Hatch 1
2Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to promptly identify source of leakage under Unit 1 reactor vessel
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)

Inspection Report# : 2013005 *(pdf)*

Mitigating Systems

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Scope Safety System MOVs in the GL 96-05 Periodic Verification Program
Green. The inspectors identified a Green NCV of 10 CFR 50.55a, "Codes and Standards," for the licensee's failure to establish a periodic verification program for the core spray, high pressure core injection, and reactor core injection cooling systems pump outboard discharge motor-operated valves (MOVs) to ensure their long-term capability to perform their design bases safety functions. The licensee provided operators with interim instructions to declare the affected systems inoperable until permanent corrective actions are implemented. This violation has been entered into the licensee's corrective action program as CR 799261.

Failure to establish a periodic verification program for the core spray, high pressure core injection, and reactor core injection cooling systems pump outboard discharge MOVs to ensure their long-term capability to perform their design basis safety functions was a performance deficiency. The 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, failure to ensure the long-term capability of the valves to perform their design basis safety functions overestimated the availability and reliability of the core spray, high pressure core injection, and reactor core injection cooling systems during testing or other activities that would place the valves in their non-safety position. The inspectors screened this finding using IMC 0609, Appendix A, "The Significant Determination Process (SDP) For Findings At-Power", dated June 19, 2012. The finding screened as Green per Section A of Exhibit 2, "Mitigating Systems Screening Questions," because each of the four screening questions were answered "no." The inspectors determined the finding had a cross-cutting aspect of "evaluation" in the problem identification and resolution area because in 2013 the licensee had corrective actions in the corrective action program to evaluate the adequacy of the MOV periodic verification program scope and failed to identify that reliance on the valves to reposition when in the closed position required the valves to be in the program. [P.2] (Section 4OA2.2)
Inspection Report# : 2014002 *(pdf)*

Significance: G Dec 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Scaffolding installed in safety related areas failed to meet procedureal requirements
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)

Inspection Report# : 2013005 *(pdf)*

Significance: G Dec 31, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to implement an administrative procedure for equipment control when using personal danger tags
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)

Inspection Report# : 2013005 *(pdf)*

Significance: G Sep 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to take required actions for inoperable equipment in accordance with Hatch's fire hazards analysis, Appendix B
The NRC identified a non-cited violation of Unit 1 License Condition 2.C.(3), “Fire Protection,” and Unit 2 License Condition 2.C.(3)(a), “Fire Protection,” which occurred on September 3, 2013, when the licensee failed to establish fire watches and compensatory measures required by Hatch’s Fire Hazards Analysis, Appendix B, after a fire header pipe rupture rendered sprinklers and hose stations inoperable. The licensee returned the fire header to operable status September 4, 2013, to restore compliance. This violation was entered into the licensee’s corrective action program as condition report (CR) 700402.

Failure to establish fire watches and compensatory actions as required by Hatch’s Fire Hazards Analysis, Appendix B, when sprinkler systems and hose stations became inoperable on September 3, 2013, was a performance deficiency. This performance deficiency was more-than-minor because the performance deficiency is associated with the mitigating systems cornerstone protection against external factors (fire) attribute and adversely affected the cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to establish fire watches and alternate compensatory measures resulted in the loss of fixed fire suppression capabilities within each fire area on the plant site for up to 6 hours. The inspectors screened this finding using IMC 0609, Appendix F, Attachment 1, dated February 28, 2005. Using Part 1, “Fire Protection SDP Phase 1 Worksheet,” this finding screened as requiring a Phase 2 analysis, because the duration factor was determined to be 0.01 (< 3 Days), the summation of estimated fire frequency for the fire areas was calculated to be 3.78E-01, and the delta core damage frequency (CDF) calculation of 3.78E-03 was greater than a high degradation value of 1E-6 in Table A1.1. The inspectors submitted this finding to the Region II senior reactor analyst for further processing. A detailed SDP risk evaluation was performed by a regional senior reactor analyst. A bounding SDP risk evaluation was completed using a hand calculation and guidance from NRC IMC 0609 Appendix F. The significant analysis assumptions included a five hour exposure time, plant wide ignition frequency of

approximately 3E-1/year, severity factor of 1E-1 (only large fires likely to require use of fixed suppression), probability of non-suppression (PNS) of 5E-1 (10 minute fire growth scenario for base case and PNS of 1.0 no suppression due to the PD for the non-conforming case), and a conditional core damage probability of 1E-1 (assumed that large unsuppressed fire would lead to alternate shutdown scenario). The low exposure period mitigated the risk of the performance deficiency. The result of the bounding SDP evaluation was a core damage frequency increase (?CDF) of < 1E-6/year, a GREEN finding of very low safety significance. 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 when applying actions for inoperable fire hose stations, yard fire hydrants, and sprinklers. [H.1(b)] (Section 4OA3.1)

Inspection Report# : 2013004 *(pdf)*

Barrier Integrity

Significance: G Jun 30, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Prove Operability Following the Failure of the Secondary Containment Surveillance Test
Green. The inspectors identified a Green non-cited violation of 10 CFR 50, Appendix B, Criterion V, "Procedures, Instructions, and Drawings," for the licensee's failure to prove operability following a failure of a surveillance test as required by Hatch procedure 90AC-OAM-001-0, "Test and Surveillance Control," Ver. 1.0, on May 12, 2014. To restore compliance, the licensee isolated the refueling floor dampers and re-performed Surveillance Requirement 3.6.4.1.3 with satisfactory results later that day on May 12, 2014. This violation was entered into the licensee's corrective action program as condition report (CR) 819563.

Failure to prove operability following failure of a surveillance test as required by Hatch procedure 90AC-OAM-001-0, "Test and Surveillance Control," Ver. 1.0, on May 12, 2014, was a performance deficiency. The performance deficiency affected the barrier integrity cornerstone and was more-than-minor because, if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, declaring equipment operable following a failed surveillance test would have the potential for the facility to operate outside of technical specification requirements. The inspectors screened this finding using IMC 0609, Appendix A, "The Significant Determination Process (SDP) For Findings At-Power", dated June 19, 2012. The finding screened as Green per Section C of Exhibit 3, "Barrier Integrity Screening Questions," because the finding only represented a degradation of the radiological barrier function provided by the standby gas treatment system. The inspectors determined the finding had a cross-cutting aspect of "training" in the human performance area, because the licensee did not ensure knowledge transfer of Surveillance Requirement 3.0.1 requirements to maintain a knowledgeable, technically competent workface and instill nuclear safety values. [H.9]

Inspection Report# : 2014003 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Dec 13, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Update the UFSAR Following a Change in Neutron Fluence Calculation Methodology
SL IV. The inspectors identified an NRC-identified Severity Level IV non-cited violation (NCV) of 10 CFR 50.71(e) for the licensee's failure to update the UFSAR following the change in methodology used to calculate reactor vessel neutron fluence. Specifically, the licensee did not completely update the UFSAR to reflect the change in fluence calculation methodology from the General Electric methodology to the Radiation Analysis Modeling Application (RAMA) methodology described in BWRVIP-114-A, "BWR Vessel and Internals Project, RAMA Fluence Methodology Theory Manual." The licensee entered this issue into their corrective action program as condition report (CR) 744853.

The inspectors determined that the failure to update the UFSAR as required by 10 CFR 50.71(e) was a performance deficiency. The performance deficiency was greater than minor because the failure to provide complete licensing and design basis information in the UFSAR could result in either the licensee making an inappropriate licensing interpretation or the NRC making an inappropriate regulatory decision based on incomplete information in the UFSAR. This performance deficiency was dispositioned using the traditional enforcement process because failing to update a UFSAR had the potential to adversely impact the NRC's ability to perform its regulatory function. The performance deficiency was characterized as a Severity Level IV violation in accordance with the NRC Enforcement Policy (dated July 9, 2013), Section 6.1.d.3. Since this issue was dispositioned using traditional enforcement, there was no cross-cutting aspect associated with this violation (Section 4OA5.3).
Inspection Report# : 2013007 *(pdf)*

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