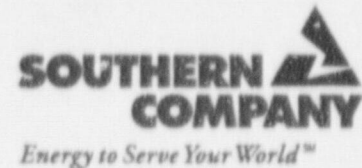


Lewie Sumner  
Vice President  
Hatch Project Support

Southern Nuclear  
Operating Company, Inc.  
40 Inverness Parkway  
Post Office Box 1295  
Birmingham, Alabama 35201  
Tel 205.992.7279  
Fax 205.992.0341



February 20, 1998

Docket Nos. 50-321  
50-366

HL-5576

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

Edwin I. Hatch Nuclear Plant  
Reply to a Notice of Violation

Gentlemen:

In response to your letter dated January 23, 1998, and according to the requirements of 10 CFR 2.201, Southern Nuclear Operating Company (SNC) is providing the enclosed response to the Notices of Violation associated with Inspection Report 97-11. In the enclosure, a transcription of the NRC item precedes SNC's response.

If you have any additional questions on this subject, please contact this office.

Sincerely,

H. L. Sumner, Jr.

IFL/eb

Enclosures:

1. Violation 97-11-02 and SNC Response
2. Violation 97-11-03 and SNC Response
3. Violation 97-11-06 and SNC Response
4. Violation 97-11-07 and SNC Response

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U.S. Nuclear Regulatory Commission

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February 20, 1998

cc: Southern Nuclear Operating Company  
Mr. P. H. Wells, Nuclear Plant General Manager  
NORMS

U.S. Nuclear Regulatory Commission, Washington, D.C.  
Mr. L. N. Olshan, Project Manager - Hatch

U.S. Nuclear Regulatory Commission, Region II  
Mr. L. A. Reyes, Regional Administrator  
Mr. B. L. Holbrook, Senior Resident Inspector - Hatch

## Enclosure 1

### Edwin I. Hatch Nuclear Plant Violation 97-11-02 and SNC Response

#### VIOLATION 97-11-02

10 CFR 50.72 (b)(2)(ii), Four-hour reports, states, in part, that the licensee shall notify the NRC as soon as practical and, in all cases, within four hours of...any event or condition that results in a manual or automatic actuation of any engineered safety feature...

Contrary to the above, a four-hour reporting requirement was not met on November 18, 1997. A nitrogen supply line in the Unit 1 drywell developed a leak. Primary containment isolation valve 1-P70-F004 (sic) closed at about 5:52 p.m. on November 18, after a 10-minute delay following a high flow condition. This was a valid Engineered Safety Feature actuation. The required 4-hour NRC report was not made until 12:58 p.m. on November 19, 1997.

This is a Severity Level IV Violation (Supplement I). (This violation is applicable to Unit 1 only.)

#### RESPONSE TO VIOLATION 97-11-02

##### Reason for the violation:

The cause of this event was personnel error. Personnel were aware at the time of the isolation that nitrogen supply line valve 1P70-F004 had closed on a high flow isolation signal. However, they did not realize that this valve was a primary containment isolation valve and that its automatic isolation was reportable per the requirements of 10 CFR 50.72 (b)(2)(ii). Personnel failed to realize valve 1P70-F004 is a primary containment isolation valve in part because the function of the valve is atypical. Its automatic isolation prevents excessive nitrogen from *entering* primary containment whereas the typical function of a primary containment isolation valve is to prevent material from *leaving* primary containment. Therefore, the fact that this valve is a primary containment isolation valve was not obvious.

##### Corrective steps which have been taken and the results achieved:

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

1. Involved personnel have been counseled regarding the need to fully utilize the resources available to them to ensure that events are reported to the NRC as required. This includes the use of information available in the Technical



Enclosure 1

Violation 97-11-02 and SNC Response

Requirements Manuals and/or input from support departments as necessary. This expectation has also been communicated to all licensed personnel on operating crews.

2. Operations management has emphasized to shift personnel their role of verifying that the proper actuations, particularly primary containment isolation valve closures, have occurred for the given actuation signals. Additionally, shift personnel have been instructed to notify the Shift Operations Superintendent, as well as the Shift Supervisor on the affected unit, of any actuations that have occurred.

Corrective steps which will be taken to avoid further violations:

This event, along with three previous events in which required reports were not made within the times specified in 10 CFR 50.72, will be included in license requalification training. Because three of these four events have occurred during refueling outages, this training module will be completed prior to the next scheduled refueling outage.

Date when full compliance will be achieved:

Full compliance was achieved on 11/19/97 when the required notification of the automatic isolation of valve 1P70-F004 was made.

## Enclosure 2

### Edwin I. Hatch Nuclear Plant Violation 97-11-03 and SNC Response

#### VIOLATION 97-11-03

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires, in part, corrective actions to preclude repetition of significant conditions adverse to quality.

Contrary to the above, on November 18, 1997, a required 10 CFR 50.72 4-hour notification was not made within the required time. As a result, the NRC was not timely informed of an Engineered Safety Feature actuation. The previous corrective actions for late 10 CFR 50.72 4-hour reports which occurred on June 10, 1996, August 30, 1996, and May 5, 1997 were not adequate to preclude repetition of significant conditions adverse to quality.

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

#### RESPONSE TO VIOLATION 97-11-03

##### Reason for the violation:

In the first event cited in the Notice of Violation, personnel failed to report the automatic start of a diesel generator on 4/24/96. The diesel generator was considered inoperable at the time of its auto start and responsible personnel misinterpreted the term "properly removed from service" to mean that if the system or component was considered inoperable its actuation did not have to be reported. In the second cited event, an event which rendered the high pressure coolant injection system inoperable on 6/29/96 was not reported within four hours of its discovery. The high pressure coolant injection system was already inoperable at the time of the event. Responsible personnel interpreted the requirement to report those events which could have rendered a safety system inoperable as not applying to those systems already considered inoperable at the time of discovery. In the third event cited, personnel failed to report the automatic isolation of some primary containment isolation valves on 3/25/97. Responsible personnel failed to note that the valves closed making the event reportable. Other personnel failed to adequately communicate this information to the responsible personnel. In the last event cited, responsible personnel failed to note that the isolation of valve 1P70-F004 on 11/18/97 was reportable. Responsible personnel failed to recognize that valve 1P70-F004 was a primary containment isolation valve and that its automatic isolation was reportable as an engineered safety feature system actuation.



The corrective actions taken for each event cited in this Notice of Violation were adequate to address the causes of that particular event. In all cases, each event was the result of circumstances unrelated to any of the other cited events: corrective actions taken for one event would not be expected to prevent the occurrence of any of the other events. However, reviewing the events and their causes in the aggregate indicates that personnel may have erred in that they may not have attached the proper level of importance to a common factor in the first three events that, had it been better addressed, might have prevented the fourth event cited in the violation.

In all four events, shift personnel failed to fully utilize the resources available to them in making the reportability decision. Although personnel investigating these events knew of this, it appears now that they did not assign the proper level of importance to this common factor. As a result, corrective actions did not adequately address this factor.

Corrective steps which have been taken and the results achieved:

As a result of this violation, a team was formed which reviewed each event, its causes, and the corrective actions already taken. They also reviewed administrative control procedures covering reporting and training provided on reporting requirements. The team reached the following conclusions regarding the four events:

- a) Support personnel were not contacted for input regarding the reportability of any of the events.
- b) In each of the events, shift Operations personnel did consider whether it should be reported; however, they incorrectly concluded the event was not reportable.
- c) In the first two events, the reporting requirements contained in 10 CFR 50.72 could be considered unclear. Only when reviewing information provided in NUREG-1022 and its supplements is it clear these two events were required to be reported. Procedure 00AC-REG-001-0S, "Federal and State Reporting and Federal Document Posting Requirements," did not incorporate the clarifying information contained in the NUREG or its supplements.
- d) PCIV 1P70-F004 isolates to prevent excessive nitrogen from entering the primary containment. It does not isolate to prevent primary containment atmosphere from escaping. The latter is a typical function of a primary containment isolation valve.
- e) Neither the TRM nor the FSAR PCIV tables list valve 1P70-F004 as belonging to a "group" as, for example, Group 1 PCIVs, Group 5 PCIVs, et cetera.

Based upon these conclusions and their discussions of the four events, the team recommended the corrective actions which follow.

Enclosure 2

Violation 97-11-03 and SNC Response

As mentioned in the response to Notice of Violation 97-11-02, Operations management has emphasized to shift personnel their role of verifying that the proper actuations have occurred for the given actuation signals. Shift personnel have been instructed to notify the Shift Operations Superintendent, as well as the Shift Supervisor on the affected unit, of any actuations that have occurred.

Corrective steps which will be taken to avoid further violations:

The four events cited in this violation will be included in license requalification training. Because three of the four events occurred during refueling outages, this training module will be completed prior to the next scheduled refueling outage.

Procedure 00AC-REG-001-0S has been revised to include some additional clarifying information provided in NUREG-1022 and its supplements. However, the team identified additional information which could be included, and some formatting changes which could be made, to benefit shift Operations personnel in determining if an event is reportable. Therefore, procedure 00AC-REG-001-0S will be revised as recommended by the team. The revision will be effective by 3/16/98.

The Unit 1 and Unit 2 Technical Requirements Manuals and Final Safety Analysis Reports tables of primary containment isolation valves will be revised to place automatic isolation valves in "groups." This will help to emphasize to personnel that automatic valves listed in the tables are part of the primary containment isolation system, an engineered safety feature system, and that the unplanned actuation of any of them may be reportable.

Date when full compliance will be achieved:

Plant Hatch presently is in full compliance with the reporting requirements of 10 CFR 50.72. SNC believes that with the implementation of the aforementioned corrective actions, it will be in compliance with the requirements of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," and that these actions are, to the extent possible, adequate to preclude the occurrence of similar events.



Enclosure 3

Edwin I. Hatch Nuclear Plant  
Violation 97-11-06 and SNC Response

VIOLATION 97-11-06

TS 5.4.1.a requires that written procedures be established, implemented, and maintained covering activities delineated in Appendix A of RG 1.33, Rev. 2, dated February 1978. Regulatory Guide 1.33, Appendix A, "Typical Procedures for Pressurized Water Reactor and Boiling Water Reactors, Paragraph 7.e, requires, in part, radiation protection procedures for bioassay programs.

Radiation Protection (RP) procedure 62RP-RAD-004-OS, Personnel Decontamination, Rev. 8, effective February 18, 1997, Section 7.1.5.2, requires that if contamination occurs on or near the nose and/or mouth area, then have the individual perform a nasal swab and count for contamination and if the results are positive, then initiate a whole body count in the Whole Body Counter (WBC) by completing a WBC Worksheet.

Administrative control (AC) procedure 60AC-HPX-004-OS, Radiation and Contamination Control, Rev. 15, effective August 29, 1997, requires, in part, that whenever internal contamination is suspected, bioassays shall be performed in accordance with 60AC-HPX-003, Bioassay Program procedure.

Contrary to the above, for a November 14, 1997, contamination event resulting in two laborers having distributed contamination on the face and nasal area, the licensee personnel failed to follow procedure in that nasal swabs were not taken, or were not taken until the nose was cleaned and individuals were not sent for a whole body analyses (sic) as required.

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

RESPONSE TO VIOLATION 97-11-06

Reason for the violation:

The cause of this event was personnel error. Health Physics personnel failed to follow procedure 62RP-RAD-004-OS, "Personnel Decontamination." The personnel did not obtain nasal smear from and whole body counts on persons who were contaminated near the nose and mouth areas as required by procedure 62RP-RAD-004-OS.



Enclosure 3

Violation 97-11-06 and SNC Response

Corrective steps which have been taken and the results achieved:

The required whole body counts of the contaminated personnel were performed on 11/15/97. The appropriate internal doses were calculated and assigned as required by plant procedures and 10 CFR 20.

Corrective steps which will be taken to avoid further violations:

Training materials for in-house, contract, and control point Health Physics technicians will be reviewed and revised as necessary to include more instruction and place more emphasis on Health Physics procedures and required follow-up actions covering the handling of contaminated personnel. These actions have been completed.

Date when full compliance will be achieved:

Full compliance was achieved on 11/15/97 when the required whole body counts of the contaminated personnel were performed.

#### Enclosure 4

#### Edwin I. Hatch Nuclear Plant Violation 97-11-07 and SNC Response

##### VIOLATION 97-11-07

TS 5.4.1.a requires that written procedures be established, implemented, and maintained covering activities delineated in Appendix A of Regulatory Guide (RG) 1.33, Rev. 2, dated February 1978. Regulatory Guide 1.33, Appendix A, "Typical Procedures for Pressurized Water Reactor and Boiling Water Reactors," Paragraph 7.e, requires, in part, radiation protection procedures for Radiation Work Permit (RWP) system.

Administrative control (AC) Health Physics procedure 60AC-HPX-004-OS, Radiation and Contamination Control, Rev. 14, effective October 14, 1996, Section 4.6, required plant personnel to read and comply with the requirements of the RWP whenever their duties require such authorization.

Contrary to the above, between March 17 and April 11, 1997, several workers involved in Unit 2 outage activities signed into the Radiologically Controlled Area (RCA) on improper RWPs. At least three instances of worker entry into high radiation areas on RWPs intended for use in non-high radiation areas were identified.

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

##### RESPONSE TO VIOLATION 97-11-07

##### Reason for the violation:

The cause of this violation was personnel error. Personnel in some cases failed to ensure the radiation work permit they were using was appropriate for the work to be performed or the area of the plant in which they were working. Contributing to use of incorrect radiation work permits were changes in the use of printer stations and when outage-related radiation work permits were allowed to be used. In the case of the former, the use of printer stations at the turbine building access control points had been discontinued. The printer generated a print-out which indicated which radiation work permit the worker was using. Discontinuing the use of the printers prevented Health Physics technicians from determining which radiation work permit personnel were using and thereby detecting incorrect radiation work permit use prior to the workers being allowed to begin work. In the case of the latter, some workers continued to use non-outage radiation work permits out of habit because they had been using these permits prior to the outage. Outage-related radiation work permits were not available to be used until the actual start of the outage.



Enclosure 4  
Violation 97-11-07 and SNC Response

Corrective steps which have been taken and the results achieved:

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

1. Contract supervision were notified and the involved personnel were counseled regarding the expectation that they sign onto the radiation work permit that is appropriate for the work to be performed.
2. Prior to the start of the Unit 1 refueling outage in the fall of 1997, the turbine building access control printer stations were reinstalled. This allowed Health Physics technicians the opportunity to verify workers were using the correct radiation work permit prior to beginning work.
3. Outage-related radiation work permits were identified and made active before contractors began in-processing. This eliminated the confusion among contract personnel regarding which permit, non-outage or outage, they should use once the outage actually began.
4. Copies of outage-related radiation work permits were posted or otherwise made available at access control stations to assist workers in selecting the correct permit to use for their particular work activity and location.

Corrective steps which will be taken to avoid further violations:

No additional corrective actions to prevent further violations are necessary at this time. However, it is worth noting that Health Physics technicians occasionally perform quality checks of radiation work permit usage, especially during refueling outages. Health Physics, Maintenance, and Contractor supervision are notified of events which appear to warrant action. This routine process allows early detection and correction of problems and should help prevent events similar to those described in the Notice of Violation. Although not a commitment to do so, management anticipates these types of quality checks will continue for the immediate future.

Date when full compliance will be achieved:

Plant Hatch presently is in full compliance with radiation work permit use requirements