plant modification listed below did not affect the safety functions of important safety systems. The inspectors confirmed the modifications did not degrade the design bases, licensing bases and performance capability of risk significant structures, systems and components. The inspectors also verified modifications performed during plant configurations involving increased risk did not place the plant in an unsafe condition. Additionally, the inspectors evaluated whether system operability and availability, configuration control, post-installation test activities, and changes to documents, such as drawings, procedures, and operator training materials, complied with licensee standards and NRC requirements. In addition, the inspectors reviewed a sample of related corrective action documents to verify the licensee was identifying and correcting any deficiencies associated with modifications. Documents reviewed are listed in the Attachment.

Modification:

- SNC474610, Replace 1P41F422A (Temp Mod 1-10-024)

b. Findings

No findings were identified.

1R19 Post-Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors either observed post-maintenance testing or reviewed the test results for the four maintenance activities listed below to verify the work performed was completed correctly and the test activities were adequate to verify system operability and functional capability. The inspectors evaluated these activities for the following: acceptance criteria were clear and demonstrated operational readiness; effects of testing on the plant were adequately addressed; test instrumentation was appropriate; tests were performed in accordance with approved procedures; equipment was returned to its operational status following testing; and test documentation was properly evaluated. Additionally, the inspectors reviewed a sample of corrective action documents to verify the licensee was identifying and correcting any deficiencies associated with post-maintenance testing. Documents reviewed are listed in the Attachment.

- Work order (WO) SNC528709, Replace directional control valve for hydraulic control unit 1C11 H10-07, October 24
- WO SNC423570, 1A RHR pump partial discharge test, October 30
- WO SNC417929, Replace 2C emergency diesel generator heat exchangers, November 23
- WO SNC418123, Replace solenoid valve, 1Z41-F030A, for the “A” main control room air conditioner, December 10

b. Findings

No findings were identified.

1R20 Refueling and Other Outage Activities (71111.20)

.1 Unit 1 Forced Maintenance Outage

a. Inspection Scope

The inspectors evaluated the outage activities listed below for the Unit 1 forced maintenance outage from October 21 through October 24. The inspectors verified that the licensee: 1) considered risk in developing the outage schedule; 2) controlled plant configuration in accordance with administrative risk reduction methodologies; 3) developed work schedules to manage fatigue; 4) developed mitigation strategies for loss of key safety functions; and 5) adhered to operating license and technical specification requirements. Additionally, inspectors verified that safety-related and risk significant structures, systems, and components not accessible during power operations were maintained in an operable condition.

- Outage planning
- Shutdown, cooldown, heatup, and startup
- Reactor coolant system instrumentation and electrical power configuration
- Reactivity and inventory control
- Decay heat removal
- Containment closure

Additionally, the inspectors reviewed a sample of related corrective action documents to verify the licensee was identifying and correcting any deficiencies associated with outage activities. Documents reviewed are listed in the Attachment.

b. Findings

No findings were identified.

.2 (Closed) Unresolved Item 05000321/2013002-02, Unit 1 Under Vessel Leak Source Not Identified

a. Inspection Scope

On October 25 with Unit 1 at 920 psig the inspectors accompanied the licensee on a primary containment drywell inspection under the Unit 1 reactor vessel during plant startup. The purpose of this inspection was to determine if the failure to identify the source of leakage under Unit 1 reactor vessel on February 26, 2013, constituted a violation of Technical Specification 3.4.4 for plant operation with pressure boundary leakage, and/or a violation of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," for not promptly identifying a condition adverse to quality. Documents reviewed are listed in the Attachment.

b. Findings

Introduction: NRC inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to promptly identify the source of leakage under Unit 1 reactor vessel on February 26, 2013.

Description: On February 26, 2013, during the Unit 1 reactor coolant system 920 psig normal operating temperature primary containment drywell walkdown, licensee personnel discovered a 15 drop-per-minute water leak under the reactor vessel. At the time of the discovery personnel within the drywell were unable to go under Unit 1 reactor vessel to identify the source of the leak because they did not meet radiological work permit dress requirements for going under the reactor vessel. The leak was reported to the Outage Control Center and CR 596805 was initiated. CR 596805 documented that the leak was accepted by management. Justification for accepting the leak is documented in technical evaluation 596805, which states in part "no steam leaks were visible, no sounds of leakage were heard, through indirect observation the water appeared to be cold. The drywell atmosphere consisted of humid air and due to the

drywell cooler discharging in the area, it appeared to be condensation. Based on his judgment, it did not appear to the individual performing the walkdown to be pressure boundary leakage." Hatch Unit 1 Technical Specification 3.4.4, "Reactor Coolant System Operational Leakage," limits reactor coolant system leakage to no pressure boundary leakage. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action", requires in part that measures shall be established to assure that conditions adverse to quality are promptly identified. On October 25 with Unit 1 at 920 psig the inspectors accompanied the licensee on a primary containment drywell inspection under the Unit 1 reactor vessel during plant startup. The source of the leak was determined to be from two bolts on control rod drive mechanism 06-35. Leakage from this location is not pressure boundary leakage, however, this component is safety-related and 10 CFR 50 Appendix B applies to this issue. Therefore, because this leak was not promptly identified on February 26, 2013, the licensee failed to meet the requirements of 10 CFR 50 Appendix B, Criterion XVI, for prompt identification of a condition adverse to quality between February 26, 2013 and October 25, 2013.

Analysis: Failure to promptly identify leakage from control rod drive mechanism 06-35 on February 26, 2013, as required by 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," was a performance deficiency. This performance deficiency affected the initiating events cornerstone and was determined to more-than-minor because, if left uncorrected, failure to identify the location of leakage sources within the drywell has the potential to lead to a worse leak and a more significant safety concern. The inspectors screened this finding utilizing IMC 0609 Attachment 4, "Initial Characterization of Findings," dated June 19, 2012. The finding screened as Green using the initiating events loss of coolant accident initiator screening questions, because the finding degradation assessment did not result in exceeding the reactor coolant system leak rate for a small loss of coolant accident and did not affect the functions of other systems used to mitigate a loss of coolant accident.

The inspectors determined this performance deficiency had a cross cutting aspect in the human performance area decision-making attribute because the licensee did not use conservative assumptions in decision making by demonstrating that a condition adverse to quality was identified or did not exist in order to proceed with plant startup. [H.1(b)]

Enforcement: 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires in part that measures shall be established to assure that conditions adverse to quality are promptly identified. Contrary to the above on Hatch Unit 1 from February 26, 2013, to October 25, 2013, the licensee failed to promptly identify leakage from control rod drive mechanism 06-35. The licensee entered Unit 1 drywell and identified the leakage source on October 25, 2013, to restore compliance. This violation is being treated as an NCV, consistent with Section 2.3.2 of the Enforcement Policy. The violation was entered into the licensee's corrective action program as CR 723942. (NCV 05000321/2013005-02, "Failure to Promptly Identify Source of Leakage Under Unit 1 Reactor Vessel.")

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors reviewed the three surveillance tests listed below and either observed the test or reviewed test results to verify testing adequately demonstrated equipment operability and met technical specification and licensee procedural requirements. The inspectors evaluated the test activities to assess for preconditioning of equipment, procedure adherence, and equipment alignment following completion of the surveillance. Additionally, the inspectors reviewed a sample of related corrective action documents to verify the licensee was identifying and correcting any deficiencies associated with surveillance testing. Documents reviewed are listed in the Attachment.

Routine Surveillance Tests

- 34SV-C41-001-2, "Standby Liquid Control Monthly Test"
- 34SV-R43-001-2, "Diesel Generator 2A Monthly Test"

In-Service Test

- 34SV-E51-002-1, "Reactor Core Isolation Cooling Pump Operability"

b. Findings

No findings were identified.

Cornerstone: Emergency Preparedness

1EP4 Emergency Action Level and Emergency Plan Changes

a. Inspection Scope

The NSIR headquarters staff performed an in-office review of the latest revisions of various Emergency Plan Implementing Procedures (EPIPs) and the Emergency Plan located under ADAMS accession numbers ML130320650 and ML13165A369 as listed in the Attachment.

The licensee determined that in accordance with 10 CFR 50.54(q), the changes made in the revisions resulted in no reduction in the effectiveness of the Plan, and that the revised Plan continued to meet the requirements of 10 CFR 50.47(b) and Appendix E to 10 CFR Part 50. The NRC review was not documented in a safety evaluation report and did not constitute approval of licensee-generated changes; therefore, these revisions are subject to future inspection. The specific documents reviewed during this inspection are listed in the Attachment. This inspection activity satisfied one inspection sample for the emergency action level and emergency plan changes on an annual basis.

b. Findings

No findings were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator (PI) Verification (71151)

a. Inspection Scope

The inspectors reviewed a sample of PI data, submitted by the licensee, for the PIs listed below. To verify the accuracy and completeness of the data reported for the station, the inspectors reviewed plant records compiled between October 2012 and October 2013. The inspections verified that the PI data complied with guidance contained in NEI 99-02, "Regulatory Assessment Indicator Guideline," and licensee procedures. The inspectors also confirmed the PIs were calculated correctly. In addition, the inspectors reviewed a sample of related corrective action documents to verify the licensee was identifying and correcting any deficiencies associated with PI data. Documents reviewed are listed in the Attachment.

Cornerstone: Mitigating Systems

- Safety System Functional Failures
- Heat Removal System
- Cooling Water System

b. Findings

No findings were identified.

4OA2 Problem Identification and Resolution (71152)

.1 Routine Review

The inspectors performed a daily screening of items entered into the licensee's corrective action program in order to identify repetitive equipment failures or specific human performance issues for follow-up. The inspectors reviewed daily condition reports, attended screening meetings, or accessed the licensee's computerized corrective action database.

.2 Semi-Annual Trend Review

a. Inspection Scope

The inspectors reviewed the licensee's corrective action program and associated documents to identify trends which could indicate the existence of a more significant safety issue. The inspectors focused their review on repetitive equipment issues and human performance trends, but also considered the results of inspector daily condition

report screenings, licensee trending efforts, and licensee human performance results. The review nominally considered the six month period of July 2013 thru December 2013 although some examples extended beyond those dates when the scope of the trend warranted. The inspectors compared their results with the results contained in the licensee's trend documents. Additionally, the inspectors reviewed the adequacy of corrective actions associated with a sample of the issues identified in the licensee's trend reports. The inspectors also reviewed corrective action documents which have been processed by the licensee to identify potential adverse trends in structures, systems, and/or components as evidenced by acceptance of long-standing non-conforming or degraded conditions. Documents reviewed are listed in the Attachment.

b. Findings:

No findings were identified.

.3 Annual Follow-up of Selected Issues

a. Inspection Scope

The inspectors selected condition report 713629, "Mechanics Closed Wrong Valve and Tripped Chiller," for detailed review. The inspectors evaluated the following attributes of the licensee's actions:

- complete and accurate identification of the problem in a timely manner
- evaluation and disposition of operability/reportability issues
- consideration of extent of condition, generic implications, common cause, and previous occurrences
- classification and prioritization of the problem
- identification of root and contributing causes of the problem
- identification of any additional condition reports
- completion of corrective actions in a timely manner

Documents reviewed are listed in the Attachment.

b. Findings:

Introduction: A self-revealing Green NCV of Hatch Unit 1 and Unit 2 Technical Specification 5.4., "Procedures," was identified on October 5, 2013, when the licensee failed to implement an administrative procedure for equipment control which caused the "A" main control room air conditioning unit to trip.

Description: The licensee's procedure governing the use of personal danger tags (PDTs) is procedure NMP-AD-003-005, "PDT Tags/Maintenance Locks Use With Operating Permit Tags or PDT Documentation Sheets," Ver. 3.1. Section 4.1 of this procedure requires in part that, prior to approval, tagged equipment configuration must be evaluated against plant conditions to ensure the use of the PDTs will have no adverse effects on the continued operation of the plant. On October 5, 2013, the

licensee issued a PDT clearance sheet for the Hatch "A" main control room air conditioning unit plant service water strainers 1P41-D173A and 1P41-D173B in order to clean the strainers. The two strainers are in a parallel arrangement, with one always required to be in service to supply cooling water to the air conditioning unit. Two licensee mechanical maintenance personnel were given the task of executing the PDT clearance and cleaning strainers without knowing which strainer was out-of-service. The personnel were briefed on the task to clean the strainers, and the work orders and PDT clearance to clean both strainers were provided to them. When the mechanics arrived at the work location, they found a drain cap removed on the drain line for the 1P41-D173A strainer. They incorrectly assumed that this was the out-of-service strainer. At 1303, the mechanics proceeded to close the strainer isolation valve, 1P41-F1415A, per the PDT clearance sheet. This action resulted in isolating the in-service strainer and tripping the "A" main control room air conditioning unit. At 1305 the licensee declared 1Z41B008A, "A" main control room air conditioner, out of service and entered technical specification 3.7.5 Action Statement A for the inoperable control room air conditioner. At 1330, "A" main control room air conditioner was restarted and declared operable. The licensee entered this issue into their corrective action program as CR 713629.

Analysis: Failure to ensure the use of PDTs will have no adverse effects on the continued operation of the plant as required by procedure NMP-AD-003-005 was a performance deficiency. This performance deficiency was more-than-minor because it adversely affected the equipment performance attribute of the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, a PDT clearance sheet was performed on in-service equipment and resulted in the tripping of the "A" main control room air conditioner. The inspectors evaluated the finding in accordance with IMC 0609, Attachment 4, "Initial Characterization of Findings," dated June 19, 2012. Using Table 2, "Cornerstones Affected by Degradation Condition or Programmatic Weakness," the finding affected the mitigating systems cornerstone and required further evaluation using IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012. Based on Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," the finding screened as Green because all the questions were answered "no." The inspectors determined this finding has a cross-cutting aspect in the work control aspect of the human performance area, because the licensee did not coordinate work activities by incorporating actions to address the need to keep personnel apprised of work status, the operational impact of work activities, or plant conditions that may affect work activities. [H.3(b)]

Enforcement: Hatch Unit 1 and Unit 2 Technical Specification 5.4.1, "Procedures," requires, in part, that procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Regulatory Guide 1.33, Appendix A, Section 1.c requires administrative procedures for equipment control (e.g., locking and tagging). Procedure NMP-AD-003-005, "PDT Tags/Maintenance Locks Use With Operating Permit Tags or PDT Documentation Sheets," Ver. 3.1, Section 4.1, requires in part that prior to approval, tagged equipment configuration must be evaluated against plant conditions to ensure the use of the PDTs will have no adverse effects on the continued operation of the plant. Contrary to the above, on October 5, 2013, the licensee did not implement

their administrative procedure for equipment control, NMP-AD-003-005, Ver. 3.1, Section 4.1 which resulted in tripping of the "A" main control room air conditioning unit. The licensee properly realigned the system and restarted the "A" main control room air conditioning unit to restore compliance. This violation is being treated as an NCV, consistent with Section 2.3.2 of the Enforcement Policy. The violation was entered into the licensee's corrective action program as CR 713629. (NCV 05000321,366/2013005-03; "Failure to Implement an Administrative Procedure for Equipment Control When Using Personal Danger Tags")

4OA3 Follow-up of Events and Notices of Enforcement Discretion (71153)

.1 (Closed) LER 05000366/2013-005 and LER 05000366/2013-005, Revision 1, Main Steam Isolation Valve Failed to Close During Surveillance Testing

a. Inspection Scope

The inspectors reviewed this LER for potential performance deficiencies and/or violations of regulatory requirements. Additionally, discussions were held with Operations, Engineering and Licensing staff members to understand the details surrounding this issue. This condition was documented in the licensee's corrective action program as CR 702823. LER 05000366/2013-005 and LER 05000366/2013-005, Revision 1, are closed.

b. Findings

The enforcement aspects of this finding are discussed in Section 4OA7.

4OA5 Other Activities

.1 Quarterly Resident Inspector Observations of Security Personnel and Activities

a. Inspection Scope

During the inspection period, the inspectors conducted observations of security force personnel and activities to ensure that the activities were consistent with licensee security procedures and regulatory requirements relating to nuclear plant security. These observations took place during both normal and off-normal plant working hours.

These quarterly resident inspector observations of security force personnel and activities did not constitute any additional inspection samples. Rather, they were considered an integral part of the inspectors' normal plant status review and inspection activities.

b. Findings

No findings were identified.

4OA6 Meetings, Including Exit

On January 24, 2014, the resident inspectors presented the inspection results to Mr. Richard Spring and other members of the licensee's staff. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

4OA7 Licensee-Identified Violations

The following violation of very low safety significance (Green) or Severity Level IV was identified by the licensee and is a violation of an NRC requirement which met the criteria of the NRC Enforcement Policy for being dispositioned as a Non-Cited Violation.

- A licensee-identified violation of Hatch Unit 2 Technical Specification 3.6.1.3 was discovered on September 14, 2013, when the Unit 2 "D" outboard main steam isolation valve failed to stroke closed during surveillance testing. Technical Specification 3.6.1.3 requires that each primary containment isolation valve, except reactor building-to-suppression chamber vacuum breakers, shall be operable and, when a main steam isolation valve penetration flow path is inoperable, the steam line penetration shall be isolated within eight hours. Contrary to this technical specification, Hatch Unit 2 "D" outboard main steam isolation valve was determined to be inoperable from March 17, 2013, through September 14, 2013, and the unit was operated with the main steam isolation valve penetration not isolated. This violation screened as Green because the "D" inboard main steam isolation remained operable and therefore resulted in no loss of isolation function. (Section 4OA3.1)

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel
B. Anderson, Health Physics Manager
G. Brinson, Maintenance Director
V. Coleman, Chemistry Manager
A. Giancatarino, Engineering Director
C. Lane, Engineering Systems Manager
K. Long, Operations Director
M. Madigan, Work Management Director
R. Spring, Plant Manager
S. Tipps, Principal Licensing Engineer
M. Torrance, Nuclear Oversight Manager
D. Vineyard, Hatch Vice President
A. Wheeler, Site Projects Manager

LIST OF ITEMS OPENED AND CLOSED

Closed

05000321/2013002-01	URI	Unit 1 Under Vessel Leak Source Not Identified (Section 1R20.2)
05000366/2013-005, and 05000366/2013-005 Rev. 1	LER	Main Steam Isolation Valve Failed to Close During Surveillance Testing (Section 4OA3.1)

Opened & Closed

05000321, 366/2013005-01	NCV	Scaffolding Installed in Safety Related Areas Failed to Meet Procedural Requirements (Section 1R12)
05000321/2013005-02	NCV	Failure to Promptly Identify Source of Leakage Under Unit 1 Reactor Vessel (Section 1R20.2)
05000321, 366/2013005-03	NCV	Failure to Implement an Administrative Procedure for Equipment Control When Using Personal Danger Tags (Section 4OA2.3)

LIST OF DOCUMENTS REVIEWED

Section 1R01: Adverse Weather

Procedures

DI-OPS-36-0989, Cold Weather Checks
52PM-MEL-005-0, Cold Weather Checks

Other

Individual Plant Examination of External Events

Section 1R04: Equipment Alignment

Procedures

34SO-E11-010-1, Residual Heat Removal System, Ver. 41.0
34SO-E11-010-2, Residual Heat Removal System, Ver. 40.0
34SO-E21-001-1, Core Spray System, Ver. 23.1

Other

Tagout 1-DT-13-1E11-00245

Section 1R05: Fire Protection

Procedures

E.I. Hatch Fire Protection Fire Hazards Analysis
42FP-FPX-018-0, Use, Control and Storage of Flammable/Combustible Materials, Version 1.2
34AB-X43-001-1, Fire Procedure, Version 10.25
42SV-FPX-024-0, Fire Hose Stations – Appendix B Areas, Version 3.2

Drawings

A-43966 sheet 27A/B, Unit 1 & 2 Pre-Fire Plan Intake Structure
A-43966 sheet 6A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Oil Storage Room 1C
A-43966 sheet 7A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Battery Room 1C
A-43966 sheet 8A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Diesel Generator Room 1C
A-43966 sheet 10A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Oil Storage Room 1B
A-43966 sheet 11A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Battery Room 1B
A-43966 sheet 12A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Diesel Generator Room 1B
A-43966 sheet 14A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Oil Storage Room 1A
A-43966 sheet 15A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Battery Room 1A
A-43966 sheet 16A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Diesel Generator Room 1A
A-43966 sheet 18A/B, Unit 2 Pre-Fire Plan Diesel Generator Building Oil Storage Room 2A
A-43966 sheet 19A/B, Unit 2 Pre-Fire Plan Diesel Generator Building Battery Room 2A
A-43966 sheet 20A/B, Unit 2 Pre-Fire Plan Diesel Generator Building Diesel Generator Room 2A
A-43966 sheet 22A/B, Unit 2 Pre-Fire Plan Diesel Generator Building Oil Storage Room 2C
A-43966 sheet 23A/B, Unit 2 Pre-Fire Plan Diesel Generator Building Battery Room 2C
A-43966 sheet 24A/B, Unit 1 Pre-Fire Plan Diesel Generator Building Diesel Generator Room 2C
A-43966 sheet 43A/B, Unit 1 Pre-Fire Plan Condensate Storage Tank
A-43966 sheet 44A/B, Unit 2 Pre-Fire Plan Condensate Storage Tank
A-43966 sheet 48A/B, Unit 1 Pre-Fire Plan Service Water Valve Pit 1A
A-43966 sheet 49A/B, Unit 1 Pre-Fire Plan Service Water Valve Pit 1B
A-43966 sheet 50A/B, Unit 2 Pre-Fire Plan Service Water Valve Pit 2A
A-43966 sheet 51A/B, Unit 2 Pre-Fire Plan Service Water Valve Pit 2B

Condition Reports
733490, 733603

Section 1R06: Internal Flood Protection
Condition Reports
733037

Documents
HNP-2-FSAR Chapter 9.3.3.2.2.B

Procedure
52PM-Y46-001-0, Inground Pullbox Debris Removal / Inspection, Ver. 10.0
NMP-ES-051-004, Pull Box Inspection Procedure, Ver. 1.1

Work Orders
SNC309608

Section 1R11: Licensed Operator Requalification
Drill Scenario
LT-SG-50464-10.1
LT-SG-51076-04.1

Procedure
34GO-OPS-014-1, Fast Reactor Shutdown, Ver. 14.0

Section 1R12: Maintenance Effectiveness
U41 System Health Report
U41 Maintenance Rule Scoping Manual Documents
U41 MR Performance Criteria
Z41 System Health Report
Z41 Maintenance Rule Scoping Manual Documents
Z41 MR Performance Criteria
NMP-ES-002, System Monitoring and Health Reporting, Ver. 15.2
NMP-ES-027, Maintenance Rule Program, Ver. 2.0

Condition Reports
672249
TE 663983
CAR 207457

Section 1R13: Maintenance Risk Assessments and Emergent Work Evaluation
Other
Equipment Out of Service calculations 09/28/13 - 10/04/13
Equipment Out of Service calculations 11/02/13 - 11/08/13
Equipment Out of Service calculations 11/16/13 – 11/22/13

Procedures
NMP-DP-001, Operational Risk Awareness, Ver. 14.1
90AC-OAM-002-0, Scheduling Maintenance, Ver. 6.0
50AC-MNT-001-0, Maintenance Program, Ver. 33.3
NMP-OS-010-002, Hatch Protected Equipment Logs, Ver. 8.6

Section 1R15: Operability Evaluations
Procedures
NMP-AD-012, Operability Determinations and Functional Assessments, Ver. 6.0

Condition Reports
CR 729565/TE 730290

Other
Control room logs
Operating Experience Smart Sample 2012/02

Section 1R18: Plant Modifications
Procedures
NMP-ES-034, Equivalency Determinations, Ver. 14.4

Condition Reports
646093

Other
SNC474610
SNC359362
TE647040

Section 1R19: Post Maintenance Testing
Maintenance Work Orders
SNC528709, SNC423570, SNC417929, SNC418123

Procedures
34SV-C11-004-1, Control Rod Drive Timing, Ver. 8.0
34SV-E11-001-1, Residual Heat Removal Pump Operability, Ver. 24.5
42IT-TET-004-0, Operating Pressure Testing of Piping and Components, Ver. 9.1

Condition Reports
722797, 743375

Section 1R20: Refueling and Outage Activities
34GO-OPS-028-1, Drywell Closeout

Section 1R22: Surveillance Testing

Procedures

34SV-C41-001-2, Standby Liquid Control Monthly Test, Ver. 12.3
34SV-E51-002-1, Reactor Core Isolation Cooling Pump Operability, Ver. 26.0
34SV-R43-001-2, Diesel Generator 2A Monthly Test, Ver. 28.0

Work Orders

SNC482660, SNC482659, SNC446400

Section 1EP4: Emergency Action Level and Emergency Plan Changes

Change Packages

Emergency Plan, Revision 32
NMP-EP-110, "Emergency Classification Determination and Initial Action," Version 6.0
NMP-EP-111, "Emergency Notifications," Version 8.0

Section 4OA1: Performance Indicators

Procedures

00AC-REG-005-0, Preparation and Reporting of NRC PI Data

Other

E. I. Hatch Mitigating System Performance Index Basis Document, Ver. F

Consolidated Data Entry MSPI Derivation Report

Unit 1 and Unit 2 Heat Removal System Unavailability
Unit 1 and Unit 2 Heat Removal System Unreliability
Unit 1 and Unit 2 Cooling Water System Unavailability
Unit 1 and Unit 2 Cooling Water System Unreliability

Section 4OA2: Identification and Resolution of Problems

Procedures

NMP-AD-003-005, PDT Tags/Maintenance Locks Use With Operating Permit Tags or PDT Documentation Sheets, Ver. 3.1

Condition Reports

713629, 728085

Other

CAR 208216
CAR 208509
TE 713936

Section 4OA3: Event Follow-up

Condition Report

702823

Documents
TE 704641
Unit 2 LER 2013-005

Other
E.I. Hatch Nuclear Plant Technical Specifications and Bases
E.I. Hatch Unit 1 and Unit 2 Final Safety Analysis Report