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THE BOK (THIRD) ELECTRIC SYSTEM

W. G. Hairston, III  
Senior Vice President  
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HL-1395  
00062

December 11, 1990

U.S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, D.C. 20555

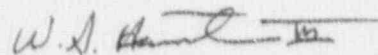
PLANT HATCH - UNITS 1, 2  
NRC DOCKETS 50-321, 50-366  
OPERATING LICENSES DPR-57, NPF-5  
RESPONSE TO INSPECTION REPORT 90-20

Gentlemen:

In response to your letter of November 14, 1990, and in accordance with the provisions of 10 CRF 2.201, Georgia Power Company (GPC) is providing the enclosed response to the Notice of Violation associated with Inspection Report 90-20. A copy of this 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 at any time.

Sincerely,

  
W. G. Hairston, III

SJB/rw

Enclosure: Violation 90-20-01 and GPC Response

c: (See next page.)

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U.S. Nuclear Regulatory Commission

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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. Ebner, Regional Administrator  
Mr. L. D. Wert, Senior Resident Inspector - Hatch

ENCLOSURE

PLANT HATCH - UNITS 1, 2  
NRC DOCKETS 50-321, 50-366  
OPERATING LICENSES DPR-57, NPF-5  
VIOLATION 90-20-01 AND GPC RESPONSE

VIOLATION 90-20-01

"Technical Specifications 3.1.A (Table 3.1-1: Reactor Protection System Instrumentation Requirements, Item 9), 3.2.A (Table 3.2-1: Instrumentation which initiates Reactor Vessel and Primary Containment Isolation, Item 4), and 3.2.H (Table 3.2-9[sic]: Radiation Monitoring Systems Which Limit Radioactivity Release, Item 5) require the Main Steam Line Radiation Monitor trip settings to be less than or equal to three times the normal full power background radiation levels.

Contrary to the above, between September 21 and September 25, 1990, the Main Steam Line Radiation Monitor trip settings were set at approximately six to seven times normal full power background radiation levels. At the time of this finding, Unit 1 was operating at approximately 100 percent rated power.

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

RESPONSE TO VIOLATION 90-20-01

Admission or denial of violation:

The violation occurred as described in the Notice of Violation.

Reason for the violation:

The violation was caused by an ambiguous Technical Specifications requirement, a less-than-adequate procedure, equipment malfunction, and personnel error. Footnotes (c), (e), and (e) of Unit 1 Technical Specifications Tables 3.1-1, 3.2-1, and 3.2-8, respectively, specify a time limit for changing the Main Steam Line Radiation Monitor (MSLRM) setpoints to less than or equal to three times the expected normal, full-power background radiation levels prior to placing the Hydrogen Injection System into service. However, the footnotes do not clearly specify a time limit for making adjustments to the setpoints if the actual radiation levels do not reach the levels which would result in the setpoints being within Technical Specifications limits. Consequently, the MSLRM setpoints were adjusted within 24 hours of placing the Hydrogen Injection System into service as required. However, when the MSL radiation levels did not reach their expected levels, personnel did not believe they were under time restraints to make adjustments to the setpoints. It was decided to monitor the readings and make the appropriate adjustments to the setpoints when the readings stabilized.

ENCLOSURE (Continued)

VIOLATION 90-20-01 AND GPC RESPONSE

Plant Procedure 62CI-CAL-005-0S, "Main Steam Line Radiation Monitors," was less than adequate in that it did not require updating the Daily Comparison Check Data Sheet, which is used to perform the daily comparison check of the MSLRM readings and setpoints, with new setpoints each time they were input into the MSLRMs. As a consequence, the setpoints that were calculated and input into the MSLRMs on 9/21/90 were not recorded on the Daily Comparison Check Data Sheet. The comparison checks performed between 9/21/90 and 9/24/90 were performed with out-of-date setpoints which were less than three times the actual MSLRM readings. Therefore, the setpoint problem was not identified and communicated to the Unit 1 Shift Supervisor during this time.

The hydrogen injection flowrate monitor/element malfunctioned, resulting in an actual system flowrate lower than that programmed into and displayed by the monitor. Because of the malfunction, the monitor indicated a system flowrate of 16 standard cubic feet per minute (scfm), when the actual system flowrate was only 12 scfm, as determined by subsequent flowrate testing of the monitor. This lower system flowrate resulted in lower than expected MSL radiation levels; therefore, the setpoints input into the MSLRMs on 9/21/90 were too high.

Finally, personnel error by a Chemistry technician and a Chemistry foreman resulted in corrective action being taken on 9/25/90 instead of 9/24/90 when the technician became aware of the setpoint problem. On 9/24/90, the Chemistry technician who calculated the MSLRM setpoints for hydrogen injection on 9/21/90 returned to work following his regular off-days. That morning, he performed the daily comparison check of the MSLRM readings and setpoints per procedure 62CI-CAL-005-0S. The technician noted the setpoints listed on the Daily Comparison Check Data Sheet were lower than those calculated on 9/21/90. He checked the actual setpoints on the MSLRMs, verified they were the same setpoints he had calculated, and compared them to the MSLRM readings. The technician found the setpoints were not less than or equal to three times the actual radiation levels. Consequently, he notified his foreman, as required by procedure 62CI-CAL-005-0S; however, he did not notify the Unit 1 Shift Supervisor, as is also required by the same procedure. Even though the Chemistry foreman was notified of the discrepancy in setpoints, he also failed to inform the Unit 1 Shift Supervisor.

On 9/25/90, the technician noted the setpoints had not been changed and were still not less than or equal to three times actual radiation levels. The technician then notified the Unit 1 Shift Supervisor, as required. At that time, the Shift Supervisor took action to bring the unit into compliance with Unit 1 Technical Specifications requirements.

ENCLOSURE (Continued)

VIOLATION 90-20-01 AND GPC RESPONSE

Corrective steps which have been taken and the results achieved:

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

1. On 9/25/90, the setpoints for the MSLRMs were adjusted to meet Technical Specifications requirements.
2. On 10/12/90, procedure 62CI-CAL-005-0S was temporarily revised to require the Chemistry technician to use the setpoints displayed on the MSLRM instruments in the Main Control Room in performing the daily comparison checks. This temporary revision also added emphasis to the requirement to notify the Shift Supervisor any time MSLRM setpoints indicate greater than three times actual MSLRM radiation levels. Appropriate procedures will be permanently revised by 12/10/90 to require the setpoint/reading comparison be performed using the setpoints displayed on the MSLRM instruments. The permanent revisions will become effective before the temporary change to procedure 62CI-CAL-005-0S expires on 12/31/90.
3. Clarifications to the Unit 1 and Unit 2 Technical Specifications were issued in accordance with procedure 40AC-REG-003-0S, "Licensing Document Revision and Clarification Program." The clarifications specify that MSLRM setpoints be adjusted to compensate for changes in hydrogen injection flowrates, taking into account the 24-hour grace period allowed by the Technical Specifications. (The Unit 2 Technical Specifications clarification was issued in anticipation of using hydrogen injection on Unit 2.)
4. An analysis of the flowrate monitor's performance was performed by the vendor (General Electric) and plant personnel. It was determined one possible cause of the monitor malfunction was improper installation of the instrument cable between the monitor and element. Another possible cause of the flow discrepancy was a faulty linearization circuit board. The instrument cable was reinstalled correctly, and the flow monitor/element was replaced. System performance will be monitored, and additional actions taken, as warranted, to ensure reliable operation.
5. The appropriate personnel were counseled as to the requirement for strict procedural compliance and the importance of timely dissemination of information regarding plant operating condition

Corrective steps which will be taken to avoid further violations:

The appropriate Unit 2 procedures will be revised similarly to the procedure revisions previously discussed to require the setpoint/reading

ENCLOSURE (Continued)

VIOLATION 90-20-01 AND GPC RESPONSE

comparison be performed using the setpoints displayed on the MSLRMs. The Unit 2 procedure revisions will become effective prior to using hydrogen injection on Unit 2.

Although not a contributing factor to this event, it was noted procedure 62CI-CAL-005-05 may not contain sufficient guidance necessary to properly calculate the MSLRM trip setpoints when the Hydrogen Injection System is in service. Accordingly, this procedure will be reviewed and any necessary changes made by 2/15/91.

Date when full compliance will be achieved:

Full compliance was achieved on 9/25/90 when the setpoints for the MSLRMs were adjusted to meet Technical Specifications requirements.