



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

Report Nos.: 50-321/85-16 and 50-366/85-16

Licensee: Georgia Power Company  
P. O. Box 4545  
Atlanta, GA 30302

Docket Nos.: 50-321 and 50-366

License Nos.: DPR-57 and NPF-5

Facility Name: Hatch 1 and 2

Inspection Dates: April 28 - May 24, 1985

Inspection at Hatch site near Baxley, Georgia

Inspectors: R. E. Canally for  
P. Holmes-Ray, Senior Resident Inspector

6/17/85  
Date Signed

R. E. Canally for  
G. Neffelt, Resident Inspector

6/17/85  
Date Signed

Approved by: V. W. Panciera  
V. W. Panciera, Chief, Project Section 2B  
Division of Reactor Projects

6/18/85  
Date Signed

SUMMARY

Scope: This inspection involved 144 inspector-hours on site in the areas of Technical Specification compliance, operator performance, overall plant operations, quality assurance practices, station and corporate management practices, corrective and preventive maintenance activities, site security procedures, radiation control activities, refueling (Unit 2), and surveillance activities.

Results: Of the areas inspected, one violation was identified in the area of Technical Specification compliance (testing of molded case circuit breakers, paragraph 7).

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## REPORT DETAILS

### 1. Persons Contacted

#### Licensee Employees

H. C. Nix, Site General Manager  
T. Greene, Deputy Site General Manager  
\*L. Sumner, Operations Manager  
\*T. Seitz, Maintenance Manager  
C. T. Jones, Engineering Manager  
R. W. Zavadski, Health Physics and Chemistry Manager  
P. Fornel, Site QA Manager  
S. B. Tipps, Superintendent of Regulatory Compliance

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

\*Attended exit interview

### 2. Exit Interview

The inspection scope and findings were summarized on May 24, 1985, with those persons indicated in paragraph 1 above. During the reporting period frequent discussions were held with the General Manager and/or his assistants concerning inspection findings. The licensee acknowledged the findings and took no exception. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during this inspection.

### 3. Licensee Action on Previous Inspection Findings

The following items have been reviewed by the inspectors and are considered resolved.

(Closed) Violation (366/84-34-01); Failure to follow procedure.

(Closed) Violation (321/84-41-02), (366/84-41-02); Failure to make timely reports within 4 hours of an engineered safety feature actuation.

(Closed) Violation (366/84-48-01); Improper Work Control Operations.

(Closed) Violation (366/84-48-02); Failure to follow procedure and limiting condition for operation discrepancy.

(Closed) Violation (366/84-48-03); Failure to meet reporting time limits.

### 4. Unresolved Items

Unresolved items were not identified during this inspection.

## 5. Plant Tours (Units 1 and 2)

The inspectors conducted plant tours periodically during the inspection interval to verify that monitoring equipment was recording as required, equipment was properly tagged, operations personnel were aware of plant conditions, and plant housekeeping efforts were adequate. The inspectors also determined that appropriate radiation controls were properly established, critical clean areas were being controlled in accordance with procedures, excess equipment or material was stored properly and combustible material and debris were disposed of expeditiously. During tours the inspectors looked for the existence of unusual fluid leaks, piping vibrations, pipe hanger and seismic restraint settings, various valve and breaker positions, equipment caution and danger tags, component positions, adequacy of fire fighting equipment, and instrument calibration dates. Some tours were conducted on backshifts and/or weekends.

The inspectors routinely conduct partial walkdowns of Emergency Core Cooling Systems. Valve and breaker/switch lineups and equipment conditions are randomly verified both locally and in the control room. During the inspection period the inspectors conducted a complete walkdown of the accessible areas of the Unit 1 standby liquid control system to verify that the lineups were in accordance with licensee requirements for operability and equipment material conditions were satisfactory.

Within the areas inspected, no violations or deviations were identified.

## 6. Plant Operations Review (Units 1 and 2)

The inspectors, periodically during the inspection interval, reviewed shift logs and operations records, including data sheets, instrument traces, and records of equipment malfunctions. This review included control room logs and auxiliary logs, operating orders, standing orders, jumper logs and equipment tagout records. The inspectors routinely observed operator alertness and demeanor during plant tours. During normal events, operator performance and response actions were observed and evaluated. The inspectors conducted random off-hours inspections during the reporting interval to assure that operations and security remained at an acceptable level. Shift turnovers were observed to verify that they were conducted in accordance with approved licensee procedures.

Within the areas inspected, no violations or deviations were identified.

## 7. Technical Specification Compliance (Units 1 and 2)

During this reporting interval, the inspectors verified compliance with selected limiting conditions for operations (LCOs) and results of selected surveillance tests. These verifications were accomplished by direct observation of monitoring instrumentation, valve positions, switch positions, and review of completed logs and records. The licensee's compliance with selected LCO action statements were reviewed on selected occurrences as they happened.

The licensing project manager brought to the attention of the senior resident inspector that the licensee was requesting an emergency Technical Specification change which seemed to identify an area of non-compliance. This area was the method of testing molded case circuit breakers (MCBs). The Technical Specification requires that the functional test shall consist of injecting a current input at the specified setpoint to the circuit breaker and verifying that the circuit breaker functions as designed. Hatch procedure HNP-2-3850 calls for injecting 1275 percent or 300 percent of the setpoint value. This method of testing MCBs is in accordance with the National Electrical Manufacturers Association standards and is technically sound but not as required by Technical Specification. This deviation from the required testing method without proper prior approval is a Violation (366/85-16-01).

#### 8. Physical Protection (Units 1 and 2)

The inspectors verified by observation and interviews during the reporting interval that measures taken to assure the physical protection of the facility met current requirements. Areas inspected included the organization of the security force, the establishment and maintenance of gates, doors and isolation zones in the proper condition, that access control and badging was proper, and procedures were followed.

Within the areas inspected, no violations or deviations were identified.

#### 9. Review of Nonroutine Events Reported by the Licensee (Units 1 and 2)

The following Licensee Event Reports (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 that the public health and safety were of utmost consideration. The following LERs are considered closed:

Unit 1: 84-02, 84-19\*

Unit 2: 84-07

\*In-depth review performed.

#### 10. Refueling

During the startup of Unit 2 following refueling, the inspectors reviewed the startup, heatup, and the determination of shutdown margin. Lineup of systems distributed during the outage were audited prior to startup.

On May 24, 1985, when changing from air to nitrogen to the drywell pneumatics, Unit 2 scrambled from a main steam isolation valves (MSIVs) "not full open" trip. The inboard MSIVs drifted toward the shut direction after the supply to their pneumatic control system was switched from air to nitrogen, due to bleed off of the pressure holding them open. Subsequently, two valves in the nitrogen supply path were found shut. The cause of these

valves being shut is under review and will be tracked as Inspector Followup Item 50-366/85-16-02.

11. Unusual Event on May 15, 1985

On May 15, 1985, at approximately 10:22 p.m. EST, a manual reactor scram from 100 percent reactor power was inserted for Unit 1, because the non-automatic depressurization system (non-ADS) 'A' safety relief valve was unable to be closed either from the control room panel or locally. The safety relief valve was actuated by a small amount of water leaking into the Analog Transmitter Trip System Panel H11-P926. The water came from the control room emergency ventilation supply line passing above this panel. Water entered this ventilation line, because the charcoal filter train 'A' deluge system initiated - due to a loss of pressure caused from a cracked pressure gage fitting - with the filter train drains clogged.

The On Shift Operations Supervisor maintained safe control of the reactor during the event and subsequent recovery. A normal reactor shutdown was initially attempted. Reactor Core Isolation Cooling was inoperable due to maintenance and a spurious alarm condition for the High Pressure Coolant Injection turbine exhaust discharge pressure resulted in the unavailability of the HPCI system until it was reset. After attempts to close the safety relief valve failed, the reactor was manually scrammed prior to the automatic scram setpoint of 850 psig. In accordance with HNP-1-1907, Failure of Safety/Relief Valves to Operate, reactor water level was maintained by the condensate and condensate booster pumps; and notification of an unusual event was issued.

During the event, minimum reactor water level was approximately 11" with a system pressure of approximately 370 psig and the suppression pool was available as the heat sink (i.e., maximum suppression pool temperature was approximately 123° F). Also, no Engineering Safety Features were automatically initiated.

The analysis of this event by the licensee will be tracked as Inspector Followup Item 50-321/85-16-03.