



UNITED STATES
NUCLEAR REGULATORY COMMISSION

REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30303

Report Nos.: 50-321/84-34 and 50-366/84-34

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 Units 1 and 2

Inspection Dates: August 21 - September 20, 1984

Inspection at Hatch site near Baxley, Georgia

Inspectors: John F. Rogge for 10/4/84
B. V. Crlenjak, Senior Resident Inspector Date Signed

John F. Rogge for 10/4/84
P. Holmes-Ray, Resident Inspector Date Signed

Approved by: V. W. Panciera 10/4/84
V. W. Panciera, Chief, Project Section 2B Date Signed
Division of Reactor Projects

SUMMARY

Areas Inspected

This inspection involved 184 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, refueling (Unit 2), and surveillance activities.

Results

Of the areas inspected, one violation was identified (failure to follow procedures, paragraph 5).

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REPORT DETAILS

1. Persons Contacted

Licensee Employees

- H. C. Nix, Site General Manager
- *T. Greene, Deputy Site General Manager
- *L. Sumner, Operations Manager
- *P. Fornel, Site QA Manager
- S. B. Tipps, Superintendent of Regulatory Compliance
- *T. Seitz, Maintenance Manager
- *C. Jones, Engineering 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 September 28, 1984, with those persons indicated in paragraph 1 above.

3. Licensee Action on Previous Inspection Findings

The following items have been reviewed by the inspectors and are considered resolved.

- a. (Closed) Violation (366/83-26-02) - MSIV leakage control system inoperable due to maintenance.
- b. (Closed) Violation (366/83-26-01) - Inadequate administrative and managerial control systems designed to assure safe operation upon restart from outage.
- c. (Closed) Violation (366/83-26-04) - Complete Technical Specification change to incorporate ATWS reactor pressure switches.
- d. (Closed) Violation (366/83-38-01) - 10 CFR 50, Appendix B, Criterion V, maintenance conducted without appropriate procedures on RHR testable check valve.

4. Unresolved Items

Unresolved items were not identified during this inspection.

5. Plant Tours (Units 1 and 2)

The inspectors 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 inspectors 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 inspectors 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 instrument calibration dates. Some tours were conducted on backshifts.

The inspectors routinely conduct 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 inspectors conducted a complete walkdown in the accessible areas of the Unit 2 Core Spray Train A and Residual Heat Removal Low Pressure Core Injection Train A to verify that the lineups were in accordance with licensee requirements for operability and equipment material conditions were satisfactory.

On August 30, 1984, with Unit 2 in Condition 2, the Resident Inspector noticed that the sealing wire on two instrument valves were cut. The inspector reported this finding to the Operations Manager who initiated an investigation. The investigation, performed by the licensee, found forty (40) cut seal wires and four instruments with valves out of position, however with the seal wires intact. Three of the instruments were in the low-low set logic system (2B21-N120 C, 2B21-N120 D and 2B21-N122B), the fourth was a Reactor Core Isolation Cooling (RCIC) turbine exhaust diaphragm pressure instrument. The licensee stated that even through the valve on the atmospheric leg of the instrument was closed the instrument would still have functioned, however, the response of the instrument may have been somewhat slower than normal. No test was performed to prove this mode of operation.

The licensee's investigation showed that the normal valve line up was performed between August 21, 1984 and August 23, 1984, and that all four instruments were lined up during that time. This lineup was the last known action on the RCIC instrument. On August 25, 1984, due to a Technical Specification set point change, the three low-low set instruments were calibrated. This calibration was the last action on those valves. All personnel interviewed believed they properly performed the required valve positioning. The valve seal wires, put on during the last known actions, were still in place when the valves were determined to be out of position. Review of the procedures involved revealed no abnormalities.

The mispositioning of the valves, even with independent verification in force, is an error in implementing the procedures and is a violation of Technical Specification 6.8.1. (366/84-34-01).

6. Plant Operations Review (Units 1 and 2)

The inspectors 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 inspectors routinely observed operator alertness and demeanor during plant tours. During normal events, operator performance and response actions were observed and evaluated. The inspectors 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 September 11, 1984, the Resident Inspector witnessed the dual recirculating pump trip test on Unit 2. This test was done from 100% flow and about 70% thermal power. A pretest briefing was held with test personnel to discuss the test sequence, data to be taken and by whom, what communications were to be used, and the expected plant response. The test stations were manned and the test performed with no problems. The plant response was as expected. This test was performed in a very professional manner.

Within the areas inspected, no violations or deviations were identified.

7. Technical Specification Compliance (Units 1 and 2)

During this reporting interval, the inspectors 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.

Within the areas inspected, no violations or deviations were identified.

8. Physical Protection (Units 1 and 2)

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

Unit 1: 84-13

Unit 2: 83-28 Rev. 1, 84-08 Rev. 1, 84-12, *84-14, 84-15, *84-16

*In-depth review performed.

10. Refueling (Unit 2)

The shutdown margin determination for Unit 1 was reviewed by the inspector and found to be satisfactory.

Within the area inspected, no violations or deviations were identified.