

Hatch 1

2Q/2016 Plant Inspection Findings

Initiating Events

Significance: TBD Jun 30, 2016

Identified By: NRC

Item Type: AV Apparent Violation

Inaccurate Information Provided Regarding N2E Nozzle Weld Overlay

The NRC identified an AV of 10 CFR 50.9, “Completeness and Accuracy of Information,” for the licensee’s failure to provide data to the NRC that was accurate in all material aspects. Specifically, on two occasions (October 1995, May 2000), the licensee stated that weld 1B31-1RC-12BR-E-5 had been modified with a full-structural weld overlay (FSWOL), when in fact it had only been modified with a less robust design overlay (leak barrier). The NRC approved the licensee’s requests/proposed alternatives in part based on the inaccurate characterization of the welds. The licensee has since installed the FSWOL and entered the issue into the corrective action program as CR 10197850.

The NRC is considering escalated enforcement on the basis that had the licensee provided accurate information, it would likely have caused the NRC to reconsider a regulatory position.

Inspection Report# : [2016010](#) (*pdf*)

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Identify N2E Nozzle Weld Through-Wall Flaw

The inspectors identified a Green NCV of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Actions,” for the licensee’s failure to promptly identify a condition adverse to quality regarding a through-wall flaw in the safe end-to-nozzle weld of the reactor coolant system N2E nozzle. The licensee has since repaired the flaw, completed all required postrepair examinations, and entered this issue into their corrective action program as CR 10247856.

The performance deficiency was more than minor because it was associated with the Equipment Performance attribute of the Initiating Events cornerstone and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors screened this finding using IMC 0609, Appendix A, “The Significance Determination Process (SDP) For Findings At-Power”, dated June 19, 2012. Because after a reasonable assessment of degradation, the finding could neither result in exceeding the RCS leak rate for a small LOCA, nor likely affected other systems used to mitigate a LOCA resulting in a total loss of their function, the finding screened as Green. This finding has a cross-cutting aspect of Challenge the Unknown in the area of Human Performance (H.11) because upon discovery of a less robust configuration of the N2E nozzle overlay, the licensee failed to consider the implications on the flaw that had existed in that component since 1988.

Inspection Report# : [2016010](#) (*pdf*)

Mitigating Systems

Significance:  Jun 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

, Failure to Implement Maintenance Procedure for Control Room Air Conditioning System

A self-revealing Green NCV of Hatch Unit 1 and Unit 2 Technical Specification 5.4, "Procedures," was identified when the 'B' main control room air conditioning condenser tripped on high discharge pressure due to an improperly adjusted water regulating valve. The licensee entered the condition into their corrective action program as CR 10217777, adjusted the water regulating valve to the appropriate set-point.

Failure to adjust the water regulating valve in accordance with preventive maintenance procedure 52PM-Z41-002-1, "Control Room Air Conditioning Maintenance," was a performance deficiency. The performance deficiency was more than minor because it associated with the 'Equipment Performance' attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective in that the failure resulted in the inoperability of the 'B' main control room air conditioner. The finding screened as Green because the loss of component function did not significantly affect the function of the train or system. The inspectors determined that this finding had a cross-cutting aspect in the 'Resources' aspect of the Human Performance area, because licensee leadership did not ensure that procedures were available and adequate to support nuclear safety [H.1].

Inspection Report# : [2016002](#) (pdf)

Significance:  Jun 24, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Adequately Qualify Modifications to Class 1E 4160V Buses

The inspectors identified a non-cited violation of Title 10 Code of Federal Regulations (CFR) Part 50 Appendix B, Criterion III, "Design Control," for the failure to verify adequate design and qualification of Class 1E buses in accordance with Institute for Electronics and Electrical Engineering (IEEE) 279-1971, "Standard Criteria for Protection Systems for Nuclear Power Generating Stations." The licensee entered this issue into the licensee's corrective action program as CR10240030. The licensee planned to correct the issue prior to installing new transformers.

The performance deficiency was determined to be more than minor because if left uncorrected, it would have the potential to lead to a more significant safety concern. The finding determined to be of very low safety significance (Green) because the system, structure, or component maintained its operability or functionality. The finding was assigned a cross-cutting aspect of Training [H.9], in the Human Performance area because the organization did not provide training and ensure knowledge transfer to maintain a knowledgeable, technically competent workforce to adequately complete a modification of the Class 1E buses.

Inspection Report# : [2016008](#) (pdf)

Significance:  Jun 24, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to identify a condition adverse to quality for Masterpact 600V breakers

The inspectors identified a non-cited violation of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," for failing to identify the applicability of US NRC Part 21 Report 2016-20-01 to the 1B emergency diesel generator's (EDG's) motor control center (MCC 1B). The licensee entered this issue into the corrective action program for resolution as CR 10240007. For corrective actions, the licensee performed an immediate operability determination and established compensatory measures to reset the breaker linkage in the event that it malfunctions.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attribute of Equipment Performance and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of the systems that respond to initiating events to prevent undesirable consequences. The inspectors determined the finding to be of very low safety significance (Green) because the structure, system, or component maintained its operability or functionality. The finding was assigned a cross-cutting aspect of Evaluation [P.2], in the Problem Identification and Resolution area because the organization did not thoroughly evaluate the Masterpact breaker Part 21 to ensure that resolutions addressed the causes.

Inspection Report# : [2016008](#) (pdf)

Significance:  Jun 24, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Control Qualification of Purchased 1E Components in Accordance to IEEE 323-1974

The inspectors identified two examples of a non-cited violation of 10 CFR 50 Appendix B, Criterion VII, “Control of Purchased Material, Equipment, and Services,” for failing to assure that vendors met the quality standards specified in procurement documents (IEEE 323-1974, “IEEE Standard for Qualifying Class IE Equipment for Nuclear Power Generating Stations”). The licensee entered this issue into the licensee’s corrective action program as CR10240023 and CR102399929. The licensee planned to ensure the adequate qualification of Class 1E components.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attribute of Design Control and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of the systems that respond to initiating events to prevent undesirable consequences. The inspectors determined the finding to be of very low safety significance (Green) because the structure, system, or component maintained its operability or functionality. The finding was assigned a cross-cutting aspect of Field Presence [H.2], in the Human Performance area because senior managers did not ensure supervisory and management oversight of contractors.

Inspection Report# : [2016008](#) (pdf)

Significance:  Apr 22, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to provide reasonable assurance that Appendix R time critical operator actions (TCOAs) can be completed in a timely manner

The NRC identified a Green non-cited violation (NCV) violation of Hatch Technical Specifications 5.4.1.d, “Procedures,” for Units 1 and 2, for not ensuring manual action feasibility for actions in fire area (FA) 0024. Specifically, the licensee failed to provide reasonable assurance that a credited manual action to ensure emergency power was both feasible and reliable in response to a fire event. The licensee plans to assess the issue and entered this violation into their Corrective Action Program (CAP) based upon CR10209664, CR10213119, & CR10212821.

The licensee’s failure to provide reasonable assurance that Appendix R time critical operator actions (TCOAs) associated with fire events can be completed in a timely manner was a performance deficiency (PD). The PD was more than minor because if left uncorrected, it could lead to a more significant safety concern. Specifically, the exclusion of TCOAs from a validation process could lead to plant or program changes that prohibit the completion of actions required to meet the licensing basis. Using the guidance of IMC 0609, App. F, the finding was screened as Green because the finding did not affect the ability to reach and maintain a stable plant condition within the first 24 hours of a fire event. The deficiency was screened with IMC 0310, “Aspects Within Cross Cutting Areas,” to determine if any cross-cutting areas were applicable. The team concluded cross-cutting was applicable to the problem

identification and resolution (PI&R) area, evaluation attribute due the licensee's failure to thoroughly evaluate issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance (P.2).

Inspection Report# : [2016007](#) (pdf)

Significance:  Oct 23, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Assure that Class 1E Components were Qualified for Design Temperatures

The NRC identified a Non-cited Violation of 10 CFR Part 50, Appendix B, Criterion VII, "Control of Purchased Material, Equipment, and Services," for the licensee's failure to ensure that adequate environmental test requirements were satisfied before relying on safety-related components to perform their intended safety functions. As an immediate corrective action, the licensee performed an operability evaluation and determined the components were operable. In addition, the licensee indicated that they planned to determine adequate corrective actions to restore full qualification of these commercial grade components, and entered this issue into their Corrective Action Program as Condition Report 10138133.

The performance deficiency was determined to be more than minor because it was associated with the Design Control attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone objective, in that the licensee failed to verify the environmental qualification of safety-related components to ensure their performance up to the expected temperature of 150 degrees F. The finding was determined to be of very low safety significance (Green) because it was a deficiency affecting the design or qualification of a mitigating SSC, and the SSC maintained its operability or functionality. This finding was not assigned a cross-cutting aspect because the issue did not reflect current licensee performance

Inspection Report# : [2015007](#) (pdf)

Significance:  Oct 23, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Verify Design Basis Timing Margins for Safety Related Motor Operated Valves

Green: The NRC identified a Non-cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to evaluate if transients in control power voltage could affect the design basis margins for the timing of safety-related motor operated valves (MOVs).

The licensee planned to perform corrective actions to ensure that the safety analysis remains bounded, and entered this violation into their Corrective Action Program as Condition Report 10138053.

The performance deficiency was determined to be more than minor because it was associated with the Design Control attribute of the Mitigating Systems Cornerstone, and adversely affected the cornerstone objective, in that the failure to evaluate transients that effect the timing margins for NOVs affected the established reliability and capability of the valves. The finding was determined to be of very low safety significance (Green) because the deficiency did not result in actual loss of safety function. This finding was no assigned a cross-cutting aspect because the issue did not reflect current licensee performance

Inspection Report# : [2015007](#) (pdf)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Perform Adequate Surveillance on Fire Barriers and Penetration Seals

The NRC identified a non-cited violation (NCV) of Hatch Operating License Conditions (OLCs) 2.C.(3) and 2.C.(3)(a), for Units 1 and 2 respectively, for the licensee's failure to perform fire barrier penetration seal inspections in accordance with the requirements of Surveillance Requirement 2.1.1.c of Appendix B of the Fire Hazard Analysis (FHA). Specifically, the licensee failed to ensure that fire-rated penetrations and fire-rated barriers separating redundant safe-shutdown trains were adequate to keep a fire from spreading from one fire area to another. To restore compliance the licensee performed a 100 percent inspection of fire-rated penetrations to verify the material condition of the site's rated fire barrier penetrations.

The licensee's failure to perform fire barrier penetration seal inspections was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the reactor safety Mitigating Systems cornerstone attribute of protection against external factors (i.e. fire), and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Based on the finding being of very low probability, the finding was determined to be of very-low safety significance (Green). The cause of the finding had a cross-cutting aspect in the area of Human Performance, field presence, because plant leadership did not reinforce standards and expectations, and did not ensure that deviations from standards and expectations were corrected promptly (H.2). Specifically, licensee oversight was not properly engaged to ensure that surveillances were performed adequately, and that deviations were addressed appropriately.

Inspection Report# : [2015003](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

"1A" PSW Pump High Vibration Failure

A self-revealing, NCV of 10 CFR 50, Appendix B, Criterion V, "Procedures, Instructions, and Drawings," was identified when the licensee failed to provide instructions to ensure alignment of the "1A" plant service water (PSW) pump column in the true vertical position. The failure to align the "1A" PSW pump column resulted high stresses which caused the failure of the "1A" PSW pump. To restore compliance, the licensee replaced the "1A" PSW pump and revised the pump installation procedure to ensure the pump column is aligned in the true vertical position.

Failure to provide instructions to ensure appropriate vertical alignment of the "1A" PSW pump column was a performance deficiency. This performance deficiency was more than minor because it affected the Mitigating Systems cornerstone attribute of Equipment Performance and adversely affected the cornerstone objective in that the misalignment of the pump column resulted in inoperability of the "1A" PSW pump. A regional Senior Reactor Analyst (SRA) performed a detailed risk review of the finding. The SRA calculated the difference between the risk associated with loss of offsite power (LOOP) events with extended recovery times with the "1A" pump available, and without the pump. Because of the low frequency of the seismic event, the finding was determined to be Green. The inspectors determined that this finding did not have an associated cross cutting aspect because this finding was not reflective of current licensee performance. (4AO3.3)

Inspection Report# : [2015003](#) (*pdf*)

Barrier Integrity

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

Last modified : August 29, 2016