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J. T. Beckham, Jr.
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September 23, 1996

Docket No. 50-321
50-366

HL-5241

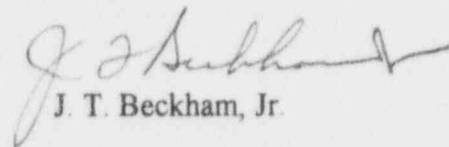
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

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

Gentlemen:

In response to your letter dated August 30, 1996, and according to the requirements of 10 CFR 2.201, Georgia Power Company (GPC) is providing the enclosed response to the Notices of Violation associated with Inspection Report 96-10. In the enclosure, a transcription of the NRC violation precedes GPC's response.

Sincerely,



J. T. Beckham, Jr.

DLM/eb

Enclosures:

1. Violation 96-10-01 and GPC Response
2. Violation 96-10-02 and GPC Response
3. Violation 96-10-05 and GPC Response

cc: Georgia Power Company

Mr. H. L. Sumner, Jr., Nuclear Plant General Manager
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. Ebnetter, Regional Administrator
Mr. B. L. Holbrook, Senior Resident Inspector - Hatch

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Enclosure 1

Edwin I. Hatch Nuclear Plant Violation 96-10-01 and GPC Response

VIOLATION 96-10-01

Hatch Unit 1 Technical Specification 5.4.1.a requires that written procedures be established, implemented and maintained as recommended in Appendix A, of Regulatory Guide 1.33, Revision 2, February 1978.

Regulatory Guide 1.33, Revision 2, February 1978, Appendix A, lists service water as a system procedure for startup, operation and shutdown of safety related systems.

Hatch Unit 1 Technical Specification surveillance requirement 3.7.2.1 (sic) requires that personnel verify each plant service water subsystem manual, power operated, and automatic valve in the flow paths servicing safety related systems or components, that is not locked, sealed, or otherwise secured in position, is in the correct position every 31 days.

Contrary to the above:

Unit 1 Technical Specification surveillance requirement 3.7.2.1 (sic) was not completely implemented in that, procedure 34SV-SUV-012-1S, Plant Service Water and Residual Heat Removal Service Water Valve Position Verification, Revision 2, did not require the correct position verification every 31 days of the discharge valves for plant service water pumps 1A, 1B, 1C and 1D.

As a result, the Unit 1 service water pump discharge valves were not verified in their proper position in accordance with the surveillance procedure from at least July 13, 1995, to July 9, 1996, (sic)

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

RESPONSE TO VIOLATION 96-10-01

Reason for the violation:

This violation was caused by inadequate procedures. Plant surveillance procedures 34SV-SUV-012-1S, "Plant Service Water and Residual Heat Removal Service Water Valve Position Verification," and 34SV-SUV-012-2S, "Plant Service Water, Residual Heat Removal Service Water, and Standby Service Water Subsystem Valve Position Verification," did not include a position check of numerous PSW system valves in the flow

path servicing safety-related systems or components as required by Unit 1 and Unit 2 Technical Specifications Surveillance Requirement 3.7.2.2.

It should be noted that an adequate valve position check was being performed for the Plant Service Water pump 1A, 1B, 1C, and 1D discharge valves. This check consisted of daily verification that Plant Service Water pump flow rates were above a minimum value per plant procedure 34GO-OPS-031-1S, "Daily Outside Rounds." With pump flow rates above the procedure-specified minimum, it is ensured the discharge valves are open sufficiently for the Plant Service Water system to perform its intended function. Therefore, the flow rate verification met the intent of Unit 1 Technical Specifications Surveillance Requirement 3.7.2.2. However, further review of the surveillance procedures revealed the positions of numerous other valves were not being checked periodically as required by the Technical Specifications. This event was reported in Licensee Event Report 50-321/1996-011, dated August 16, 1996.

Corrective steps which have been taken and the results achieved:

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

1. The valve positions not being checked every 31 days as required by the Unit 1 and Unit 2 Technical Specifications were checked and found to be in their correct positions.
2. Procedures 34SV-SUV-012-1S and 34SV-SUV-012-2S were revised to include a periodic position check of the required valves.
3. Operations personnel reviewed the surveillance procedures used to perform the position checks for valves in the Unit 1 and Unit 2 High Pressure Coolant Injection, Reactor Core Isolation Cooling, Residual Heat Removal Service Water, Core Spray, and Residual Heat Removal systems. No additional problems were found.

Corrective steps which will be taken to avoid further violations:

No additional corrective actions to prevent further violations are necessary at this time.

Date when full compliance will be achieved:

Full compliance was achieved on July 24, 1996 when the required valve position checks were performed.

Enclosure 2

Edwin I. Hatch Nuclear Plant Violation 96-10-02 and GPC Response

VIOLATION 96-10-02

10 CFR 50.72 (b)(2)(iii)(D), 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 alone could have prevented the fulfillment of the safety function of structures, or systems that are needed to mitigate the consequence of an accident.

Contrary to the above:

A four-hour reporting requirement was not met on June 29, 1996. During system surveillance activities to verify operability of the Unit 1 high pressure coolant injection system, a maintenance deficiency was discovered that made the system inoperable and a report was not made until 11:14 a.m. on July 3, 1996.

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

RESPONSE TO VIOLATION 96-10-02

Georgia Power Company respectfully denies this violation. The event which made the Unit 1 High Pressure Coolant Injection system inoperable on June 29, 1996, was reported within four hours of the event being determined to be reportable as required by 10 CFR 50.72 (b)(2)(iii)(D). Per the guidance given in NUREG-1022, Supplement No. 1, "Licensee Event Report System," February 1984, the "reportability date" is "when someone decides or 'discovers' that the event is reportable." [Page 22, item 3 of the answer to question 14.5] The subject event was reported within 4 hours of GPC personnel determining it was reportable per the requirements of 10 CFR 50.72 (b)(2)(iii)(D). Therefore, the applicable reporting requirements were met and no violation occurred.

The Unit 1 High Pressure Coolant Injection system was inoperable for planned maintenance on the oil system, a condition not reportable per 10 CFR 50.72 (b)(2)(iii)(D). On June 29, 1996, prior to restoring system operability following completion of the oil system maintenance, a valve failed. This failure, which was unrelated to the oil system maintenance, would have rendered the system inoperable; however, personnel did not immediately report this event because the system was already considered inoperable. The CFR does not clearly state this event was reportable regardless of the status of the system upon discovery of the valve failure. Only after GPC engineers reviewed additional guidance, provided in NUREG-1022, Supplement No. 1 [Section II, "Questions and

Enclosure 2

Violation 96-10-02 and GPC Response

Answers From The LER Workshops," subsection 7.0, questions and answers 7.9 and 7.10, page 11], as part of a routine review of deficiency cards, was it determined this event was reportable.

Within 4 hours of making this determination, the event was reported per 10 CFR 50.72 (b)(2)(iii)(D). Per the previously cited guidance given in NUREG-1022, Supplement 1, the reporting clock does not start until a reportability determination is made. The applicable reporting requirements were met within the requisite time frame because the required report was made within 4 hours of the reportability determination. Therefore, Georgia Power Company respectfully denies the violation.

Enclosure 3

Edwin I. Hatch Nuclear Plant Violation 96-10-05 and GPC Response

VIOLATION 96-10-05

10 CFR 50, Appendix B, Criteria XVI states in part that, measures shall be established to assure that conditions adverse to quality such as deficiencies are promptly corrected.

The Edwin I. Hatch Nuclear Plant Quality Assurance Manual, Section 16, Corrective Action, requires in part that, the Hatch Project shall establish measures to assure conditions adverse to quality such as deficiencies are promptly corrected.

Procedure 10AC-MGR-004-OS, Deficiency Control System, Revision 10, establishes the requirements and responsibilities for accomplishing the major components of deficiency control and applies to deficiencies affecting equipment, procedures or personnel.

Contrary to the above:

Procedure 10AC-MGR-004-OS was not implemented to ensure prompt corrective actions were completed for a Unit 1 main control room alarm. A deficient alarm for the 1D 600 volt AC safety related bus, was identified and documented on April 18, 1995, and was not corrected as of August 3, 1996.

As a result the control room personnel received an erroneous alarm on the safety related 600V AC Bus 1D, on July 25, 1996, when a non-safety related electrical board, control building motor control center 1D, tripped.

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

RESPONSE TO VIOLATION 96-10-05

Georgia Power Company respectfully denies this violation. The requirements of 10 CFR 50, Appendix B, Criterion XVI, and procedure 10AC-MGR-004-OS, "Deficiency Control System," were met in that the receipt of the erroneous alarm was promptly identified and was to be corrected. Criterion XVI does not contain a specific time frame for correcting an identified deficiency; therefore, scheduling the deficiency for correction is left to the discretion of the licensee. The fact a deficient condition recurs before corrective actions can be implemented is not a violation of regulatory requirements. Depending on the nature of the deficiency, recurrence of a deficient condition may be acceptable if licensee resources are used to resolve issues of greater safety and operational significance. GPC engineering personnel recognized and noted the need for a design change to correct the

annunciator wiring deficiency, and realizing the limited significance of the problem, prioritized further corrective actions accordingly.

The receipt of the alarm incorrectly indicating a breaker fed by 600V bus 1D has tripped was not a safety significant event or problem. The erroneous alarm conservatively indicated to the Operator that he had lost a potentially safety-related load. Annunciator Response Procedures require the Operator to verify the validity of the alarm before taking extensive compensatory actions. In both events cited in this Notice of Violation, Operations personnel confirmed the alarm was erroneous and no unnecessary compensatory actions were taken. Therefore, this problem was not operationally or safety significant and corrective action was assigned a low priority relative to other work activities. This was appropriate considering the nature of the deficient condition and its lack of safety significance and meets the requirements of 10 CFR 50, Appendix B, Criterion XVI, and procedure 10AC-MGR-004-0S. Therefore, Georgia Power Company respectfully denies the violation.