



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

Report Nos. 50-321/82-25 and 50-366/82-24

Licensee: Georgia Power Company
P.O. Box 4545
Atlanta, GA 30302

Facility Name: Hatch 1 and 2

Docket Nos. 50-321 and 50-366

License Nos. DPR-57 and NPF-5

Inspection at Hatch site near Baxley, Georgia and Licensee requested management meeting at NRC Region II Office, Atlanta, Georgia

Inspectors: Vincent L. Brownlee for
R. F. Rogers

8/20/82
Date Signed

Vincent L. Brownlee for
P. Holmes-Ray

8/20/82
Date Signed

Approved by: Vincent L. Brownlee
V. L. Brownlee, Section Chief, Division of
Project and Resident Programs

8/20/82
Date Signed

SUMMARY

Inspection on June 22 - July 26, 1982

Areas Inspected

This inspection involved 194 inspector-hours on site in the areas of Technical Specification compliance, operator performance, overall plant operations, quality assurance practices, station and corporate management practices, corrective and preventive maintenance activities, site security procedures, radiation control activities, surveillance activities, previous unresolved items, and Licensee Event Reports.

Results

Of the 11 areas inspected, no violations or deviations were identified in nine areas, two violations were identified in two areas (Failure to follow procedure - Reactor Overpressure Incident, paragraph 5; Failure to follow Technical Specifications - Fire Doors, paragraph 7.).

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DETAILS

1. Persons Contacted

Licensee Employees

- *H. C. Nix, Plant Manager
- *T. Greene, Assistant Plant Manager
- *C. T. Jones, Assistant Plant Manager
- *S. Baxley, Superintendent of Operations
- *C. Belflower, QA Site Supervisor

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

*Attended site exit interviews

2. Exit Interview

The inspection scope and findings were summarized on July 2, 13 and 26, 1982, with those persons indicated in paragraph 1 above.

3. Licensee Action on Previous Inspection Findings

Unresolved Items

(Closed) (321 and 366/80-36-06) fire door problems. This item has been closed as an unresolved item and upgraded to a violation as discussed in paragraph 7.

4. Unresolved Items

Unresolved items were not identified during this inspection.

5. Plant Tours (Units 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 unusual fluid leaks, piping vibrations, pipe hanger and seismic restraint settings, various valve and breaker positions, equipment caution and danger tags, component positions, adequacy of fire fighting equipment, and instrument calibration dates. Some tours were conducted on backshifts.

Within the areas inspected, no violations or deviations were identified.

6. Plant Operations Review (Units 1 and 2)

The inspector periodically during the inspection interval reviewed shift logs and operations records, including data sheets, instrument traces, and records of equipment malfunctions. This review included control room logs and auxiliary logs, operating orders, standing orders, jumper logs and equipment tagout records. The inspector routinely observed operator alertness and demeanor during plant tours. During normal events, operator performance and response actions were observed and evaluated. The inspector conducted random off-hours inspection 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.

On July 3, 1982, Unit 1 experienced a spurious reactor scram from 100% power when an instrument rack was inadvertently bumped. Subsequent to the scram, the main steam isolation valves (MSIVs) closed on low reactor level isolating the reactor. Decay heat inventory resulted in a slow pressure increase. The plant operator did not notice the pressure increase as the one indication he was monitoring (Narrow Range Chart Recorder) was stuck at 850 psig. The operator failed to verify reactor pressure with any of the other four installed indications in the proximity of the stuck indication. Pressure increased over an eleven minute interval to approximately 1200 psig when three safety relief valves (SRVs) lifted to reduce plant pressure. All eleven valves are set to open between 1080 and 1100 psig. The failure of the licensed operator to control plant pressure as required by plant procedures is a violation (50-321/82-25-01). During the shutdown to determine why all eleven SRVs failed to open at their proper pressure, all SRVs were cycled successfully manually. Visual inspections of 2 SRVs did not reveal any abnormalities. All eleven SRV pilot assemblies were tested at Wyle Laboratories. Three of the eleven pilot assemblies lifted slightly higher than set point pressure during initial lift at Wyle. Subsequent lifts were within set point limits. It has been postulated that the pilot valve disc on these two stage Target Rock valves (Model 7567) may have stuck to the seats as the valves had not been operated in approximately nine months. Also, Unit 1 experienced a significant chemical intrusion on April 24, 1982 which may have contributed to the sticking condition.

On July 8, 1982, Representatives of the Georgia Power Company met with NRC personnel in Atlanta, GA. to discuss investigation and corrective actions for both Hath units. A periodic cycling and inspection program was agreed on to prevent recurrence.

7. Technical Specification Compliance (Units 1 and 2)

During this reporting interval, the inspector verified compliance with selected limiting conditions for operations (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.

On April 26 1982 the licensee contacted the NRC Regional Office and requested an official interpretation of the word "functional" as used in the facility's technical specification, (section 3.13.6) which reads in part.... all fire barrier penetrations protecting safety-related areas to be functional at all times. Region II informed the licensee that functional meant operable and that the item and or component must met the design requirements. Based on this interpretation the licensee informed Region II that certain fire doors in both Units 1 and 2 were not of the proper fire barrier rating (1.5 hrs vice 3.0 hrs), however they were operable.

On April 14, 1982 the licensee issued LER #50-321/82-34 stating that a total of 20 fire doors (16 in Unit 1 and 4 in Unit 2) were installed with incorrect fire ratings or non-verifiable ratings (no labels). Accordingly, these doors should have been technically classified as nonfunctional and fire watches should have been established per technical specification sections 3.13.6 and 3.7.7. In a followup report to this LER the licensee informed Region II that the posting of fire watches were inadvertently overlooked prior to April 14, 1982. Upon receipt of Region II's interpretation of the word functional, the licensee immediately established fire watches and maintained them until no longer needed. All fire door deficiencies were corrected by May 31, 1982. This item has been identified as a violation (50-321/82-25-02 and 50-366/82-24-01).

8. Physical Protection (Units 1 and 2)

The inspector verified by observation and interviews 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, and procedures were followed.

Within the areas inspected, no violations or deviations were identified.

9. Review of Nonroutine Events Reported by the Licensee (Unit 1)

The following Licensee Event Reports (LERs) were reviewed for potential generic impact, to detect 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 the public health and safety were of utmost consideration. Asterisked reports were followed up indepth onsite.

All LERs were reviewed in accordance with the current NRC enforcement policy.

LER No.	Date of Report	Description
50-321/82-01	1/21/82	Inop Air intake isolation valve
50-321/82-02	1/21/82	Nuclear Correlation Coefficients*
50-321/82-04	02/16/82	Reactor Pressure Setpoint High
50-321/82-05	02/02/82	Main Steam Flow Setpoint High*
50-321/82-07	02/09/82	Failed Reactor Level Switch
50-321/82-08	02/25/82	Drywell Temp. Recorder Inop
50-321/82-10	03/30/82	Valve 1P41-F437A Unlocked*
50-321/82-11	03/04/82	RCIC Oil Leak (Loose Pipe)*
50-321/82-12	03/04/82	HPCI AOP Malfunction
50-321/82-14	03/02/82	Reactor High Pressure Switch Setpoint Drift*
50-321/82-15	02/25/82	Missed Serveillance on PSW Pump*
50-321/82-16	03/02/82	Fission Product Sample Pump Inop
50-321/82-17	03/04/82	Drywell H ₂ -O ₂ Analyzer Out of Cal.
50-321/82-18	03/16/82	Drywell/Torus Temperature Recorder Inoperable
50-321/82-20	04/08/82	RCIC Oil Leak (Drain Orifice Plugged)*
50-321/82-21	04/20/82	Drywell/Torus Multipoint Recorder Failure
50-321/82-22	04/20/82	Reactor Water Shroud Level* Indicators
50-321/82-23	04/28/82	Torus Water Level Indicator Inop.
50-321/82-24	05/04/82	Drywell O ₂ Analyzer Drift