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Georgia Power

the southern electric system

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L. T. Guwra
Manager Nuclear Engineering
and Chief Nuclear Engineer

NED-84-619

January 3, 1985

U. S. Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region II - Suite 2900
101 Marietta Street, NW
Atlanta, Georgia 30323

REFERENCE:
RII: JPO
50-321/50-366
I&E Inspection
84-41

ATTENTION: Mr. James P. O'Reilly

GENTLEMEN:

Georgia Power Company hereby provides the following information in response to the violation cited in NRC I&E Report 50-321/84-41 and 50-366/84-41 dated December 5, 1984. The subject violation was identified during the NRC inspection conducted at Plant Hatch Units 1 and 2 by Mr. R. V. Crlenjak of your staff on September 21 - November 20, 1984.

VIOLATION 1:

Technical Specification 6.8.1 requires that procedures controlling the operations and maintenance of safety-related systems be established and implemented. Plant Procedure HNP-34, Rules for Performing Procedures, requires verbatim compliance.

Contrary to the above, procedures were not properly established/implemented in that:

- a. On October 6, 1984, while attempting to perform preventive maintenance on Unit 1 residual heat removal (RHR) service water pumps (1E11-C001B and 1E11-C001D), plant personnel mistakenly disconnected the electrical motor leads for Unit 2's RHR service water pumps (2E11-C001B and 2E11-C001D).
- b. Reactor water cleanup (RWCU) system flow transmitter (2G31-N012, EIIS-CE) was improperly installed during completion of Design Change Request (DCR) 83-285 on December 21, 1983.
- c. The keep-full system jockey pump discharge valves for Unit 2, train A core spray (CS) and RHR systems were improperly aligned. The improper alignment (shut) rendered the keep-full system incapable of maintaining the CS and RHR systems discharge lines full.

This is a Severity Level IV violation (Supplement I.D.2) Units 1 and 2.

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RESPONSE VIOLATION 1a:

- a. Admission or denial of alleged violation: The violation occurred.

Reason for the violation: The disconnection of the motor leads for Unit 2's RHR system was the result of personnel error. The responsible individual checked the motor MPL number twice against the procedure, but did not realize that the MPL numbers were different. The redundant 'A' loop of RHRSW remained operable.

Corrective steps which have been taken and the results achieved: Upon discovery, the actions required by the Limiting Condition for Operation and an equipment clearance were initiated without delay. Personnel reconnected and tested the Unit 2 pumps' motor leads per procedure HNP-6920, "Hi Potential Testing of Plant Equipment". The pumps were returned to service 6 1/2 hours after the leads were removed. The responsible personnel were counseled by their supervisors with regard to the event. A critique on the event was held with responsible personnel. The responsible individuals held a briefing for the rest of the maintenance shop about the incident.

Corrective steps which will be taken to avoid future violations: The above actions are sufficient to prevent recurrence.

Date when full compliance was achieved: Full compliance was achieved on October 6, 1984, when the RHRSW pumps were returned to service.

RESPONSE VIOLATION 1b:

- b. Admission or denial of alleged violation: A violation of NRC requirements occurred in that the flow transmitter was incorrectly installed.

Reason for the violation: The incorrect installation of the RWCU dump flow transmitter was the result of personnel error. Sensing lines were incorrectly connected during completion of a Design Change Request (DCR 83-285). The RWCU area temperature detection system (2G31-N600A-F) which also gives an isolation valve group 5 isolation signal remained operable.

Corrective steps which have been taken and the results achieved: The RWCU dump flow transmitter was installed correctly and returned to service on January 17, 1984. This is a correction of the date listed on

RESPONSE VIOLATION 1b (continued):

page 6 of the Inspection Report details. The responsible personnel were counseled by their supervisors with respect to this incident. The RWCU system was demonstrated to be operable by satisfactorily performing the "RWCU-System Differential Flow Instrument FT&C", procedure HNP-2-3501. Additionally, the "RWCU Auto Isolation LSFT", procedure HNP-2-3504, was satisfactorily completed. A general presentation was given to personnel stressing the requirements for proper connection of the sensing lines. Subsequent to this 1983 event, additional administrative controls have been implemented at Plant Hatch for the purpose of increasing management control of the DCR process. Review of safety related maintenance work orders before and after work is being done by the Site Work Planning Group. The administrative process for assignment and review of functional tests was upgraded with the implementation of procedure 50AC-MNT01 on July 30, 1984.

Corrective steps which will be taken to avoid future violations: The above actions are sufficient to prevent recurrence.

Date when full compliance was achieved: Full compliance was achieved on January 17, 1984 when the RWCU dump flow transmitter was returned to service.

RESPONSE VIOLATION 1c:

c. Admission or denial of alleged violation: The violation occurred.

Reason for the violation: The keep-full system jockey pump discharge valves for Unit 2, train 'A', CS and RHR systems were improperly aligned as a result of personnel error during the performance of a surveillance procedure.

Corrective steps which have been taken and the results achieved: The jockey pump discharge valves were immediately placed in their proper positions. CS and RHR pressure returned to normal. The resultant lowest system pressure was approximately 20 PSIG. The systems were vented to verify that the discharge piping was full of water. The two personnel responsible for the incident were given written reprimands on October 12, 1984. Additional counselling was given to other personnel for failure to recognize the abnormally low system pressures. In reference to your letter of November 28, 1984, you noted that the corrective actions taken as a result of violation 84-34-01 had not been adequate to prevent the occurrence of violation 84-41-01c. We note that

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RESPONSE VIOLATION 1c (continued):

the violations are of the same type and that the corrective actions of the second should, therefore, be similar to those of the first. The date of violation 84-41-01c was October 1, 1984, while corrective actions for violation 84-34-01 were still being implemented. Had all the corrective actions of the first incident been in place prior to the second event, we believe that the second event would have been prevented.

Corrective steps which will be taken to avoid future violations: The above actions are sufficient to prevent recurrence.

Date when full compliance was achieved: Full compliance was achieved on October 3, 1984, when the jockey pump discharge valves were placed in their proper positions and the systems were verified full.

VIOLATION 2:

10 CFR 50.72(b)(2)(ii) requires notification within four hours of an Engineered Safety Feature actuation, as implemented by plant procedure HNP-424, paragraph B.2.b.

Contrary to the above:

- a. On September 8, 1984, with Unit 2 operating at 1745 mwt, the RWCU inboard and outboard isolation valves shut due to a high differential flow signal. This ESF actuation was not reported until September 26, 1984.
- b. On November 6, 1984, with Unit 1 in refueling mode and the core unloaded, an actuation of Group 2 primary containment isolation system (PCIS) and an actuation of the reactor protection system (RPS) occurred. These two ESF actuations were not reported until November 7, 1984.

This is a Severity Level IV violation (Supplement I.D.3) Unit 1 and 2.

RESPONSE VIOLATION 2:

Admission or denial of alleged violation: The violation occurred.

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RESPONSE VIOLATION 2 (continued):

Reason for the violation: Both of the instances of late reporting were the result of misinterpretation of the requirements for reporting ESF actuations. On September 8, 1984, personnel failed to recognize that closure of the isolation valves should be interpreted as meeting the requirements of Standing Order 84-21 for "activation of an ESF actuation system." On November 6, 1984, personnel made an incorrect interpretation that the ESF actuations need not be reported with no fuel in the reactor vessel. With the absence of fuel, neither system was required to be operable.

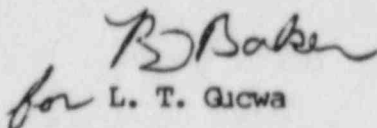
Corrective steps which have been taken and the results achieved: The required reports were made without delay upon recognition of reportability. Shift personnel were briefed by shift meetings regarding requirements to report all unplanned ESF actuations. In addition, personnel are being routinely reminded of the requirements of the Standing Order. Other unplanned ESF actuations have occurred since November 6, 1984, and have been reported as required.

Corrective steps which will be taken to avoid future violations: The above actions are sufficient to prevent recurrence.

Date when full compliance was achieved: Full compliance was achieved on November 7, 1984, when all outstanding unplanned ESF actuations were reported.

Should you have any questions in this regard, please contact this office.

Very truly yours,


for L. T. Gicwa

MJB/blm

xc: H. C. Nix, Jr.
Senior Resident Inspector

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Note: Questions concerning the attached correspondence may be directed
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MJB: 01/07/85