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

MAR 30 1981

Georgia Power Company
ATTN: J. H. Miller, Jr.
Executive Vice President
270 Peachtree Street
Atlanta, GA 30303



Gentlemen:

Subject: Confirmation of Action

This refers to R. D. Martin's telephone conversation of March 24, 1981, with Mr. W. A. Widner, Vice President and General Manager-Nuclear Generation regarding operation of Hatch Unit 2 with the four channels of safety-related drywell pressure instrumentation inoperable.

With regard to the matters discussed, we understand that you will initiate the following actions:

1. Investigate the event of March 23, 1981, involving operation of the reactor with the required safety-related drywell pressure systems inoperable due to misalignment of instrumentation isolation valves. As a minimum, your investigation will include the following items:
 - a. Determine the cause of the incorrectly positioned valves.
 - b. Determine why the mispositioned valves were not identified by the operating staff for over fourteen days.
2. Initiate a special audit including representatives from the Georgia Power Company corporate quality assurance and training staffs, of the facility management control systems and personnel, to determine the deficiencies which contributed to the event described above. As a minimum, this audit will include the following items:
 - a. A review of the independent verification controls which assure proper safety-related system alignment.
 - b. A review of the procedural controls which govern proper safety-related system operation.
 - c. A review of the verification controls that assure proper safety-related system restoration following maintenance or testing.
 - d. A review of the verification and documentation controls which assure that all operations personnel are cognizant of the current status of all safety-related equipment, and control board switches, parameters, and alarms on each shift.

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3. Identify critical system valves whose mispositioning could defeat the designed safety functions of those systems. Perform a verification of the valve positions to assure correct alignment. Subsequent manipulation of these critical system valves will have independent verification performed until the results of the investigation and audit have been discussed with Region II.
4. Discuss the results of your investigation and corrective actions in a meeting to be conducted in the Region II office no later than April 3, 1981. The results of these activities will be documented in a special report following this meeting.

Please inform this office promptly if your understanding of this matter is different from that stated above.

Sincerely,


James P. O'Reilly
Director

CC

W. E. Ehrensperger, Vice President
Engineering/Construction
W. A. Widner, Vice President and
General Manager--Nuclear Generation -
M. Manry, Plant Manager