

UNITED STATES NUCLEAR REGULATORY COMMISSION REGION II 101 MARIETTA STREET, N.W. ATLANTA, GEORGIA 30323

Report Nos.: 50-321/92-03 and 50-366/92-03

Licensee: Georgia Power Company P. O. Box 1295 Birmingham, AL 35201

Docket Nos: 50-321 and 50-366

License No.: DPR-57 and NPF-5

Facility Name: Hatch 1 and 2

Inspection Conducted: February 10 - 14, 1992

Inspector: Cuthan

Accompanying Personnel: C. Rapp

Approved by:

Crlenjak, Chief Operational Programs Section Division of Reactor Safety

3/16/92 Date Signed

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SUMMARY

- This was a routine announced Emergency Operating Procedure (EOP) Scope: follow-up inspection. Its purpose was to verify that corrective actions for previous findings were adequate.
- Results: The inspectors found the licensee had applied adequate efforts to address previous inspection findings. The inspectors did not identify any violations or deviations.

## REPORT DETAILS

### 1. Persons Contacted

Licensee Employees

\*J. Lewis, Operations Manager \*D. Read, Assistant General Manager - Operations \*K. Breitenbach, Engineering Support Manager \*S. Tipps, Nuclear Safety and Compliance Manager \*J. Hammonds, Regulatory Compliance Supervisor \*S. Curtis, Operations Support Superintendent \*W. Berry, Shift Supervisor \*B. Manning, SAER Supervisor (Acting) \*P. Wells, Unit Superintendent

Other licensee employees contacted included engineers, technicians, operators, and office personnel.

NRC Representatives

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\*L. Wert, Senior Resident Inspector R. Musser, Resident Inspector

\*Attended exit interview on February 14, 1992

Acronyms and initialisms are defined in Appendix A

### 2. Actions on Previous Inspection Findings (92701)

 a. (Closed) IFI 321,366/90-16-01, Resolution of Previously Identified Labeling Deficiencies

The licensee conducted a walkdown of EOP supplemental procedures to identify plant labeling that was inconsistent. The inspectors reviewed a representative sample of previously identified labeling deficiencies. To correct any labeling deficiencies, the licensee changed either the label or the procedure as appropriate. To prevent recurrence, review of plant labeling was included as part of the verification and validation program. Also, operations coordinates labeling requests to identify and change affected procedures. This IFI is considered closed.

b. (Closed) IFI 321,366/90-16-02, Control of Operator Action Setpoints

The licensee has included setpoint changes in the DCR process. These DCRs are reviewed to determine if any EOPs or AOPs are affected. Additionally, the setpoint index controls setpoints for instrumentation refered to in the EOPs. The inspectors reviewed both the Unit One and Two setpoint indices to ensure they included all instrumentation referenced by the EOPs. During this review, the inspectors found the setpoints for the RB corner rooms sump level were not in the Unit 2 satpoint index. This was identified by SCS during a routine review and will be included in the next revision. The inspectors also reviewed the previously identified setpoint inconsistencies and found they were corrected. However, the inspectors did note a setpoint inconsistency for the southwest diagonal MSO value. The secondary conatinment control flowchart used a value of 260" verses the PSTG value of 280". This IFI is considered closed.

During a review of the secondary containment control flowchart, the inspectors found that non-safety related level instruments were used for entry into this flowchart for diagonal area flooding. The licensee had not analyzed the use of these non-safety related instruments for EOP entry conditions. The licensee agreed to conduct a review to determine if these instruments need to be safety related. This will be tracked as IFI 321,366/92-03-01 and followed up during future inspections.

c. (Closed) IFI 321,366/90-16-03, Technical Content of Some Procedures

The inspectors reviewed all of the responses to the Appendix B technical concerns and found they were adequately addressed. During the review, a procedural improvement was not incorporated in the latest revision. This improvement was to add a list of the numbers and locations of infrequently operated valves as an operator aide. This procedural improvement was placed in the Operations Procedure Hold File but was not added to the procedure. The inspectors found the procedural improvements remained in the Operations Procedure Hold File. The licensee will include this improvement in the next procedure revision. This IFI is considered closed.

d. (Open) IFI 321,366/90-16-04, Correction of Cable Spreading Room Cables

This item was originally identified in IR 321,366/88-36 as IFI 321,366/88-36-01. The licensee had not yet completed action on this item. The inspectors reviewed the licensees' efforts to date and found they were appropriate. SCS completed a walkdown of the control room panels to identify affected cables and recommended corrective actions. The licensee plans to complete an engineering evaluation of the SCS recommendations by 09/92. This IFI remains open.

#### 3. Exit Interview

The inspection findings were summarized on February 14, 1992, with those individuals identified in paragraph 1. The areas inspected and findings were discussed in detail. These findings are summarized below. No proprietary material was reviewed by the inspectors. No dissenting comments were received from the licensee.

Item Number	<u>Status</u>	Description (Paragraph)
321,366/90-16-01	Closed	IFI-Resolution of Previously Identified Labeling Deficiencies (paragraph 2.a.)
321,366/90-16-02	Closed	IFI-Control of Operator Action Setpoints (paragraph 2.b.)
321,366/92-03-01	Open	IFI-Use of non-safety related instruments for entry conditions in EOPs (paragraph 2.b.)
321,366/90-16-03	Closed	Technical Content of Some Procedures (paragraph 2.c.)
321,366/90-16-04	Open	Correction of Cable Spreading Room Cables (paragraph 2.d.)

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# APPENDIX A Acronyms

AOPs DCR	Abnormal Operating Procedures Design Change Review
EOPs	Emergency Operating Procedures
RB	Reactor Building
SCS	Southern Company Services
PSTG	Plant Specific Technical Guideline
IFI	Inspector Followup Item
MSO	Maximum Safe Operating

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