

## Hatch 2

### 4Q/2014 Plant Inspection Findings

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#### Initiating Events

**Significance:**  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*)

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#### Mitigating Systems

**Significance:**  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:**  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:**  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*)

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## Barrier Integrity

**Significance:**  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 workforce and instill nuclear safety values. [H.9]

Inspection Report# : [2014003](#) (*pdf*)

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## 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.

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## Miscellaneous

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