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Georgia Power

*The Southern Electric System*

HI-2925  
004046

September 25, 1992

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

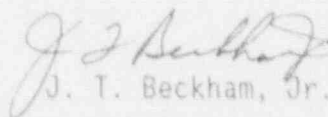
PLANT HATCH - UNITS 1, 2  
NRC DOCKETS 50-321, 50-366  
OPERATING LICENSES DPR-57, NPF-5  
REPLY TO A NOTICE OF VIOLATION

Gentlemen:

In response to your letter dated August 26, 1992 and in accordance with the provisions of 10 CFR 2.201, Georgia Power Company is providing the enclosed response to the Notice of Violation associated with Inspection Report 92-18. A copy of this response is being provided to NRC Region II for review. In the enclosures, a transcription of the NRC violation precedes GPC's response.

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

Sincerely,

  
J. T. Beckham, Jr.

JKB/cr

Enclosures

cc: Georgia Power Company  
Mr. H. L. Sumner, General Manager - Nuclear Plant  
NORMS

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

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ENCLOSURE 1

PLANT HATCH - UNIT 2  
NRC DOCKET 50-366  
OPERATING LICENSE NPF-5  
VIOLATION 92-18-01 AND GPC RESPONSE

VIOLATION 92-18-01

Hatch Unit 2 Technical Specification 6.5.1.6.d requires that the Plant Review Board (PRB) review all proposed changes and modifications to unit systems or equipment that affect nuclear safety. Technical Specification 6.5.1.7.a requires that the PRB recommend in writing to the General Manager - Nuclear Plant, approval or disapproval of the proposed changes or modifications. Technical Specification 6.5.1.7.b requires that the PRB render determinations in writing with regard to whether or not a proposed change or modification constitutes an unreviewed safety question.

Contrary to the above, on July 4, 1992, temporary modification 2-92-60 was installed without being reviewed by the PRB.

This is a Severity Level IV violation (Supplement I)

This violation is applicable to Unit 2 only.

RESPONSE TO VIOLATION 92-18-01

Admission or denial of the violation:

The violation occurred as described in the Notice of Violation.

Reason for the violation:

The violation was caused by personnel error. A member of plant management inappropriately determined that Temporary Modification (TM) 2-92-60 did not require Plant Review Board (PRB) review prior to its implementation. Consequently, the TM was installed on 7/4/92 without first obtaining PRB review in violation of plant procedure 30AC-OPS-005-0S, "Temporary Modification Control."

On 6/30/92, Unit 2 Turbine Building Temperature Switch 2U6I-N110B, one of 64 instruments monitoring Unit 2 Turbine Building temperatures, caused a trip in one channel of the Group 1 Primary Containment Isolation System (PCIS) logic.

ENCLOSURE 1 (Continued)

VIOLATION 92-18-01 AND GPC RESPONSE

It was found to be reading approximately 189 degrees F, seven to 17 degrees F higher than other Turbine Building temperature switches. Therefore, it was electrically bypassed on 7/1/92 per TM 2-92-59 following review of the TM by the PRB and approval by the appropriate level of plant management. Temperature switch 2U61-N110B was returned to service on 7/3/92 after actions had been taken to reduce the general area temperature in the Unit 2 Turbine Building. Although temperature switch 2U61-N110B was still reading higher than the other switches, its reading had decreased, i.e., it had tracked the general area temperature decrease. Thus, TM 2-92-59 was removed and the TM was closed.

A few hours later, on 7/4/92, the switch again caused a trip in one channel of the Group 1 PCIS logic. TM 2-92-60 was written to electrically bypass the switch. The TM was identical to TM 2-92-59, removed a few hours earlier. When site personnel contacted a member of plant management regarding the new TM, he determined that TM 2-92-60 did not require review by the PRB. He made this decision based on the facts that TM 2-92-60 was identical to TM 2-92-59 and that TM 2-92-59 had been reviewed previously by the PRB. Consequently, TM 2-92-60 was installed without first obtaining PRB review. This was a violation of plant procedure 30AC-OPS-005-05.

Corrective steps which have been taken and the results achieved:

On 7/6/92, TM 2-92-61 was written to electrically bypass temperature switch 2U61-N110B. The safety evaluation for this new TM was rewritten to address the comments of the Plant Hatch Senior Resident Inspector regarding the adequacy of the safety evaluation for TMs 2-92-59 and 2-92-60. TM 2-92-61 and its revised safety evaluation were reviewed by the PRB and approved by the appropriate level of management on 7/6/92. TM 2-92-60 was closed.

The responsible member of management has been counseled regarding his inappropriate actions and the need to comply with plant procedures.

Corrective steps which will be taken to avoid further violations:

No further corrective actions are necessary to prevent further violations.

Date when full compliance will be achieved:

Full compliance was achieved on 7/6/92 when TM 2-92-61 was written, reviewed by the PRB, approved by the appropriate level of management, and implemented. TM 2-92-60 was closed.

ENCLOSURE 2

PLANT HATCH - UNIT 1  
NRC DOCKET 50-321  
OPERATING LICENSE DPR-57  
VIOLATION 92-18-02 AND GPC RESPONSE

VIOLATION 92-18-02

Criterion XVI of Appendix B of 10CFR50 requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measure shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, effective corrective actions were not promptly taken to preclude repetitive failures of the spent fuel pool makeup valve (1G41-F041) and the spent fuel pool level alarm systems. Numerous incidents of the valve failing to shut have been identified as early as 1987. On July 26, 1992, failure of the valve to shut and inadequate functioning of the level alarms resulted in an overflow of the Unit 1 spent fuel pool into portions of the reactor building ventilation system.

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

This violation is applicable to Unit 1 only.

RESPONSE TO VIOLATION 92-18-02

Admission or denial of the violation:

The violation occurred as described in the Notice of Violation.

Reason for the violation:

The violation was caused by a lack of proper management attention to resolution of the subject problems. Specifically, Engineering Support personnel failed to implement the necessary corrective actions following a previous similar event to ensure that the Unit 1 skimmer surge tank and spent fuel pool level instruments were working properly. Additionally, Plant Hatch management personnel in the Engineering Support and Maintenance departments failed to ensure proper attention was placed on determining and correcting the root causes of the level instrument and makeup valve problems.

ENCLOSURE 2 (Continued)

VIOLATION 92-18-02 AND GPC RESPONSE

Following an overflow of the Unit 2 spent fuel pool on 12/27/90, an Event Review Team was formed to investigate the event, determine its causes, and recommend corrective actions. This was done and, in January 1991, Event Review Team Report 90-25 was issued. This report contained a description of the event, its causes, and the team's recommended corrective actions. There were a total of eight recommended corrective actions, two of which addressed problems with the skimmer surge tank and spent fuel pool level instruments and one of which addressed problems with the Unit 1 spent fuel pool makeup valve, 1G41-F041. Action Items were assigned to each recommended corrective action as is the standard practice at Plant Hatch. The Action Items on the level instruments were assigned to personnel in the Engineering Support department and the Action Item on the makeup valve was assigned to personnel in the Maintenance department.

As part of the corrective action for the 12/27/90 event, a design change was implemented to correct float binding problems on the Unit 2 spent fuel pool level switch. However, Engineering Support department personnel failed to take the necessary actions to ensure the Unit 1 spent fuel pool level instrument was working properly or to investigate and correct the problems with the skimmer surge tank level instruments on either unit.

Valve 1G41-F041 was repacked per Maintenance Work Order 1-91-132 in February 1992 to address the Action Item and the Event Review Team recommendation. It was subsequently stroked open and closed with no evidence of binding. However, no actions were taken to determine why the valve had a history of failing to close or to correct the fundamental causes of this problem.

Corrective steps which have been taken and the results achieved:

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

1. Extensive maintenance has been performed on valve 1G41-F041 in an attempt to fix the problems causing the valve, on a random basis, not to close fully. The valve itself has been replaced and its operator reworked. The operator's closing spring force was measured and determined to be within design limits. This valve is an air to open, spring to close valve. Steps were taken to reduce the number of valve packing rings, to reduce stem drag, by the use of a packing spacer block. In addition, a spacer plate was used to increase the preload on the operating spring. This action assured that the spring pressure available at the end of the close cycle met the vendor requirement. The solenoid operated valve in the air supply to the valve operator was replaced and the air lines were determined to be the proper size for this application.





ENCLOSURE 2 (Continued)

VIOLATION 92-18-02 AND GPC RESPONSE

Date when full compliance will be achieved:

Full compliance was achieved on 9/7/92 at which time the spent fuel pool level instrumentation had been calibrated and compensatory measures had been put in place to ensure proper operation of valve 1G41-F041.