



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

Report Numbers: 50-321/89-06 and 50-366/89-06

Licensee: Georgia Power Company
 P.O. Box 1295
 Birmingham, AL 35201

Docket Numbers: 50-321 and 50-366

License Numbers: DPR-57 and NPF-5

Facility Name: Hatch 1 and 2

Inspection Dates: March 21 - April 21, 1989

Inspection at Hatch site near Baxley, Georgia

Inspectors:	<i>John E. Menning</i>	<i>5-8-89</i>
	John E. Menning, Senior Resident Inspector	Date Signed
	<i>Randall A. Musser</i>	<i>5-8-89</i>
	Randall A. Musser, Resident Inspector	Date Signed
Approved by:	<i>Marvin V. Sinkule</i>	<i>5-8-89</i>
	Marvin V. Sinkule, Chief, Project Section 3B Division of Reactor Projects	Date Signed

SUMMARY

Scope: This routine inspection was conducted at the site in the areas of Operational Safety Verification, Maintenance Observations, Surveillance Testing Observations, Reportable Occurrences, 10 CFR Part 21 Inspections, and Three Mile Island Items.

Results: The professionalism and attentiveness of control room personnel were observed to be a strength during this reporting period. Operators and their supervisors responded promptly and effectively to equipment problems that were experienced, observing procedural and technical specification requirements (paragraph 2).

A weakness was noted in the area of surveillance. Recently submitted LERs reveal an increase in the number of missed surveillances due primarily to cognitive personnel errors. Licensee management appears to be sensitive to the problem and has taken steps to re-emphasize the importance of surveillance requirements with plant personnel. Continued management attention is needed to ensure that this recent negative trend in surveillance performance is reversed (paragraph 5).

Within the areas inspected, one violation was identified for failure to perform daily surveillance checks of two A.C. circuits within primary containment (paragraph 5). Four additional licensee-identified violations, which are not being cited, were also identified (paragraph 5). One licensee-identified violation involved a Main Control Room Environmental Control system design deficiency, and the second licensee-identified violation was for deficient jet pump surveillance. The third licensee-identified violation involved a Standby Gas Treatment system design deficiency, and the fourth licensee-identified violation was for deficient drywell atmosphere sampling.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *C. Coggin, Training and Emergency Preparedness Manager
- D. Davis, Manager General Support
- *J. Fitzsimmons, Nuclear Security Manager
- *P. Fornel, Maintenance Manager
- *O. Fraser, Site Quality Assurance Manager
- *G. Goode, Acting Engineering Manager
- *M. Googe, Outages and Planning Manager
- *W. Kirkley, Acting Health Physics and Chemistry Manager
- *J. Lewis, Acting Operations Manager
- *C. Moore, Assistant General Manager - Plant Support
- *H. Nix, General Manager - Nuclear Plant
- *H. Sumner, Assistant General Manager - Plant Operations
- S. Tipps, Nuclear Safety and Compliance Manager

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

NRC Resident Inspectors

- J. Menning
- *R. Musser

NRC management on site during inspection period:

- A. Herdt, Chief, Project Branch 3, Region II
- E. Merschhoff, Deputy Director, Division of Reactor Safety, Region II

*Attended exit interview

Acronyms and initialisms used throughout this report are listed in the last paragraph.

2. Operational Safety Verification (71707) Units 1 and 2

The inspectors kept themselves informed on a daily basis of the overall plant status and any significant safety matters related to plant operations. Daily discussions were held with plant management and various members of the plant operating staff. The inspectors made frequent visits to the control room. Observations included control room manning, access control, operator professionalism and attentiveness, adherence to procedures, adherence to limiting conditions for operation, instrument readings, recorder traces, annunciator alarms, operability of nuclear instrumentation and reactor protection system channels, availability of power sources, and operability of the Safety Parameter Display system.

These observations also included log book entries, tags and clearances on equipment, temporary alterations in effect, ECCS system lineups, containment integrity, reactor mode switch position, conformance with technical specification safety limits, daily surveillances, plant chemistry, scram discharge volume valve positions, and rod movement controls. This inspection activity involved numerous informal discussions with operators and their supervisors.

The operability of selected safety-related systems was confirmed on essentially a weekly basis. These confirmations involved verification of proper valve and control switch positioning, proper circuit breaker and fuse alignment, and operability of related instrumentation and support systems. Major components were also inspected for leakage, proper lubrication, cooling water supply, and general condition. On March 29, 1989, the inspector confirmed the operability of the Unit 1 RCIC system. Proper electrical, valve, and switch alignments were confirmed using Attachments 2 and 3 to procedure 34SO-E51-001-1S. On April 6, 1989, the inspector confirmed the operability of the Unit 1 RHRSW system. Proper electrical, switch, and valve lineups were confirmed using Attachments 2 and 3 to procedure 34SO-E11-010-1S. During this walkdown, the inspector noted that valve 1E11-F012D ("D" RHRSW pump discharge valve) was unlabeled. This discrepancy was brought to the attention of the Unit 1 Shift Supervisor. On April 12, 1989, the operability of the Unit 2 emergency diesel generators was confirmed. Proper valve lineups were verified using Data Package 2 of procedure 34SO-R43-001-2S.

General plant tours were conducted on at least a weekly basis. Portions of the control building, diesel generator building, intake structure, turbine building, reactor building, and outside areas were toured. Observations included general plant/equipment conditions, fire hazards, fire alarms, fire extinguishing equipment, emergency lighting, fire barriers, emergency equipment, control of ignition sources and flammable materials, and control of maintenance/surveillance activities in progress. Radiation protection controls, implementation of the physical security program, housekeeping conditions/cleanliness, control of missile hazards, and instrumentation and alarms in the main control room were also observed.

The inspectors observed selected operations shift turnover briefings to confirm that all necessary information concerning the status of plant systems was being addressed. Each briefing was conducted by the oncoming OSOS. The inspectors noted that each OSOS discussed existing plant problems, activities that were anticipated for the shift, and any new standing orders or management directives. Radiological and industrial safety were generally stressed. The STAs discussed any recent procedure revisions that impacted on the attendees. The inspectors attended shift turnover briefings on the following dates and shifts; April 10, 1989 - day, April 13, 1989 - day, April 16, 1989 - day, April 16, 1989 - evening, and April 19, 1989 - evening.

Several safety-related equipment clearances that were active were reviewed to confirm that they were properly prepared and placed. Involved circuit breakers, switches, and valves were walked down to verify that clearance tags were in place and legible, and that equipment was properly positioned. Equipment clearance program requirements are specified in licensee procedure 30AC-OPS-001-OS, "Control of Equipment Clearances and Tags." On March 28, 1989, Unit 2 equipment clearance 2-89-269 was walked down. This clearance was placed to support maintenance on the "A" Train of the SBT system. On April 11, 1989, Unit 1 equipment clearance 1-89-442 was walked down. This clearance was placed to isolate the DWED sump pump 1G11-C006B for maintenance.

Implementation of the licensee's sampling program was reviewed by the inspector. This review involved observation of sampling activities (reactor coolant and tank sampling) and chemistry surveillance. Related records were also reviewed. During this inspection period, the inspector monitored the following activities. On March 29, 1989, the inspector accompanied a chemistry technician on the daily rounds check of sampling related control room instrumentation. The following instruments were checked by the technician: Main Steam Line Radiation Monitors, Pretreatment Monitors, Post-Treatment Monitors, Main Stack Monitors, Fission Product Monitors, Service Water Effluent Monitor, and the RBCCW Monitor. Additionally, the inspector observed the changeout of the Unit 1 and 2 Reactor Building gaseous effluent sampling filters per procedure 64CH-SAM-005-OS. On March 30, 1989, the inspector observed the monthly SLC tank Sodium Pentaborate Concentration test on Units 1 and 2.

The licensee's deficiency control system was reviewed to verify that the system is functioning as intended. Licensee procedure 10AC-MGR-004-OS, "Deficiency Control System," establishes requirements and responsibilities for the preparation, processing, review, and disposition of deficiency reporting documents. This procedure applies to all deficiencies affecting equipment, procedures, or personnel. Deficiencies are reported on Deficiency Cards (DCs). On March 29, 1989, the inspector reviewed recently generated DCs. The inspector verified that DCs had been prepared as required by the controlling procedure, and that several deficiencies that were noted in the Shift Supervisors' logs had been documented on DCs. More specifically, the inspector noted that DC 1-89-1372 had been prepared to document observed leakage past "B" CRD pump discharge valve 1C11-F014B. It was also noted that DC 2-89-898 had been generated to document repeated tripping of Waste Collector Tank pump 2G11-C011. On April 11, 1989, the inspector also reviewed recently prepared DCs and verified that problems observed in the plant had been properly documented. The inspector noted that DC 1-89-1471 had been generated to document apparent water in the upper motor bearing of PSW pump 1P41-C001D. It was also noted that DC 2-89-1003 had been prepared to document high tailpipe temperatures on SRV 2B21-F013H.

Selected portions of the containment isolation lineup were reviewed to confirm that the lineup was correct. The review involved verification of proper valve positioning, verification that motor and air-operated

valves were not mechanically blocked and that power was available (unless blocking or power removal was required), and inspection of piping upstream of the valves for leakage or leakage paths. On March 28, 1989, the inspector reviewed the following Unit 1 containment isolation valves; 1E11-F011A, 1E11-F011B, 1E11-F016A, 1E11-F016B, 1E11-F023, 1E11-F026A, 1E11-F026B, 1E11-F0103A, 1E11-F103B, 1E21-F015A, and 1E21-F015B. On April 10, 1989 the inspector reviewed the following Unit 2 containment isolation valves; 2E11-F041B, 2E11-F041D, 2E11-F103A, 2E21-F001A, 2E21-F001B, 2E21-F005A, 2E21-F005B, 2E21-F015A, 2E21-F015B, 2E41-F012, 2E41-F104, and 2E41-F111.

Unit 2 power level was reduced to approximately 30 percent of rated for five days during this reporting period. Condenser retubing interference walkdowns were performed at that time. These interference walkdowns were required to support retubing of the main condenser during the upcoming Fall 1989 refueling/maintenance outage. The reduction from rated power commenced at 2315 on April 9, 1989. Approximately 30 percent of rated power was reached (and subsequently maintained) at 0310 on April 10, 1989. Following the completion of the walkdowns, power increase started at 1315 on April 14, 1989. Rated thermal power was achieved at 1715 on April 15, 1989.

The professionalism and attentiveness of control room personnel were observed to be a strength during this reporting period. Operators and their supervisors responded promptly and effectively to equipment problems that were experienced, observing procedural and technical specification requirements.

No violations or deviations were identified.

3. Maintenance Observations (62703) Unit 1

During the report period, the inspectors observed selected maintenance activities. The observations included a review of the work documents for adequacy, adherence to procedure, proper tagouts, adherence to technical specifications, radiological controls, observation of all or part of the actual work and/or retesting in progress, specified retest requirements, and adherence to the appropriate quality controls. The primary maintenance observations during this month are summarized below:

<u>Maintenance Activity</u>	<u>Date</u>
1. Installation of Pipe Hanger P41-102-H800A on the Service Water System per MWO 1-89-1044	04/05/89
2. Maintenance on CRD Hydraulic System Pump 1C11-C001B per MWO 1-89-1578	04/11/89

3. Replacement of the Key Lock Switch on the 1D11-K603D Main Steam Line Radiation Monitor per MWO 1-89-1797 04/17/89

No violations or deviations were identified.

4. Surveillance Testing Observations (61726) Unit 1

The inspectors observed the performance of selected surveillances. The observation included a review of the procedure for technical adequacy, conformance to technical specifications, verification of test instrument calibration, observation of all or part of the actual surveillances, removal from service and return to service of the system or components affected, and review of the data for acceptability based upon the acceptance criteria. The primary surveillance testing observations during this month are summarized below:

<u>Surveillance Testing Activity</u>	<u>Date</u>
1. HPCI Monthly Testing per procedure 34SV-E41-002-1S	03/29/89
2. SLC Tank Sodium Pentaborate Concentration Monthly Test per procedures 64CH-SAM-004-0N and 64CH-SAM-009-0S	03/30/89
3. Diesel Generator 1A Monthly Test per procedure 34SV-R43-001-1S	03/31/89
4. Core Spray Pumps A and B Monthly Test per procedure 34SV-E21-001-1S	04/07/89

No violations or deviations were identified.

5. Reportable Occurrences (90712 and 92700) Units 1 and 2

A number of 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 the public health and safety were of utmost consideration.

Unit 1: 88-11 Design Deficiency Could Affect Control Room Environmental Control System

This LER concerns a design deficiency that made the automatic initiation of the isolation and pressurization modes of the MCREC system vulnerable to

a single failure. More specifically, four refueling area ARMs that provide anticipatory trips to the MCREC system are not seismically qualified. In a seismic event an electrical ground could have been created in the local auxiliary trip units of the ARMs. This situation would cause failure of some fuses in the actuation logic which would prevent automatic actuation of the MCREC system.

Corrective action involved modifying the ARMs to mitigate the consequences of a seismic event on the MCREC system actuation logic. The circuitry for the four refueling area ARM local auxiliary trip units was modified under DCR 88-177. Unit 1 (1D11-K002-2) and Unit 2 (2D11-K002-D) trip units were modified by installing two, three-amp fuses in series with their parallel trip circuits. Unit 1 (1D21-K002-4) and Unit 2 (2D21-K002-A) trip units were also modified by installing two, three-amp fuses in series with their trip circuits. On April 14, 1989, the inspector reviewed the documentation package for DCR 88-177 and confirmed that modifications described in the LER had been implemented.

Criterion 2 in Appendix A of 10 CFR Part 50 requires the MCREC system to be designed to withstand seismic events without loss of safety function capability. The design deficiency that resulted in this LER is a violation of Criterion 2. However, this licensee-identified matter was properly reported to the NRC and corrective action was timely. This violation meets the criteria specified in the NRC Enforcement Policy for not issuing a Notice of Violation, and therefore, this violation is not being cited. This matter, identified as NCV 50-321/89-06-01, is considered to be closed.

Review of the LER is closed.

88-12 Loose Gear Fastener in Flow Controller Results in Inoperability of HPCI

This LER concerns malfunctioning of the HPCI system flow controller that resulted in system inoperability. The cause of the flow controller malfunction was a loose fastener on an intermediate gear in the gearing mechanism of the controller. When the fastener became loose, the intermediate gear became unmeshed with the adjacent gearing. This caused a break in the gear train preventing adjustment of the controller setting.

Corrective action involved permanently revising three procedures to require periodic checks of the controller gearing and gearing fasteners. Procedures 57CP-CAL-044-1/2S, "GE Type 547-01, 547-12 and 543-03 Self Synchro Control Loop," were revised to require the checks during calibration of the controller. The inspector reviewed Revision 2 of each of these procedures and noted that the intended changes had been incorporated as Step 7.2.15. Procedure 52PM-E41-001-0S, "HPCI System Annual Inspection and Lubrication," was revised to require the checks on a twelve month frequency. The inspector reviewed Revision 0 of this procedure and noted that the requirement for these checks was incorporated as Step 7.7.3.15.

Review of the LER is closed.

89-04 Personnel Error Caused Missed Technical Specification Surveillance

This LER concerns a failure to properly perform Recirculation system jet pump surveillance at least once per 24 hours as required by Technical Specification 4.6.I. Due to personnel errors, the surveillance was initially delayed and then performed incorrectly. The errors were detected approximately 2 hours after the surveillance grace period had expired, and the surveillance was satisfactorily performed at that time.

This event was attributed to cognitive personnel error. One STA incorrectly assumed that the analysis of jet pump data could be delayed until the Unit 1 computer was available. A second STA incorrectly assumed that the computer analysis of Unit 1 jet pump data could be performed on the Unit 2 computer. Corrective action included reviewing the plant procedure that implements Technical Specification 4.6.I and revising the computer analysis program. The plant procedure was determined to be adequate as written. The computer program was revised to remove the unit prompt feature which incorrectly suggested to the STA that Unit 1 jet pump data could be analyzed on the Unit 2 computer. On April 16, 1989, the inspector reviewed this matter with the on-shift STA and verified that the unit prompt feature had been removed from the computer program as intended.

This matter is a violation of Technical Specification 4.6.I. However, the events of the LER were properly reported to the NRC and corrective action was prompt. This violation meets the criteria specified in Section V of the NRC Enforcement Policy for not issuing a Notice of Violation, and therefore, this violation is not being cited. This matter, identified as NCV 50-321/89-06-02, is considered to be closed.

Review of the LER is closed.

Unit 2: 88-25 Design Deficiency of Standby Gas Treatment System

This LER concerns a SGTS design deficiency that would have prevented automatic initiation of the system under certain specific conditions. More specifically, the licensee discovered that the system would not automatically start upon receipt of a SGTS initiation signal following a LOSP without manual operator action. This condition was recognized as being contrary to the FSAR's design bases. The root cause of the problem was inadequate design of the SGTS high temperature trip relay. As designed, it remained tripped following power restoration after a LOSP, thus preventing automatic system initiation.

Initial corrective action involved the implementation of TM 2-88-139. This TM removed the set in feature of the high temperature relay allowing automatic system actuation upon receipt of an initiation signal following a LOSP. A permanent design modification was subsequently implemented. This modification work was completed on January 27, 1989, and changed the high temperature relay to a normally de-energized relay. The inspector reviewed documentation for MWOs 2-89-138 and 139 and verified that the modification work was completed.

Criterion III in Appendix B of 10 CFR Part 50 requires that measures be established to assure that the design bases of the SGTS as specified in the license application are correctly translated into specifications and drawings. The design deficiency that resulted in this LER is a violation of Criterion III. However, this matter was properly reported to the NRC and the licensee took prompt corrective action when the deficiency was identified. This violation meets the criteria specified in Section V of the NRC Enforcement Policy for not issuing a Notice of Violation, and

therefore, this violation is not being cited. This matter, identified as NCV 50-366/89-06-03, is considered to be closed.

Review of this LER is closed.

89-01 Personnel Error Results in Missed Technical Specification Surveillance

This LER concerns a failure to perform drywell atmosphere grab sample surveillance at required 4-hour intervals. Technical Specification 3.4.3.1, Action a for Confirmatory Order dated July 8, 1983, requires that drywell atmosphere grab samples be taken and analyzed at 4-hour intervals if the drywell noble gas monitor is inoperable. The licensee had properly initiated this surveillance due to the noble gas monitor being inoperable. Two samples were successfully taken and analyzed. However, the third sample was not taken on time and 1.5 hours past due when discovered by the Shift Supervisor. The Shift Supervisor then instructed chemistry laboratory personnel to acquire and analyze the grab sample. When analyzed, this sample showed no appreciable change from the previous sample.

This event was attributed to cognitive personnel error. The chemistry foreman responsible for the surveillance failed to dispatch a technician to obtain and analyze the sample at the appropriate time. Corrective action involved counselling the involved individual and reviewing related plant administrative controls. The licensee determined that existing administrative controls were adequate and contemplates no procedure changes as a result of this event.

The failure to perform drywell atmosphere grab sample surveillance at the required 4-hour intervals is a violation of Technical Specification 3.4.3.1, Action a for Confirmatory Order dated July 8, 1983. However, this violation meets the criteria specified in Section V of the NRC Enforcement Policy for not issuing a Notice of Violation, and therefore, this violation is not being cited. This matter, identified as NCV 50-366/89-06-04, is considered to be closed.

Review of the LER is closed.

89-02 Personnel Error Causes Missed Technical Specification Surveillance

This LER concerns a failure to perform daily checks of two A.C. circuits inside primary containment as required by Technical Specification 4.8.2.5 which requires the daily checks of Circuit Numbers 26 and 32 in panel 2R25-S105 to ensure that the associated primary containment electrical penetration is protected from overcurrent conditions. Due to a procedural deficiency, these checks were being performed on a weekly basis.

The incorrect surveillance frequency was introduced on April 8, 1988, when Revision 5 of procedure 34GO-OPS-030-2S, "Daily Inside Rounds," became effective. Earlier revisions of this procedure specified the correct surveillance frequency. This error was not detected during reviews of two procedure revisions subsequent to Revision 5. The surveillance frequency error was discovered by the licensee on February 23, 1989, during a review of a proposed Revision 8 to procedure 34GO-OPS-030-2S. The licensee determined at that time that the surveillance checks had last been performed on February 22, 1989, and took immediate steps to correct the procedural deficiency. Unit 2 was operating at approximately 100 percent of rated power at the time this deficiency was discovered.

The failure to perform daily checks of the two A.C. circuits in panel 2R25-S105 is a violation of Technical Specification 4.8.2.5. The inspector noted that this matter was identified by the licensee and properly reported to the NRC. However, procedure 34GO-OPS-030-2S had been upgraded as part of the licensee's PUP. The licensee's response to a previous violation (50-321/88-05-01) identified the PUP as a long term corrective action to correct procedural deficiencies. Since the failure to perform the daily surveillance checks could have been prevented by the licensee's corrective action for a previous violation, this matter is being cited as violation 50-366/89-06-05. This matter will be tracked with the violation, and review of the LER is closed.

A weakness was noted in the area of surveillance. In particular, recently submitted LERs reveal an increase in the number of missed surveillances due primarily to cognitive personnel errors. Licensee management appears to be sensitive to the problem and has taken steps to re-emphasize the importance of surveillance requirements with plant personnel. Continued management attention is needed to ensure that this recent negative trend in surveillance performance is reversed.

Within the areas inspected, one violation was identified. Additionally, four licensee-identified violations, which are not being cited, were also identified.

6. 10 CFR Part 21 Inspections (36100) Units 1 and 2

The inspector reviewed the licensee's 10 CFR Part 21 program to determine whether required procedures have been established and are being implemented to ensure the reporting of defects and noncompliances. This inspection effort involved both a review of related procedures to assess their adequacy and a review of documents/records to assess program implementation.

The licensee's procedural requirements for posting are delineated in Section 8.1 of procedure 40AC-REG-002-OS, "Federal and State Reporting Requirements." The licensee has currently established posting locations at the Waste Separation and Temporary Storage Facility, Simulator Building near the breakroom, and Unit 1 Switchyard near Gate 16. A review of the licensee's posting requirements confirmed that they are consistent with the posting requirements specified in 10 CFR Part 21.6.

The licensee has assigned responsibility for the evaluation and reporting of defects and noncompliances to the Manager Nuclear Safety and Licensing in GPC's corporate organization. Related procedural requirements are contained in NOI-15-250. The inspector noted that Sections 5.A. and 5.B. of NOI-15-250 provide instructions for the screening and evaluation of issues. Instructions for informing a responsible officer of defects and noncompliances and for reporting such issues to the NRC are contained in Section 5.C of NOI-15-250. Requirements for the preparation, maintenance, and disposition of records are contained in Section 5.D of NOI-15-250. The inspector determined that the licensee's procedural requirements for the evaluation of issues, notification of a responsible officer, reporting of defects and noncompliances, and record keeping are consistent with related requirements specified in 10 CFR Part 21.

Procedural requirements for specifying the applicability of 10 CFR Part 21 provisions on procurement documents are delineated in Attachment 3 of licensee procedure 20AC-MTL-001-OS, "Procurement of Materials and Services." A review of procedure 20AC-MTL-001-OS confirmed that it adequately addresses the requirements for procurement documents specified in 10 CFR Part 21.31.

On April 7, 1989, the inspector reviewed the licensee's postings at the Unit 1 Switchyard near Gate 16. The inspector confirmed that the postings were consistent with the requirements of procedure 40AC-REG-002-OS and 10 CFR Part 21.6. Selected procurement documents were also reviewed to determine if the applicability of 10 CFR Part 21 provisions had been specified on the documents as required. More specifically, the inspector reviewed Purchase Orders P-01215, P-01227, and P-01235 for safety-related components and verified that they specified the applicability of 10 CFR Part 21 provisions.

On April 7, 1989, the inspector reviewed records of two evaluated issues that were not reported to the NRC pursuant to 10 CFR Part 21. One issue, identified by the licensee as Issue No. 87-014, related to scram discharge volume level detectors. The second issue, identified as Issue No. 87-016, related to overloading of emergency diesel generators by drywell chillers under certain conditions. The inspector determined that the issues had been identified for evaluation consistent with established procedures, information and data used in the evaluations appeared to be factual and complete, the evaluations had been performed in accordance with established procedures, and the evaluation findings were appropriate.

The inspector concluded that the licensee has adequate procedures to fully support the requirements of 10 CFR Part 21, and these procedures are being implemented by the licensee.

No violations or deviations were identified.

7. Three Mile Island Items (item number from NUREG 0737) (92701)

As discussed in NRC Inspection Report Nos. 50-321/88-29 and 50-366/88-29, of the TMI items assigned to the resident inspectors for review, only item II.F.1.6 remained open. This item concerns containment hydrogen monitoring. Related work has been performed under DCR 81-132 for Unit 1 and under DCR 81-165 for Unit 2. DCR 81-132 was closed by the licensee on February 14, 1989, and was subsequently reviewed by the inspector. Item II.F.1.6 is now closed for Unit 1. This item remains open for Unit 2 pending closure of DCR 81-165 by the licensee and subsequent review by the inspector.

No violations or deviations were identified.

8. Exit Interview (30703)

The inspection scope and findings were summarized on April 21, 1989, with those persons indicated in paragraph 1 above. Particular emphasis was placed on the one violation and four licensee-identified violations discussed in paragraph 5. A strength and a weakness in licensee performance (paragraphs 2 and 5, respectively) were also highlighted. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during this inspection. Dissenting comments were not received from the licensee.

<u>Item Number</u>	<u>Status</u>	<u>Description/Reference Paragraph</u>
50-366/89-06-05	Opened	VIOLATION - Failure to Perform Daily Checks of A.C. Circuits Within Primary Containment (paragraph 5)

50-321/89-06-01	Opened and Closed	NCV - Control Room Environmental Control System Design Deficiency (paragraph 5)
50-321/89-06-02	Opened and Closed	NCV - Missed Jet Pump Surveillance (paragraph 5)
50-366/89-06-03	Opened and Closed	NCV - Standby Gas Treatment System Design Deficiency (paragraph 5)
50-366/89-06-04	Opened and Closed	NCV - Failure to Perform Drywell Atmosphere Sampling at Required Intervals (paragraph 5)

Licensee management was also informed that the six LERs discussed in paragraph 5 were considered to be closed and that the three mile island item discussed in paragraph 7 was considered to be closed for Unit 1 but remains open for Unit 2. Another subject discussed at the exit interview was the review of the licensee's 10 CFR Part 21 program (paragraph 6).

9. Acronyms and Abbreviations

ARM	Area Radiation Monitor
CFR	Code of Federal Regulations
CRD	Control Rod Drive
DC	Deficiency Card
DCR	Design Change Request
DWED	Drywell Equipment Drain
ECCS	Emergency Core Cooling System
ESF	Engineered Safety Feature
FSAR	Final Safety Analysis Report
GE	General Electric
GPC	Georgia Power Company
HPCI	High Pressure Coolant Injection
LER	Licensee Event Report
LOSP	Loss of Offsite Power
MCREC	Main Control Room Environmental Control
MWO	Maintenance Work Order
NCV	Non-Cited Violation
NOI	Nuclear Operations Instruction
NRC	Nuclear Regulatory Commission
OSOS	On-Shift Operations Supervisor
PSW	Plant Service Water
PUP	Procedure Upgrade Program
RBCCW	Reactor Building Closed Cooling Water System
RCIC	Reactor Core Isolation Cooling
RHRSW	Residual Heat Removal Service Water
SGTS	Standby Gas Treatment System
SLC	Standby Liquid Control
SRV	Safety/Relief Valve
STA	Shift Technical Advisor
TM	Temporary Modification