Hatch 2
3Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2014
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Operate the Unit 2 Master Feedwater Controller In Accordance With Procedures
Green. A self-revealing Green non-cited violation (NCV) of Technical Specification 5.4, "Procedures," was identified when an automatic recirculation pump runback occurred after improper operations of the Unit 2 master feedwater controller "PF" push button. The licensee restored compliance when the crew responded to the runback using approved procedures, and restored reactor water level to the correct setpoint. The violation was entered into the licensee's corrective action program as condition report (CR) 759497.

Failure to operate the Unit 2 master feedwater controller, 2C32-R600, in accordance with plant procedures on January 17, 2014, was a performance deficiency. This performance deficiency was more than minor because it is associated with the human performance attribute of the initiating events cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability during power operations. Specifically, the performance deficiency directly resulted in an unplanned transient when plant systems automatically reduced reactor power. 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 B. of Exhibit 1, "Initiating Events Screening Questions," because the finding did not cause a reactor trip and the loss of mitigation equipment, a high energy line-break, internal flooding, or a fire. Inspectors determined the finding had a cross-cutting aspect of "avoid complacency" of the human performance area because the operator did not implement the error reduction tool (reading the placard below the controller) prior to performing an action. [H.12] (Section 4OA3.1)
Inspection Report# : 2014002 *(pdf)*

Mitigating Systems

Significance: G Sep 30, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Fire Surveillance Procedure Resulted in Isolation of All Fire Water to the Station
The NRC identified a NCV of Technical Specification 5.4, "Procedures," for the licensee's failure to properly implement a valve lineup in a surveillance procedure for the fire protection system. The licensee inadvertently isolated all fire suppression water during the performance of a valve lineup. Although this condition was identified by the licensee, the inspectors identified weaknesses in the licensee's apparent cause determination. Therefore, this finding is being treated as an NRC-Identified finding. The violation was entered into the licensee's corrective action program as condition report 841493.

The licensee's failure to implement the correct valve lineup in accordance with procedure 42SV-FPX-015-0, "System Flush Fire Protection Water", was a performance deficiency. This performance deficiency was more than minor

because the performance deficiency was associated with the Protection Against External Factors (Fire) attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective in that the failure to implement the correct valve lineup of 42SV-FPX-015-0 resulted in total fire suppression water isolation. The inspectors screened this finding as requiring a Phase 3 analysis, because 1) the duration factor was determined to be 0.01 (< 3 Days), 2) the summation of estimated fire frequency for the fire areas was calculated to 1.24E-01, and 3) the delta CDF calculation was greater than 1E-6 in Table 1.5.4. A Senior Reactor Analyst performed a Phase 3 analysis for the finding using licensee input from their fire PRA. Because of the short exposure time of approximately one hour, the change in risk was below 1E-6. Therefore, this finding is Green. The finding had a cross-cutting aspect of "resources" in the human performance area, because the licensee did not ensure that procedure 42SV-FPX-015-0 was adequate to support nuclear safety. [H.1]
Inspection Report# : 2014004 *(pdf)*

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Install Seismic Restraints of the Unit 2 LOCA LOSP Timer Cabinet Doors Following Inspection
Green. The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," when the licensee failed to prescribe in documented instructions, procedures, or drawings appropriate to the circumstances the inspection of the Unit 2 loss of coolant accident (LOCA)/loss of offsite power (LOSP) emergency diesel generator loading timers. The licensee restored compliance by adding a step within the operator rounds to confirm the LOCA/LOSP emergency diesel generator loading timer cabinet door fasteners are reengaged and tightened. This violation has been entered into the licensee's corrective action program as CR 793669.

Failure to engage and tighten the Unit 2 LOCA/LOSP emergency diesel generator loading timer cabinet doors following inspection on January 2, 2014, was a performance deficiency. The performance deficiency was more than minor, because it is associated with the mitigating systems cornerstone protection against external factors attribute and adversely affected the corner objective to ensure the reliability of systems that respond to initiating events to prevent undesirable consequences. Specifically, with none of the latches engaged the reliability of circuitry within the cabinet following a seismic event was adversely affected. 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 "resources" in the human performance area because the licensee did not ensure that procedures were available and adequate for performing the nightly inspection of the Unit 2 LOCA/LOSP emergency diesel generator loading timers. [H.1] (Section 1R15)

Inspection Report# : 2014002 *(pdf)*

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)*

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)*

Last modified : November 26, 2014