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March 1, 1984

J. T. Beckham, Jr.
Vice President and General Manager
Nuclear Generation

Office of Inspection and Enforcement
Attention: Mr. J.P. O'Reilly, Region Administrator
U.S. Nuclear Regulatory Commission
Region II
101 Marietta Street, N.W.
Atlanta, Georgia 30303

NRC DOCKETS 50-321, 50-366
OPERATING LICENSES DPR-57, NPF-5
EDWIN I. HATCH NUCLEAR PLANT UNITS 1, 2
Response To I&E Inspection Report 50-321/83-25 and 50-366/83-26

Gentlemen:

Georgia Power Company provides the following response to violations identified during an inspection conducted on July 21 - August 20, 1983, and reported by your letter of February 1, 1984.

VIOLATION 1:

Criterion XIV of Appendix "B" to 10 CFR Part 50 as implemented by Hatch Unit 2 FSAR Chapter 17.2.14 requires in part that measures shall be established for indicating the operating status of structures, systems and components to prevent inadvertent operation.

Technical Specification 6.8.1.a requires that written procedures be established, implemented and maintained covering the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33 Revision 2, February 1978.

Contrary to the above, during the period from July 12-25, 1983, after Unit 2 had returned to power following an extended refueling outage, it was found that safety related equipment and systems were not aligned as required by approved operating or surveillance procedures to assure safe operation under all conditions. Specifically, through inadequacies in the administrative and managerial control systems, prerequisites for startup did not confirm that necessary instruments were operable, valves properly aligned, and electrical links in the correct positions. Examples where this lack of proper confirmation existed were:

a. The Anticipated Transient Without Scram (ATWS) trip was found to have a valve shut which isolated the redundant signal to each trip system.

b. Jet pumps Nos. 18 and 19 were found to have flow instrumentation isolated.

c. The Standby Liquid Control System was found to have the pump discharge pressure instrumentation isolated.

d. The High Pressure Injection System was found to have the automatic shut feature of the minimum flow valve electrically isolated.

e. The "B" Hydrogen Recombiner, was found to have the "B" recombiner discharge valve improperly shut.

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

RESPONSE:

Admission or Denial of Alleged Violation:
The violation occurred.

Reason for the Violation: The violation occurred because administrative controls failed to ensure independent verification of valves and links following maintenance, modification, surveillance, calibration or trouble shooting. Further, the administrative controls were unclear in defining how independent verification was to be done.

Corrective Steps Which Have Been Taken and the Results Achieved: From July 28, 1983 to July 31, 1983 "a mispositioned link inspection and evaluation program" was performed by the Quality Control and Engineering Departments. The inspection and evaluation involved control room panels and safety related local panels. The inspection was conducted on an around the clock basis for most of the period. As each deviation was identified, equipment was restored to proper operation and an engineering analysis of potentially degraded modes of operation was

made. The mispositioned links inspection and evaluation report was issued to the Plant Hatch General Manager on August 1, 1983. The purpose of this report was to document the results of the control room and local panel inspection.

Due to preliminary findings of the initial control room investigation, the inspection was expanded on July 28, 1983 to include accessible instrument valves and valves that have locked position requirements. These valves were checked for proper valve position, secured and labled per the instructions of Standing Order 83-33 issued on July 28, 1983.

Maintenance Requests (MR) issued to control work during the Unit 2 outage and to perform functional tests on Unit 2 outage Design Change Requests (DCR's) were reviewed. This review was to determine the adequacy of the MR instructions for installation of equipment and system restoration after plant modification. This review was to also identify any other potential mispositioned valves or links.

Temporary additional security measures were taken until the Plant Review Board determined that insufficient evidence existed to suggest that intentional mispositioning of valves and links was involved. Until the determination was made, access was limited to Georgia Power Company and Georgia Power Company escorted personnel. Also, additional security patrols were established, the corporate manager of security was notified, and corporate investigators were put on alert.

On July 28, 1983, the Plant Review Board (PRB) and Safety Review Board (SRB) met at Plant Hatch to review the open links and mispositioned valve situation. The purpose of the meeting was to make a determination of plant status and to determine the adequacy of corrective actions.

Also, on July 28, 1983 a special, independent committee was established to investigate the mispositioned valves and misaligned terminal strip links at Plant Hatch. On August 1, 1983 the committee issued its report to the Vice President and General Manager of Nuclear Generation. Among its findings were the recommendations to clarify how independent verification was to be done, to instruct personnel regarding independent verification and procedure compliance, and to review and upgrade certain procedures.

On August 10, 1983, an enforcement conference was held between GPC and the NRC. GPC presented the results of its investigation regarding the extent of the problem. GPC also presented the actions that were being taken to prevent further occurrence of this problem. The NRC concurred with these actions.

Corrective Steps Which Will Be Taken to Avoid Future Violations: Existing administrative controls were upgraded to stress independent verification for the restoration of any safety-related components that are placed in an off-normal condition. Specifically, "Lifted Wire and Temporary Jumper Control", HNP-504, was revised September 15, 1983 to require its use whenever specific steps in procedures and tests do not restore links, or when "Red Line" procedures are not used. A new procedure, HNP-514, "Control of Locked Valves", was approved on August 30, 1983. Also, HNP-34 , "Rules for Performing Procedures", regarding procedure compliance was re-emphasized to plant personnel via a training directive completed on July 28, 1983. Administrative controls were strengthened to ensure that when work is interrupted, the condition of the plant is identified and accounted for prior to declaring systems operable. System restoration is being emphasized in Operations, Maintenance, Quality Assurance and Quality Control training programs. By September 15, 1983, valve lineup procedures were revised to ensure proper valve positioning.

Date When Full Compliance Was Achieved: Full compliance was achieved on September 15, 1983 when administrative controls were strengthened and identified problems were corrected.

VIOLATION 2:

Technical Specification 3.0.4 requires that entry into an Operational Condition shall not be made unless the conditions of the Limiting Condition for Operations are met without reliance on provisions contained in the Action Statements unless otherwise excepted.

Technical Specification 3.6.1.4 requires that two main steam isolation leakage control system subsystems shall be operable in operational conditions 1, 2, and 3.

Contrary to the above, on July 12, 1983, the Unit entered Operational Condition 1, Power Operation, without meeting the Limiting Condition For Operation for the main steam isolation leakage control system subsystem in that both subsystems were inoperable.

This is a Severity Level IV Violation (Supplement 1).

RESPONSE:

Admission or Denial of Alleged Violation:
The violation occurred.

Reason for the Violation: During the Unit 2 outage, work on Design Change Request (DCR) 81-139 was started. The DCR work required the 2E32 transmitters to be changed from Rosemount to Bartons. With the transmitters out of service and some wiring changes already completed, the decision was made to discontinue the Barton installation and restore the Rosemount instruments. GE was notified to restore the system to its original design. Maintenance was not notified to "Redline" the Rosemount reinstallation. Twelve electrical links that were used to isolate the transmitters for replacement were not reclosed after the Rosemounts were reinstalled. A Maintenance Request (MR) had been issued to redline the DCR wiring when the DCR work was completed but, because all the DCR work had not been completed prior to Unit startup, the MR requiring redlining was not performed. The Lifted Wire and Temporary Jumper Procedure (HNP-504) was not used to document the opening of the 12 electrical links.

Corrective Steps Which Have Been Taken and the Results Achieved: The 12 open electrical links were closed. Additional corrective action, as detailed in response to VIOLATION 1, was also performed.

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Corrective Steps Which Will Be Taken to Avoid Future Violations:
On September 15, 1983, the "Lifted Wire and Temporary Jumper Control" procedure was revised to require its use whenever specific steps in procedures or tests do not restore links, or when "Red Line" procedures are not used.

Date When Full Compliance Was Achieved: Full compliance was achieved on July 27, 1983 when the 12 open electrical links were discovered and closed.

This completes GPC's response to IER 50-321/83-25 and 50-366/83-26. If you have any questions regarding this response or require further information regarding our actions in this matter, please contact this office.

Very Truly Yours,

J.T. Beckham, Jr.

DLT/RT/dlt

xc: L.T. Gucwa
H.C. Nix
Site Resident