



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

Report Nos.: 50-321/84-48 and 50-366/84-48

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

Docket Nos.: 50-321 and 50-366

License Nos.: DPR-57 and NPF-5

Facility Name: Hatch 1 and 2

Inspection Conducted: November 21 - December 20, 1984

Inspector: P. Holmes-Ray
P. Holmes-Ray, Resident Inspector

1/28/85
Date Signed

Approved by: V. W. Panciera
V. W. Panciera, Chief, Project Section 2B
Division of Reactor Projects

1/28/85
Date Signed

SUMMARY

Scope: This routine, unannounced inspection entailed 104 inspector-hours on site in the areas of Technical Specification (TS) 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, refueling (Unit 1), and surveillance activities.

Results: Of the areas inspected, three apparent violations were identified in three areas; (Failure to maintain required work control, paragraph 6; failure to determine drywell floor drain leakage, paragraph 7; and failure to submit an LER within required time frame, paragraph 9).

8504170145 850328
PDR ADOCK 05000321
Q PDR

REPORT DETAILS

1. Licensee Employees Contacted

- *H. C. Nix, Site General Manager
- *T. Greene, Deputy Site General Manager
- *L. Sumner, Operations Manager
- P. Fornel, Site QA Manager
- *T. L. Elton, Superintendent of Regulatory Compliance (Acting)
- *T. A. Sietz, Maintenance Manager

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

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized on December 20, 1984, with those persons indicated in paragraph 1 above.

3. Licensee Action on Previous Inspection Findings

Not inspected.

4. Unresolved Items*

One unresolved item was identified during this inspection period in the area of refueling. See paragraph 10 for details.

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 was 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,

*Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

adequacy of fire fighting equipment, and instrument calibration dates. Some tours were conducted on backshifts.

The inspector routinely conducts partial walkdowns of ECCS systems. Valve and breaker/switch lineups and equipment conditions are randomly verified both locally and in the control room. During the inspection period the inspector conducted a complete walkdown in the accessible areas of the Unit-1 Standby Liquid Control System to verify that the lineups were in accordance with licensee requirements for operability and equipment material conditions were satisfactory.

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 11/29/84, Unit-2 was scrambled due to not properly implementing procedure HNP-501, Equipment Clearance and Tagging. The Maintenance Work Order (MWO) was properly issued and the block for "clearance required" was marked requiring a clearance to be issued. On 11/28/84, this job was discussed with the Shift Supervisor by the personnel who were going to work on the system and it was determined that a clearance was required. On 11/29/84, a different pipe fitter and a different Shift Supervisor miscommunicated and the pipe fitter opened the equalizing valve of a SPDS reactor level instrument resulting in a Reactor Scram from 100% power. This improper work control is a violation (366-84/48-01).

7. Technical Specification Compliance (Units 1 and 2)

During this reporting interval, the inspector verified compliance with selected limiting conditions for operations (LCOs) 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 12/13/84, 2109 hours, the Unit 2 Reactor Core Isolation Cooling (RCIC) system isolated on high ΔT due to a failed temperature instrument. The inboard steam supply valve shut. This valve has a history for packing leakage when not in its normal open position and electrically backseated.

The 2000 hour drywell floor drain leak rate indicated a 24 hour average of 3.8 gpm and a 4 hour average of 4.15 gpm. At midnight, the dry well floor drain leakage raw data was taken but not calculated. At 0400, the drywell floor drain leakage raw data was again taken. At about 0410, the calculations were made for the 0000 and 0400 data resulting in a leak rate of 6.0 gpm and 5.17 gpm, respectively.

The applicable TS limits per TS 3.4.3.2, as modified by Confirmatory Order of July 8, 1983, are TS 3.4.3.2.b (5 gpm unidentified leakage) or TS 3.4.3.2.d (an increase of 2 gpm within any 24 hour period). The corresponding action statements require reducing the leakage rate to within the limits within four hours or be in at least Hot Shutdown within the next twelve hours.

The RCIC ΔT problem was solved, RCIC was returned to service, and the inboard isolation valve (2E51-F007) was backseated at about 0230. Leakage rate calculations at 0000 (6.0 gpm), 0400 (5.17 gpm), and 0600 (3.6 gpm) indicate that the increased leakage into the drywell resulted from packing leakage while valve F007 was off its backseat.

There are two discrepancies associated with this event:

- a. Failure to follow procedure - HNP-2-1050 incorporates the TS requirement to determine drywell unidentified leak rate every four hours. This was not accomplished since the calculations were not made for the 0000 leak rate determination until after 0400.
- b. TS 3.4.3.2 requires an LCO action statement to be entered upon exceeding 5 gpm or an increase of 2 gpm unidentified leak rate within a 24-hour period. At 0000, enough data was collected to determine that the action statement should be entered. The LCO was not entered until about 0410. The four hour time to stop the leak expired at 0400. As some mitigation of this event, the RCIC steam supply inboard isolation valve was electrically backseated about 0230 which stopped the packing leak. This action was taken because the valve switch in the control room has a white information tag on it stating to electrically backseat the valve because of known leakage problems. As it turns out, this action was the correct action to be taken had the LCO action statement been entered in a timely manner.

These two discrepancies shall be identified as a violation (366/84-48-02).

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 (Units 1 and 2)

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 TSs were being met and that the public health and safety were of utmost consideration. The following LER's are considered closed:

Unit 1: 84-22*, 84-23*, 84-15

Unit 2: 84-10*, 84-32*

*In-depth review performed.

Review of LER 366-84-32 revealed that the event discovery time listed as 11/5/84 is in error. On 10/15/84, the test results from LETCO confirmed that the bolting material in the RHR service water pump was improper. This is the start time for reporting, not 11/5/84 when the deficiency report was written. 10 CFR 50.73 requires that the received reports be issued within 30 days of discovery of the event. This failure to meet the reporting time limits is a violation (366/84-48-03).

10. Refueling (Unit 1)

During this report period the inspector verified by observation, interviews and procedure review that the refueling was being conducted in accordance with regulations. Areas inspected included adequacy of procedures, fuel sipping, technical specification compliance and refueling floor house-keeping.

- a. Prior to loading the eight bundles to obtain three counts on the Source Range Monitors (SRM), the operators were reviewing the fuel movement sheet and determined that if fuel were positioned as per the sheet the orientation would be in error. This error was corrected on the fuel movement sheet prior to loading fuel.

The fuel movement data sheets are prepared and reviewed by Reactor Engineering and approved by Manager of Engineering prior to issue. The issue of fuel movement sheets which are in error constitutes an inadequate procedure. The alert actions by the operators to discover this error and then take steps to correct the fuel movement sheet prior to proceeding were excellent. Since no fuel was moved in error and the licensee's personnel took prompt corrective action when they discovered the mistake, no citation is issued.

- b. During reload of Unit 1, it was discovered that twelve new fuel bundles were, by prior reversal, not in their proper (expected) location in the fuel storage pool. One of these bundles was loaded into the core. When the second bundle was to be moved, it was noticed that the serial number of the bundles was not the one expected. Fuel movement stopped and all new fuel was verified as to location. No nuclear physics problem existed since all new fuel for this reload is the same. How the fuel and the location tags arrived in the "as found condition" is still under investigation by the licensee and being followed by the Resident Inspector. This is an unresolved item (321/84-48-01).