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Georgia Power
The southern electric system

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U.S. Nuclear Regulatory Commission
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PLANT HATCH - UNIT 2
NRC DOCKET 50-366
OPERATING LICENSE NPF-5
RESPONSE TO NRC CONCERN ON THE FAILURE TO
IMPLEMENT LIMITORQUE 10 CFR 21 RECOMMENDATIONS

Gentlemen:

In response to your letter of October 11, 1991, Georgia Power Company is providing the enclosed response to NRC Inspection Report 91-22. This concerns the failure to fully implement Limitorque 10 CFR 21 recommendations.

Sincerely,

J. T. Beckham, Jr.

OCV/cr

Enclosure

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

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ENCLOSURE
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CONCERN SUMMARY

In Inspection Report 91-22 dated 10/11/91, the NRC expressed concern over the failure to fully implement recommendations made by Limitorque under 10 CFR 21. Specifically, it was determined that the torque switches on 20 Unit 2 Motor Operated Valve (MOV) operators had not been inspected for fiber spacers as recommended by Limitorque in a 10 CFR 21 notification dated 9/29/89. The torque switches had been or were to be scheduled for inspection during the Unit 2 Spring 1991 Refueling Outage, but the inspection had not been performed on 20 of the Unit 2 valves. The required Unit 1 MOV torque switches had been inspected during the Unit 1 Spring 1990 Refueling Outage. The NRC requested GPC to explain why the Unit 2 MOV torque switches had not been inspected, what corrective actions were to be taken, and why the uninspected MOVs were not a safety concern.

GPC RESPONSE TO THE NRC CONCERN

Reason The Torque Switches Were Not Inspected:

Twenty of 38 Unit 2 MOV torque switches were not inspected during the Unit 2 Spring 1991 Refueling Outage because of personnel error. Nuclear Safety and Compliance (NS&C), Maintenance, and Engineering personnel failed to take sufficient actions within their areas of responsibility to ensure all the inspections were performed. Consequently, the inspection of 20 of the torque switches was either deleted from the outage schedule or, in some cases, not scheduled at all. This was not discovered until after the outage had been completed.

Maintenance personnel were responsible for ensuring non-Environmentally Qualified MOV torque switches were inspected and Engineering personnel were responsible for ensuring Environmentally Qualified MOV torque switches were inspected. NS&C personnel were responsible for tracking the required inspections to ensure they were performed. This was done via the Action Item Tracking system with an Action Item assigned to NS&C personnel. However, no Action Items were assigned to Maintenance or Engineering personnel to track the actions for which they were responsible.

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The Maintenance and Engineering personnel assigned the task of ensuring the torque switches were inspected left the company prior to the Unit 2 Spring 1991 Refueling Outage. They failed to fully communicate to their replacements during turnover the need to inspect the torque switches and why they were to be inspected. Consequently, followup actions to ensure the torque switches were inspected were not performed. The inspections were deleted from the outage scope and, in some cases, not scheduled at all. Eighteen of the required 38 inspections were performed, however, during the course of other work being performed on the MOVs. This work consisted of 36-month preventive maintenance activities which were scheduled and performed for reasons other than the required torque switch inspection. The 20 torque switches not inspected had no scheduled preventive maintenance to be performed on them during the refueling outage and the inspections were not identified as required by the 10 CFR 21 response.

NS&C personnel who were assigned the responsibility of tracking the required inspections failed to issue Action Items to appropriate Maintenance and Engineering personnel. Action Items assigned to Maintenance and Engineering would have ensured the responsible personnel were aware of the required actions and due dates in spite of the inadequate turnover. Instead, an Action Item was issued only to NS&C to ensure the required inspections were done. Additionally, NS&C personnel assigned a due date for the NS&C Action Item which was one month past the scheduled outage end date. The one Action Item with its incorrect due date was not adequate to ensure the inspections were performed during the outage as required given the inadequate turnover described above.

Corrective Actions For This Item:

Responsible NS&C personnel have been counseled regarding their inappropriate actions and the consequences of those actions. Involved Maintenance and Engineering personnel could not be counseled because they no longer work for GPC.

Existing documentation for the 20 MOVs in question was reviewed. It was discovered that 15 of the 20 MOV torque switches did not need to be inspected because either the torque switch or the entire motor operator had been replaced with non-suspect parts. Three of the remaining five MOVs were determined to be passive valves, i.e., they do not have to change position to perform their safety function. Therefore, a failure of their torque switches would not adversely affect the safety functions of the valves, making it unnecessary to inspect their torque switches. Consequently, of the original 20 valves, only two actually required inspection.

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One of the remaining two valves, 2P41-F316D, was inspected on 11/25/91 under Maintenance Work Order 2-91-4267. It was discovered that the torque switch in the operator for 2P41-F316D did have the fiber spacer as described in Limitorque's 10 CFR 21 notification of 9/29/89. The other valve in question, 2P41-F316C, is similar in operator design, service application, operating environment, and maintenance history. Therefore, it has been conservatively assumed that the operator for 2P41-F316C also contains a fiber spacer and thus this valve was not physically inspected. An evaluation by Plant Hatch's Architect/Engineer has shown it is acceptable to operate with these fiber spacers until the next Unit 2 outage at which time they will be replaced per Maintenance work orders 2-91-4266 and 2-91-4267.

Safety Assessment:

The two valves with the fiber spacers are 2P41-F316C and D, Unit 2 Turbine Building Plant Service Water isolation valves. They are redundant isolation valves for Division I and Division II Plant Service Water, respectively, and isolate Plant Service Water to non-vital equipment loads in the event of an accident. For these valves, the torque switches are in series with limit switches. The limit switch is designed to de-energize the motor operator when the valve is closed. The torque switch serves as a backup to the limit switch and also serves to de-energize the motor operator should the valve bind during movement.

The torque switch therefore can fail such that: 1) the motor will not de-energize if the valve binds while closing, 2) the motor will de-energize and thereby not close even though the valve is not bound, or 3) the motor will not de-energize when the valve closes and the limit switch fails. These failures, although causing premature motor de-energization or motor failure, will not result in a failure to isolate Plant Service Water to non-vital loads. This is because the redundant Division I and Division II Plant Service Water isolation valves, 2P41-F316A and B, respectively, would be unaffected and thus isolate the Plant Service Water lines supplying non-vital loads as designed. These two valves have no fiber spacers in their MOV torque switches.

Even if valve 2P41-F316A or B were to fail in conjunction with failures of valves 2P41-F316C and D, only one division of Plant Service Water would be lost. The Unit 2 Final Safety Analysis Report (Volume 15, Section 9.2) indicates that one division of Plant Service Water is sufficient to cool the equipment loads needed to mitigate the consequences of a design basis accident. Therefore, it was concluded by the Architect/Engineer that it was acceptable to operate with fiber spacers in the torque switches for MOVs 2P41-F316C and D until the next Unit 2 refueling outage.