UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA ST., N.W., SUITE 3100
ATLANTA, GEORGIA 30303

Report Nos. 50-321/79-37 and 50-366/79-41

Licensee: Georgia Power Company
270 Peachtree Street, N.W.
Atlanta, Georgia 30303

Facility Name: Hatch 1 and 2

Docket Nos. 50-321 and 50-366

License Nos. DPR-57 and NPF-5

Inspector: B. W. Riley Sr. 1/15/80
R. F. Rogers Date Signed

Approved by: B. W. Riley Sr. 1/15/80
H. C. Dance, Section Chief, RONS Branch Date Signed

SUMMARY

Inspection on November 10 - December 7, 1979

Areas Inspected

This inspection involved 80 inspector-hours onsite of technical specification compliance, reportable occurrences, housekeeping, operator performance, overall plant operations, quality assurance practices, station and corporate management practices, corrective and preventative maintenance activities, site security procedures, radiation control activities, surveillance activities, and followup of previous inspection findings.

Results

Of the twelve areas inspected, no apparent items of noncompliance or deviations were identified in eleven areas; one apparent item of noncompliance was found in one area (Infraction - Commencing work prior to approval of a Radiation Work Permit (366/79-41-01), Paragraph 10).

DETAILS

1. Persons Contacted

   Licensee Employees

   *M. Manry, Plant Manager
   *T. Moore, Assistant Plant Manager
   *T. Greene, Assistant Plant Manager
   S. Baxley, Superintendent of Operations
   R. Nix, Superintendent of Maintenance
   C. Coggins, Superintendent of Engineering Services
   W. Rogers, Health Physicist/Radiochemist
   [illegible]. Bellflower, QA Site Supervisor

   Other licensee employees contacted included technicians, operators, mechanics, security force members, and office personnel.

   *Attended exit interview

2. Exit Interview

   The inspection scope and findings were summarized on November 20 and 28, 1979, and December 7, 1979, with persons indicated in Paragraph 1 above.

3. Licensee Action on Previous Inspection Findings

   a. Noncomplaince

      (Closed) (321/79-22-02) Failure to follow procedures. The inspector reviewed the licensee's corrective action discussed in their letter of August 24, 1979, and had no further questions.

      (Closed) (321/79-22-05) Failure to properly lock the reactor mode switch. The inspector reviewed the licensee's corrective actions discussed in their letter of August 24, 1979, and had no further questions.

      (Closed) (366/79-29-01) Failure to review temporary procedure changes in a timely manner. The inspector reviewed the implementation of the licensee's corrective action described in their letter dated September 7, 1979, and had no further comment.

   b. Unresolved Items

      (Closed) (321-78-36-01) Data sheet reviews by supervisory personnel. This item has been reviewed and closed.

c. Open Items

(Closed) (321/78-37-03) Station position description titles. This item has been forwarded to NRR for resolution.

(Closed) (321/79-25-03) Visual snubber inspection. The visual snubber inspection was performed.

4. Unresolved Items

Unresolved items were not identified during this inspection.

5. Plant Operations Review (Unit 1 and 2)

The inspector periodically during the inspection interval reviewed shift logs and operating records, including data sheets, instrument traces, and records of equipment malfunctions. This review included control room logs, auxiliary logs, operating orders, standing orders, jumper logs and equipment tagout records. The inspector routinely observed operator alertness and demeanor during plant tours. During abnormal events, operator performance and response actions were observed and evaluated. The inspector conducted random off-hours inspections during the reporting interval to assure that operations and security remained at an acceptable level. Shift turnovers were observed to verify that they were conducted in accordance with approved licensee procedures.

6. Plant Tours (Unit 1 and 2)

The inspector conducted plant tours periodically during the inspection interval to verify that monitoring equipment was recording as required, equipment was properly tagged, operations personnel were aware of plant conditions, and plant housekeeping efforts were adequate. The inspector also determined that appropriate radiation controls were properly established, critical clean areas were being controlled in accordance with procedures, excess equipment or material is stored properly and combustible material and debris were disposed of expeditiously. During tours the inspector looked for the existence of unusal fluid leaks, piping vibrations, pipe hanger and seismic restraint settings, various valve and breaker positions, equipment caution and danger tags and component positions, adequacy of fire fighting equipment, and instrument calibration dates. Some tours were conducted on backshifts and weekends.

7. Review of Nonroutine Events reported by the Licensee (Units 1 and 2)

The following licensee event reports (LERs) were reviewed for potential generic problems, to detect possible trends, and to determine whether corrective actions appeared appropriate. Events which were reported immediately were also reviewed as they occurred to determine that technical specifications were being met and that public health and safety were of utmost consideration.

LER No.	Date of Report	Description
50-321/79-21	02/09/79	Tritium leak in plant yard
50-321/79-87	11/19/79	Low water level in fire storage tank
50-321/79-88	11/17/79	Late surveillance on scram discharge vol.
50-321/79-90	11/20/79	Blown fuse on stand-by PSW pump
50-321/79-91	11/27/79	Failure to establish a fire watch
50-321/79-92	12/05/79	Failure to telecopy within 24 hours
50-321/79-93	11/27/79	Late surveillance on liquid monitor
50-321/79-94	12/07/79	Failure of "B" PSW pump
50-366/79-112	10/24/79	Loss of control o. IRM
50-366/79-113	10/30/79	High Hydrogen concentration
50-366/79-114	11/02/79	HPCI suction valve failure
50-366/79-115	11/19/79	Instrument drift on HPCI isolation signal
50-366/79-116	11/14/79	HPCI Inboard isolation valve Failure
50-366/79/117	11/20/79	PSW Pump wear
50-366/79-118	11/15/79	2C RHR suction valve problem
50-366/79-119	11/28/79	"F" APRM Inop.
50-366/79-120	11/29/79	2C D/G Failure
50-366/79-121	11/30/79	MAPLHGR exceeded
50-366/79-122	12/07/79	LPCI inverter failure
50-366/79-123	12/06/79	"B" PSW pump we .r
50-366/79-124	12/06/79	"E" torus/drywell vacuum breaker inop.

50-366/79-127	12/06/79	HPCI isolation setpoint drift
50-366/79-128	12/06/79	Drywell Hydrogen and Oxygen recorder failure

8. Technical Specification Compliance (Unit 1 and 2)

During this reporting interval, the inspector verified compliance with selected limiting conditions for operation (LCO's) and results of selected surveillance tests. These verifications were accomplished by direct observation of monitoring instrumentation, valve positions, switch positions, and review of completed logs and records. The licensee's compliance with selected LCO action statements were reviewed on selected occurrences as they happened.

9. Physical Protection

The inspector verified by obervation and interview during the reporting interval that measures taken to assure the physical protection of the facility met current requirements. Areas inspected included the organization of the security force, the establishment and maintenance of gates, doors and isolation zones in the proper condition, that access control and badging was proper, that search practices were appropriate, and that escorting and communications procedures were followed. On December 1, 1979, The inspector observed pistol qualification training and drills at the licensee's onsite pistol range. Familiarization training with a 12 gauge shotgun was also conducted. The session was well organized and professionally conducted.

10. Failure to Approve a Radiation Work Permit (RWP) (Unit 2)

On November 27,1979, during a routine inspection tour, the inspector noted that the head had been pulled on "F" filter demineralizer and that filter element retaining clips were being removed. An RWP was not posted at the work place as required by HNP 8008, Paragraph C.5. The inspector then located the RWP in a box in the health physics office. It had not been approved as required by HNP 8008, Paragraph C.4, prior to the commencement of work. After notifying health physics personnel of the problem, the inspector then proceeded to the control room and found that the shift foreman was unaware that work had commenced on the filter demineralizer (He was aware it was tagged out). This item is the subject of the attached notice of violation to this report (366/79-41-01).