

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

Report Nos. 50-321/82-32 and 50-366/82-30

Licersee: 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 Inspectors: Holmes Approved by: Us, Brownlee, Section Chief, Division of L. Project and Resident Programs

Date aned

SUMMARY

Inspection on August 28 - September 28, 1982

Areas Inspected

This inspection involved 176 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, and surveillance activities.

Results

Of the 9 areas inspected, no violations or deviations were identified in six areas. Three violations were identified in three areas (Failure to follow HPCI surveillance procedure, paragraph 7; Failure to properly notify the NRC (2 examples), paragraph 6; Failure to follow health physics procedure, paragraph 5).

## 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, office personnel, and supervisors.

\*Attended site exit interviews

2. Exit Interview

The inspection scope and findings were summarized on September 3, 23, and 27, 1982 with those persons indicated in paragraph 1 above.

3. Licensee Action on Previous Inspection Findings

Not inspected.

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 insrument calibration dates. Some tours were conducted on backshifts.

During a plant tour on August 30, 1982, the inspector approached the Frisker (TM-14) location at the main entrance to the control building. After waiting for an individual to complete his frisking evolution, the inspector began to check himself for possible radioactive contamination in accordance

with the requirements of HNP-8009, Personnel Contamination Survey. The inspector noted that the survey instrument was turned off and also unplugged. The failure of personnel to properly frisk upon entering the control room is a violation (50-321/82-32-01, 50-366/82-30-01).

6. Plant Operations Review (Units 1 and 2)

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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.

During the reporting internal, two events were not reported to the NRC within one hour as required by 10 CFR 50.72. On August 30, 1982, Deviation Report 1-82-159 noted that at 11:00 a.m. CST it was discovered by licensee personnel that humidity controllers for both trains of standby gas treatment on Unit 1 were incorrectly wired rendering both trains inoperable and placing the Unit in a limiting condition for operation (LCO) requiring a plant shutdown. As documented on the 10 CFR 50.72 checklist for this event (#82-27), the NRC operations center was not notified until 1:49 p.m. CST. On August 25, 1982, following a scram due to an MSIV closure at power, Unit 2 containment pressure increased to approximately 2 pounds, initiating various components of the ECCS systems (core spray and low pressure coolant injection). Although the initial scram was reported properly, the pressurization of the containment (Due to a suspected stuck open SRV vacuum breaker) which occurred approximately 30 minutes later was not reported as required.

These two examples constitute a violation (50-321/82-02, 50-366/82-30-02).

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 September 24, 1982, while investigating the circumstances surrounding the failure of the Unit 1 High Pressure High Coolant Injection (HPCI) pump discharge valve (E41-F007), the inspector noted that the surveillance procedure which was being performed at the time to check HPCI valve

operability, HNP-1-3302, called for cycling this valve only under cold shutdown conditions. This prohibition prevents attempting to stroke the valve with full plant D/P across the disk. When the valve was energized to open at full D/P, the motor burned up, placing the unit into an LCO condition. The failure of shift personnel to follow the surveillance procedure is a violation (50-321/82-32-03).

8. Physical Protection (Units 1 and 2)

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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.