



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

Report Nos.: 50-321/85-24 and 50-366/85-24

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 Conducted: July 27 - August 30, 1985

Inspectors: V.W. Panciera for
P. Holmes-Kay, Senior Resident Inspector

9/19/85
Date Signed

V.W. Panciera for
G. M. Neffert, Resident Inspector

9/19/85
Date Signed

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

9/19/85
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, and Surveillance Activities.

Results: Of the areas inspected, two violations were identified, one in the area of Reporting (paragraph 6) and one in the area of Technical Specification Changes (paragraph 10).

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REPORT DETAILS

1. Persons Contacted

Licensee Employees

- *H. C. Nix, Site General Manager
- *T. Greene, Deputy Site General Manager
- *H. L. Sumner, Operations Manager
- T. Seitz, Maintenance Manager
- C. T. Jones, Engineering Manager
- R. W. Zavadoski, Health Physics and Chemistry Manager
- P. E. Fornel, Site Q.A. 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 August 30, 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 materials provided to or reviewed by the inspector(s) during this inspection.

3. Licensee Action on Previous Findings

Not inspected.

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 danger and caution 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 ECCS 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 in the accessible areas of the Unit 2 Residual Heat Removal (RHR) 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.

During a system walkdown of the Unit 2 RHR system, several valves with limitorque operators were found with local valve position not in agreement with the remote (control room) indication. These valves are listed below:

VALVE NUMBER	VALVE DESCRIPTION	LOCAL INDICATION (% OPEN)	REMOTE INDICATION
2E11-F004A	Torus Suction	34	OPEN
2E11-F004C	Torus Suction	0	OPEN
2E11-F007A	Minimum Flow	12	OPEN
2E11-F011A	RHR to Torus	60	SHUT
2E11-F026A	RHR to RCIC	OFF SCALED	SHUT
2E11-F103A	RHR Heat Ex Vent	OFF SCALED	SHUT

Also, two local indicators could not be read: 2E11-F047A due to excessive dust on the face; and another 2E11-F068A, had no scale on the face. Upon notification of the conditions found, the licensee verified: that the flow path through 2E11-F004C was open by pumping water; that the control room remote indications represented the actual valve positions; and that the RHR system operation from control room was not degraded.

Of the maintenance work orders (MWO) reviewed no confirmation of local versus remote valve position indication was specified in the test section of the MWO. Also the procedures for limitorque operator maintenance did not contain instructions for assuring proper local valve position indicator accuracy. The licensee stated that there is no functional use of local position indicators on limitorque valves at Plant Hatch.

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 acceptable levels. Shift turnovers were observed to verify that they were conducted in accordance with approved licensee procedures.

On August 27, 1985, a mechanic entered the 1C diesel generator (DG) room, thinking he was in the 1A DG room, took local control of the DG and pressed the local start button. When the DG rolled on starting air, the mechanic realized that he was in control of 1C DG and not the tagged out 1A DG. He immediately returned the 1C DG to its standby mode. The 1C DG was inoperable for automatic start for about five minutes. During the time that both the 1A and the 1C DGs were inoperable, the Technical Specifications requirement is to be in hot shutdown within six hours. However, Operations personnel a short time later verified the operability of that the 1C DG. The inadvertent actuation of an engineered safety feature (ESF) is required to be reported within four hours in accordance with 10 CFR 50.72(b)(2)(ii). The report was not made until 1245 on August 28, 1985. This is a violation (321/85-24-01). Similar violations were cited in Report 84-41 (two examples).

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 on 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.

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

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 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

The following licensee event report (LER) 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. The following LERs are considered closed:

Unit 1: 83-96*, 83-09*, 85-01, 85-04*

Unit 2: 84-09*, 85-02, 85-12, 85-13, 85-17*

*In-Depth Review Performed.

10. Drywell Pneumatic Modifications, Technical Specifications (TS) Change

On August 23, 1985, the licensee submitted a change to revise the tables of primary containment isolation valves to reflect drywell pneumatic system changes. The pneumatic system changes to Unit 1 are to be completed during the upcoming outage to commence November 30, 1985. The pneumatic system changes to Unit 2 were completed during the recirculating system pipe replacement outage which commenced in January 1984.

10 CFR 50.59(a)(1)(i) states that the holder of a license authorizing operation of a production or utilization facility may make changes in the facility as described in the safety analysis report without prior commission approval, unless the proposed change involves a change in the Technical Specifications incorporated in the license or an unreviewed safety question.

The modification to the Unit 2 drywell pneumatic system in 1984 prior to submittal and approval by the Commission is contrary to 10 CFR 50.59(a)(1). This is a violation (366/85-245-02).