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the Southern Electric system

W. G. Hairston, III
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HL-1480
001208

February 18, 1991

U.S. Nuclear Regulatory Commission
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Washington, D.C. 20555

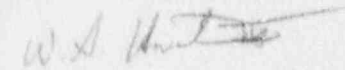
PLANT HATCH - UNIT 2
NRC DOCKET 50-366
OPERATING LICENSE NPF-5
RESPONSE TO INSPECTION REPORT 90-26

Gentlemen:

In response to your letter of January 29, 1991 and in accordance with the provisions of 10 CFR 2.201, Georgia Power Company (GPC) is providing the enclosed response to the Notice of Violation associated with NRC Inspection Report 90-26. A copy of the response is being provided to NRC Region II for review. In the enclosure, a transcription of the NRC violation precedes GPC's response.

Should you have any questions in this regard, please contact this office.

Sincerely,


W. G. Hairston, III

JKB/cr

Enclosure: Violation 90-26-03 and GPC Response

c: (See next page.)

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c: Georgia Power Company
Mr. H. L. Sumner, General Manager - Nuclear Plant
Mr. J. D. Heidt, Manager Engineering and Licensing - Hatch
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U.S. Nuclear Regulatory Commission, Washington, D.C.
Mr. K. Jabbour, Licensing Project Manager - Hatch

U.S. Nuclear Regulatory Commission, Region II
Mr. S. D. Ebnetter, Regional Administrator
Mr. L. D. Wert, Senior Resident Inspector - Hatch

ENCLOSURE 1

PLANT HATCH - UNIT 2
NRC DOCKET 50-366
OPERATING LICENSE NPF-5
VIOLATION 90-26-03 AND GPC RESPONSE

VIOLATION 90-26-03

Hatch Unit 2 Technical Specification 3.3.6.1 requires that both channels of the Offgas Post-Treatment Radiation Monitors be operable in operational conditions 1 and 2.

Contrary to the above, the Unit 2 Offgas Post-Treatment Radiation Monitors were inoperable from November 23, 1990 to December 20, 1990. During this event, Unit 2 operated at or near 100 percent of rated thermal power.

This is a Severity Level IV violation (Supplement I).

RESPONSE TO VIOLATION 90-26-03

Admission or denial of violation:

The violation occurred as described in the Notice of Violation.

Reason for the violation:

The violation was probably caused by personnel error on the part of nonlicensed personnel. It appears a Chemistry technician, in obtaining a routine, monthly offgas grab sample on 11/23/90, failed to follow the valve lineup requirements of procedure 64CH-SAM-001-0S, "Offgas Sampling." As a result, the as-left valve lineup to the Offgas Post-Treatment Radiation Monitors was such that the monitors were rendered inoperable.

A grab sample is obtained by connecting a sample flask into a bypass sample line upstream of the sample pumps. With the flask installed, the inlet and outlet valves to the flask are opened, a main sample line valve is closed, and all sample flow is then diverted through the flask to the monitors. Following collection of the grab sample, the valves are re-aligned and the flask is removed as required by procedure 64CH-SAM-001-0S. However, it was discovered on 12/20/90 that the system was aligned as if to take a grab sample yet no sample flask was installed. Therefore, with the flask connections open, the sample pumps were taking suction from the Waste Gas Treatment Building atmosphere instead of the offgas system. Since the radiation monitors were not monitoring offgas effluent, they were inoperable.

ENCLOSURE 1 (Continued)

VIOLATION 90-26-03 AND GPC RESPONSE

The Chemistry technician who obtained the grab sample on 11/23/90 stated that the system was restored to the normal lineup in accordance with procedural requirements. However, no documentation exists to confirm the valves were restored to their proper lineup. Furthermore, Chemistry logs do not show any other activities taking place between 11/23/90 and 12/20/90 which would have involved manipulation of the subject valves. Consequently, it appears the technician performing the sampling activity on 11/23/90 failed to follow procedure 64CH-SAM-001-05 by not restoring the system to the proper valve lineup.

A contributing factor to the event was a less than optimal procedure. Procedure 64CH-SAM-001-05 does not require documenting the as-left valve positions for those valves manipulated during the sampling activity. Also, it does not require independent verification that the valves were left in the correct position.

Corrective steps which have been taken and the results achieved:

As a result of this event, the following actions have been taken:

1. Offgas sample flow was restored to the radiation monitors, thereby making them operable, on 12/20/90 at approximately 0950 CST.
2. Similar radiation monitoring systems were checked on 12/20/90, subsequent to this event, for proper valve lineup. Systems checked included the Units 1 and 2 Fission Product Monitoring systems, the unit common Main Stack Radiation Monitoring system, the Unit 1 Recombiner Building Vent Stack Radiation Monitoring system (unit 2 does not have such a system), the Units 1 and 2 Reactor Building Vent Stack Radiation Monitoring systems, the Units 1 and 2 Offgas Pre-Treatment Radiation Monitoring systems, and the Units 1 and 2 Offgas Post-Treatment Radiation Monitoring systems. No valves were found mispositioned.
3. A Health Physics/Chemistry Department Standing Order was issued on 12/20/90 requiring a Chemistry foreman to be in attendance during gaseous sampling activities associated with specific systems in order to verify proper valve lineups during and after sampling. The foreman also is required to document the acceptability of the lineups on the appropriate sampling data sheets. The Standing Order was later changed to require independent verification of correct valve lineups.

ENCLOSURE 1 (Continued)

VIOLATION 90-26-03 AND GPC RESPONSE

4. A training memo was issued to Chemistry personnel on 12/21/90. this memo described this particular event, emphasized the importance of procedural compliance, emphasized the importance of step-by-step performance of procedures, emphasized the importance of attention to detail, and described the valve verification activity implemented under the aforementioned standing order.
5. A review of the appropriate Chemistry procedures was initiated to determine which procedures should include signoffs and independent verification for valve manipulations. The procedures so identified will be revised and made effective by 4/30/91. The Standing Order will be terminated only after the appropriate procedures have been revised and made effective.

Corrective steps which will be taken to avoid further violations:

No further corrective actions are necessary to prevent recurrence.

Date when full compliance will be achieved:

Full compliance was achieved on 12/20/90 when offgas sample flow was restored to the Offgas Post-Treatment Radiation Monitors thereby making them operable.