

Hatch 1

4Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2016

Identified By: Self-Revealing

Item Type: FIN Finding

Unit Downpower Caused by RFP Vent Line Failure

A self-revealing finding was identified when the licensee failed to install a reactor feed pump (RFP) vent line weld in accordance with plant procedures resulting in a failure that required an unplanned Unit 1 power reduction greater than 20%.

Failure to install the correct weld thickness on the unit 1 "B" RFP vent line, as required by procedures, was a performance deficiency. This 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 in that an unplanned reactor power reduction was required from 100 percent to 60 percent RTP. The inspectors determined this finding was of very low safety significance (Green) because there was not a reactor trip or loss of mitigation equipment. The inspectors determined that this finding had a cross-cutting aspect in the 'Resolution' aspect of the problem identification and resolution area, because the organization did not take effective corrective actions to address the previous weld configuration issue. [P.3]

Inspection Report# : [2016003](#) (*pdf*)

Significance: G 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:  Sep 30, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Ensure Work Hours are Within Work Hour Limits

An NRC-identified non-cited violation (NCV) of 10 CFR Part 26, “Fitness for Duty Programs,” was identified when the licensee failed to ensure that personnel subject to work hour controls did not exceed 72 hours in a work week. The licensee entered this condition into their corrective action program as Condition Report 10214872 and restored compliance when the affected individuals received an adequate rest period.

The failure to ensure that work hours for personnel subject to work hour controls were tracked in accordance with licensee procedures was a performance deficiency. The finding was more than minor because, if left uncorrected, the failure to appropriately implement work hour limitations for “covered” workers could adversely impact the conduct and oversight of work on safety significant components. The inspectors determined that the finding was of very low safety significance (Green) because the finding did not cause any known effects to plant safety due to worker fatigue. The inspectors determined this performance deficiency had a cross-cutting aspect of Consistent Process in the Human Performance area because the licensee failed to assess which workers were subject to work hour limits. [H.13]

Inspection Report# : [2016003](#) (*pdf*)

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*)

Barrier Integrity

Significance:  Dec 31, 2016

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Establish Icing Controls on CAD Subsystem

An NRC-identified NCV of Hatch Unit 1 Technical Specification 5.4, "Procedures," was identified when procedures did not include inspection criteria for ice buildup of the Unit 1 nitrogen storage tank piping. The licensee entered the condition into their corrective action plan as CR10296584, and performed de-icing activities to remove the ice buildup.

Failure to establish controls to ensure that ice buildup on the Unit 1 CAD subsystem piping did not exceed ten inches was a performance deficiency. This performance deficiency was more than minor because, if left uncorrected, ice buildup on the CAD system may lead to CAD subsystem inoperability. The finding screened as Green, because the CAD subsystem remained operable. The inspectors determined that this finding had a cross-cutting aspect in the 'Initiation' aspect of the problem identification and resolution area, because the licensee did not initiate a condition report upon initially identifying the issue. [P.1]

Inspection Report# : [2016004](#) (*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 Jun 30, 2016

Identified By: NRC

Item Type: VIO Violation

Inaccurate Information Provided Regarding N2E Nozzle Weld Overlay

The NRC identified an VIO 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 determined this was a SLIII violation 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*)

Inspection Report# : [2016011](#) (*pdf*)

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