

Lewis Sumner
Vice President
Hatch Project Support

**Southern Nuclear
Operating Company, Inc.**
40 Inverness Parkway
Post Office Box 1295
Birmingham, Alabama 35201
Tel 205.992.7279
Fax 205.992.0341



April 12, 2001

Docket Nos. 50-321
50-366

HL-6067

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Edwin I. Hatch Nuclear Plant
Reply to a Notice of Violation

Ladies and Gentlemen:

In response to your letter dated March 16, 2001, and according to the requirements of 10 CFR 2.201, Southern Nuclear Operating Company (SNC) is providing the enclosed response to the Notice of Violation associated with Inspection Report 01-02. In the enclosure, a transcription of the NRC violation precedes SNC's response.

If you have any additional questions on this subject, please contact this office.

Respectfully submitted,

A handwritten signature in cursive script that reads "Lewis Sumner".

H. L. Sumner, Jr.

DMC/eb

Enclosure: Violation 01-02-01 and SNC Response

Handwritten initials "JEO" in a stylized, blocky font.

U.S. Nuclear Regulatory Commission
Page Two

cc: Southern Nuclear Operating Company
Mr. P. H. Wells, Nuclear Plant General Manager
SNC Document Management (R-Type A02.001)

U.S. Nuclear Regulatory Commission, Washington, D.C.
Mr. L. N. Olshan, Project Manager - Hatch

U.S. Nuclear Regulatory Commission, Region II
Mr. L. A. Reyes, Regional Administrator
Mr. J. T. Munday, Senior Resident Inspector - Hatch

Enclosure 1

Edwin I. Hatch Nuclear Plant
Violation 01-02-01 and SNC Response

VIOLATION 01-02-01

10 CFR 50.73.b requires, in part, that Licensee Event Reports (LER) shall contain a brief abstract describing the major occurrences during the event, including all component or system failures that contributed to the event and significant corrective action taken to prevent recurrence. In addition, the LER shall contain a narrative description of the cause of each component or system failure, the effect of each failed component, and operator actions that affected the course of the event, including procedural deficiencies that contributed to the event.

Contrary to the above, on February 16, 2001, Licensee Event Report (LER) 50-321/00-02: **Reduction in Reactor Feedwater Flow Results in Automatic Reactor Shutdown on Low Water Level**, dated February 25, 2000, did not contain all information as required by 10 CFR 50.73.b. Specifically, the LER did not contain the significant complications encountered with the Reactor Core Isolation Cooling (RCIC) system failure, the cause of the RCIC system failure, or the effect of the RCIC system failure on the event. The LER did not identify several unsuccessful attempts to restart the RCIC system after the RCIC turbine tripped on high reactor water level following a reactor trip. The LER also did not document certain operator actions that affected the course of the event involving the RCIC system, including an operating procedure that allowed the operator to restart the RCIC system turbine by opening the Trip and Throttle valve with the steam supply valve full open and the turbine control system demanding maximum speed. This method of restarting the tripped RCIC system contributed to repetitive overspeed trips of the RCIC turbine during the event. In addition, the LER did not contain a description of the significant corrective actions taken or planned to prevent recurrence of the RCIC system failure.

This is a Severity Level IV Violation (Supplement 1).

RESPONSE TO VIOLATION 01-02-01

Reason for the violation:

The condition report severity level for the original non-cited violation (NCV) was inappropriately classified, which resulted in less than adequate follow-up. For the reasons discussed in the subsequent paragraphs, SNC personnel determined that the problems with the manual restarts of the RCIC system were not reportable. This conclusion and the basis for it were communicated to the Senior Resident Inspector at the exit meeting and reiterated verbally in subsequent meetings. SNC's exception to the non-cited violation was noted in the associated Inspection Report. Personnel considered these actions sufficient to resolve this issue, and therefore, closed the item in the Corrective Action Program without formally denying the non-cited violation or submitting a revised Licensee Event Report. SNC personnel concluded that other actions taken to address this issue were adequate to close the NCV and responses to NCVs have not been previously required. Nevertheless, the LER should have been revised upon receipt of the original NCV to address the

Enclosure
Violation 01-02-01 and SNC Response

administrative aspect of this violation involving addition of information to the report, since the technical aspects of the event, including RCIC operation, had been properly investigated and resolved at the site and was communicated to the industry by way of INPO's Nuclear Network.

Licensee Event Report 50-321/2000-002 did not include the problems encountered with the Reactor Core Isolation Cooling (RCIC) system, because SNC personnel concluded that these problems were not required by 10 CFR 50.73(b) to be included in the report. This conclusion was based upon a reasonable interpretation of the regulations and, in particular, the somewhat ambiguous phrase "that affected the course of the event." Factors SNC personnel considered in reaching their conclusion included the relative long lapse after the occurrence of the initiating event, that is, the reactor scram, before the RCIC system problems were encountered; the lack of significant effect on reactor vessel water level control caused by these problems; and the fact that the RCIC system was not covered by any 10 CFR 50.72 or 10 CFR 50.73 reporting requirement in effect at the time of the event. These factors led personnel to conclude that the problems with the RCIC system did not affect the "course of the event" and therefore were not required to be included in the Licensee Event Report.

The problems encountered with restarting manually the RCIC system occurred approximately twenty-one minutes after vessel water level was restored initially following the reactor scram on 01/26/2000. Moreover, reactor vessel water level fluctuations requiring the manual operation of either the RCIC or High Pressure Cooling Injection (HPCI) system are expected following any event in which the reactor feedwater system is not functioning or available. Therefore, personnel considered the reportable event to be concluded long before the problems with the RCIC system were encountered, since subsequent actions to control water level were normal, expected, and not part of the initiating event.

SNC personnel further concluded that the RCIC system problems did not contribute to or have any significant affect on any event required by the regulations in effect at the time to be reported. The RCIC system problems in no way contributed, and were totally unrelated, to the causes of the reactor scram or the failure of the HPCI system to trip at the required water level. Personnel also noted that the RCIC system problems, because they were separated by a significant period of time from the occurrence of the reportable events and occurred well after the end of the transient, did not affect the severity or outcome of the reportable events. That is, the problems with manually starting the RCIC system did not prevent or delay water level recovery following the reactor scram or cause water level to increase further following the failure of the HPCI system to trip. Therefore, the RCIC system problems could not have affected "the course" of either reportable event. Since the RCIC system problems did not contribute to the reportable events or effect their course, severity or outcome, they appeared not to meet the criteria for inclusion in the Licensee Event Report and hence were not included in the report.

Finally, SNC personnel considered the "event", to which 10 CFR 50.73(b) referred, to be those events required by 10 CFR 50.73(a) to be reported via a Licensee Event Report. Those events were the reactor protection system actuation and the Engineered Safety Feature system actuations that were a direct result of the scram, and the inoperability of the single-train HPCI system due to its failure to trip properly on high water level with the attendant complications. The problems with the manual restart of the RCIC system were not reportable in and of themselves and therefore did not appear to be an "event" as governed by 10 CFR 50.73(b).

Enclosure
Violation 01-02-01 and SNC Response

Corrective steps which have been taken and the results achieved:

Licensee Event Report 50-321/2000-002 was revised to include the information determined to be necessary by the NRC and pertaining to the problems with the manual restart of the RCIC system. The revised report was submitted to the Nuclear Regulatory Commission in SNC Letter HL-6056, dated March 9, 2001.

Responsible personnel have been counseled regarding this oversight and its consequences. They are aware of the proper method of handling a non-cited violation to which exception is taken.

SNC personnel reviewed seven other non-cited violations issued to Plant Hatch in 2000. All seven of these non-cited violations were accepted, and actions were taken to correct the identified deficiencies and restore compliance. This problem therefore was confined to the one non-cited violation in 2000 to which SNC took exception.

Corrective steps which will be taken to avoid further violations:

No further actions are planned.

Date when full compliance will be achieved:

Full compliance with the requirements of 10 CFR 50.73(b) was achieved on March 9, 2001, when a revision to Licensee Event Report 50-321/2000-002 was sent to the Nuclear Regulatory Commission. This revision described the problems experienced during attempts to restart the RCIC system following the reactor scram on 01/26/2000; the causes for these problems; and the corrective actions taken to prevent recurrence.