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USNRC REGION II  
ATLANTA, GEORGIA

Power Supply Engineering and Services

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Georgia Power

the southern electric system

June 12, 1979

United States Nuclear Regulatory Commission  
Office of Inspection and Enforcement  
Region II - Suite 3100  
101 Marietta Street  
Atlanta, Georgia 30303

REFERENCE:  
RII: RFR111  
50-321/79-11  
50-366/79-15

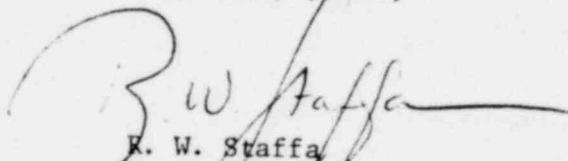
ATTENTION: Mr. R. C. Lewis

Gentlemen:

The Georgia Power Company offers the attached information in response to your letter of May 24, 1979, describing an apparent noncompliance with NRC requirements noted during your March 13 - April 6, 1979, inspection of the Hatch Nuclear Plant.

The inspection report contains no information which is believed to be proprietary.

Very truly yours,

  
R. W. Staffa  
Manager of Quality Assurance

  
RCW/mb

Attachment

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Infraction 50/321-79-11-01

The above infraction deals with failure to correct a long term problem concerning the ability to maintain secondary containment. The infraction is specifically for failure to provide an interlock system which assures that Technical Specifications are met.

Originally controlled access barriers of Plant Hatch were maintained through administrative controls based on a system of red and green lights. Secondary containment would be maintained provided these controls were followed. After repeated violations it became evident that these controls were inadequate. The system was then redesigned to install interlocks on all airlock doors to be used in conjunction with the existing light system. The interlocks prohibit opening any two doors that would violate secondary containment. IE Bulletin 77-08 states that prompt ingress and unimpeded egress must be assured into and out of certain plant areas. To obtain prompt ingress and unimpeded egress requires that door interlocks be provided with an emergency override. The system was redesigned and equipped with override pushbuttons to defeat the interlocks in an emergency situation. After additional repeated violations it became evident that personnel were utilizing the pushbuttons to bypass the interlocks in other than emergency situations. The problem was studied and airlock R106 was selected to be used for a case study. Glass covers were installed over the pushbuttons to make them less accessible. Since the glass covers were installed no containment violations have occurred at airlock R106.

Glass covers will be installed on all override pushbuttons throughout the plant by January 1, 1980. In addition, a surveillance procedure has been written to periodically inspect the condition of the interlock equipment to insure that it remains in good working order.

Infraction 366/79-15-01

In December 1978, while reviewing and comparing Unit 2 surveillance procedures with Unit 1 to verify setpoints, we discovered that the Unit 1 HPCI and RCT exhaust diaphragm pressure switches were calibrated with a head pressure. These instruments are on a dry line and should not have a head pressure. This caused the setpoint to exceed the Technical Specification limit.

We also found that surveillance procedure HNP-2-3309 for the Unit 2 HPCI exhaust diaphragm pressure switches was also incorrect. This procedure was corrected at the same time as the Unit 1 procedures, but it was not corrected immediately using the double SRO approval method. The calibration procedure was not corrected until March 3, 1979, when the instruments were found to be calibrated incorrectly during normal surveillance testing.

This deviation was caused by the failure of personnel to have the Unit 2 procedures immediately changed using the double SRO approval method and bad judgement in relying on the normal procedure change process to be completed before the next scheduled surveillance was due on January 30, 1979. The corrected procedure was not issued until after this date causing the instruments not to be corrected until March 3, 1979, during the next normal surveillance.

We are in the process of developing a program that, when a problem is discovered on one unit, will cause an immediate investigation of the same or related system, instruments, equipment, procedures, etc. of the other unit or the same unit. This should insure that any problems of a generic nature are adequately covered. This program should be completed in 90 days.