UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30303

JAN 6 1984

Georgia Power Company
ATTN: Mr. R. J. Kelly
Executive Vice President
P.O. Box 4545
Atlanta, GA 30302

Gentlemen:

SUBJECT: CORRECTION TO PROPOSED IMPOSITION OF CIVIL PENALTIES: EA 83-96
IMPROPER SHUTDOWN (REFERENCE: INSPECTION REPORT NO. 50-366/83-23)

This refers to the Notice of Violation and Proposed Imposition of Civil Penalties, issued on December 27, 1983, based upon the findings of an NRC special inspection. The inspection examined the circumstances associated with the improper shutdown of Hatch, Unit 2, on July 14, 1983.

Due to an administrative oversight page 2 of the transmittal letter contained an additional sentence which does not pertain to this event. A corrected page is enclosed for insertion into the original letter. We regret any inconvenience this may have caused.

Should you have any questions concerning this letter, we will be glad to discuss them with you.

Sincerely,

James P. O'Reilly
Regional Administrator

Enclosures:
1. Proposed Imposition of Civil Penalties: EA 83-86 Improper Shutdown, Corrected Page 2
2. Proposed Imposition of Civil Penalties: EA 83-83, Improper Shutdown, Original Page 2, dated December 27, 1983

cc w/encls:
J. T. Beckham, Vice President and General Manager-Nuclear Generation
H. C. Nix, Site General Manager
C. E. Belflower, Site QA Supervisor

To emphasize the level of unacceptability of the manner in which the reactor was controlled on July 14, 1983, and after consultation with the Director of the Office of Inspection and Enforcement, I have been authorized to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalties in the amount of One Hundred Thousand Dollars based upon the findings of the first inspection. Three separate violations were identified and a separate civil penalty could have been assessed for each. However, since all three violations stemmed from the same fundamental problem, the violations have been classified together as a Severity Level II problem (Supplement I) pursuant to the NRC Enforcement Policy, 10 CFR Part 2, Appendix C, and a single civil penalty is proposed. The base penalty of $64,000 has been escalated to $100,000 because of the seriousness of this event, the number of Technical Specifications that were violated, and the number of licensed operators and supervisors involved.

You are required to respond to the Notice and should follow the instructions specified therein when preparing your response. The sequence of events that occurred on July 14, 1983 gives rise to a number of questions which the NRC believes must be addressed by the Georgia Power Company. First, has the Georgia Power Company's policy of "safety first" been compromised by improper consideration by individual members of the Plant Hatch staff of "keeping the plant running" without proper consideration of overall plant safety? Second, has the Georgia Power Company's policy of strict adherence to approved operating procedures been compromised at Plant Hatch by individual supervisors and managers and has an effective system of audits been implemented to assure compliance with the policy? Third, is each operations supervisor fully aware of his/her individual responsibilities for making decisions? Fourth, is the role and the authority of the shift technical adviser clear to them and to each operations supervisor? And finally, is each licensed operator aware of the importance of adherence to Technical Specifications and knowledgeable of approved interpretations of those Technical Specifications? Your response to the attached Notice of Violation and Proposed Imposition of Civil Penalties should address, in detail, each of these questions with particular emphasis on assuring good vertical communications between Plant Hatch in Baxley, Georgia, and the corporate offices in Atlanta, Georgia. It is further requested that you provide sufficient information on these specific matters so that we may conclude that your corrective actions will be effective over the long run. Your reply to this letter, and the results of future inspections, will be considered in determining whether further action is appropriate.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice", Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the Notice of Violation will be placed in the NRC's Public Document Room.

ENCLOSURE 2
(Original Copy)

DEC 27 1983

To emphasize the level of unacceptability of the manner in which the reactor was controlled on July 14, 1983, and after consultation with the Director of the Office of Inspection and Enforcement, I have been authorized to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalties in the amount of One Hundred Thousand Dollars based upon the findings of the first inspection. Three separate violations were identified and a separate civil penalty could have been assessed for each. However, since all three violations stemmed from the same fundamental problem, the violations have been classified together as a Severity Level II problem (Supplement I) pursuant to the NRC Enforcement Policy, 10 CFR Part 2, Appendix C, and a single civil penalty is proposed. The base penalty of $64,000 has been escalated to $100,000 because of the seriousness of this event, the number of Technical Specifications that were violated, and the number of licensed operators and supervisors involved.

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice", Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the Notice of Violation will be placed in the NRC's Public Document Room. To protect the privacy of the individuals involved, the Letters of Reprimand will not be placed in the Public Document Room at this time.

Georgia Power Company
333 Piedmont Avenue
Atlanta, Georgia 30308
Telephone 404 526-7020

Mailing Address
Post Office Box 4545
Atlanta, Georgia 30302

Georgia Power
the southern electric system

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

January 25, 1984

Director, Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

NRC DOCKET 50-366
OPERATING LICENSE NPF-5
EDWIN I. HATCH NUCLEAR PLANT UNIT 2
RESPONSE TO ENFORCEMENT ACTION 83-86

Attention: Mr. Richard DeYoung, Director

Gentlemen:

Pursuant to the provisions of 10 CFR 2.201 Georgia Power Company (GPC) submits this response to the Notice of Violation and Proposed Imposition of Civil Penalties dated December 27, 1983 (the Notice).

We wish to emphasize that although three violations were cited, they arose out of one circumstance which involved the improper manipulation of control rods with the single objective of reducing power to avoid a reactor shutdown transient. Each violation cites a different Technical Specification which was violated as a result of the single event described in the Notice. The Nuclear Regulatory Commission (NRC) evaluated these violations collectively when arriving at the proposed civil penalty. We, therefore, wish to respond to the violations collectively.

Enclosed is full payment of the proposed civil penalty in the amount of $100,000.00. Therefore, this response does not constitute a formal reply under the provisions of 10 CFR 2.205. However, Georgia Power Company does informally request that the NRC reconsider the amount of the civil penalty and reduce the amount of the penalty on the basis of the following considerations:

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(a) The Civil penalty snould be no more than the base penalty of $64,000.00 under the factors of the enforcement policy, 10 CFR Part 2, Appendix C. The NRC escalated the penalty to $100,000.00 based on three reasons: (i) the seriousness of the event, (ii) the number of Technical Specifications that were violated, and (iii) the number of personnel involved. None of these factors are among the five factors identified in Appendix C for adjusting the base penalty. The seriousness of the event is already reflected in the base penalty of the classification (i.e., plant operations) and severity level it represents. With respect to the number of Technical Specifications and personnel involved, the Notice previously stated that all violations stemmed from the same fundamental problem and, therefore, under Appendix C a single unescalated application of the base penalty is the appropriate amount despite the latter two reasons given for escalation.

(b) The enforcement policy provides for the reduction of the civil penalty by up to 50% based on unusually prompt and extensive corrective action. Actions taken by GPC to control and prevent recurrence of such events fully support the intent of GPC to operate Plant Hatch in a safe manner. GPC promptly evaluated the event and its related root causes and implemented corrective actions in such a manner as to improve operator training and reactor safety. These actions support a reduction of the civil penalty. GPC believes that the corrective actions described in this response to the Notice are certainly timely and comprehensive, and show a significant degree of licensee initiative.

VIOLATION:

A special inspection conducted at Hatch Unit 2 on July 14 and 15, 1983, disclosed that while Unit 2 was being returned to service, a problem was experienced with main condenser vacuum. This problem required a reduction in reactor power to avoid a reactor shutdown. The on-shift operators and their supervisors recognized that the normal method of reducing power would not achieve a sufficiently timely power reduction to avoid a scram. These individuals,

apparently strongly influenced by advice from two shift technical advisors, made a "consensus decision" to achieve the necessary rapid power reduction by bypassing both the Rod Worth Minimizer and the Rod Sequence Controller and by selectively scramming individual control rods, without an approved procedure, from the Scram Time Test Panel which is out of sight of, and out of normal voice communications with, the reactor control console. The "consensus decision" and the resulting actions resulted in a control rod configuration that had not been analyzed from a reactor safety viewpoint.

To emphasize the need to adhere to facility operations and administrative procedures, and to upgrade plant management control systems relating to licensed personnel, shift technical advisers, and supervisor's decision-making responsibilities, NRC proposes to impose a civil penalty in the amount of $100,000 for the matter of the improper reactor shutdown event on July 14, 1983. In accordance with the General Policy and Procedure for NRC Enforcement Actions, 10 CFR Part 2, as amended, the violations and the associated civil penalties are set forth below:

A. Technical Specification 6.8.1 states that procedures shall be written, approved and implemented for reactor operations.

Contrary to the above, on July 14, 1983, control rod manipulations were conducted in violation of written and approved procedures, resulting in control rod patterns outside those analyzed for the Rod Drop Accident described in FSAR chapter 15.1.3.8. These manipulations were improperly accomplished by scramming control rods from the scram time test panel (2H11-P610) and inserting control rods using the Emergency In switch instead of the approved procedural method of inserting control rods in notch control from the main control panel (2H11-P603).

Examples of procedures which were not followed include:

1. Procedure, HNP-2-34, "Rules for Performing Procedures", requires that verbatim compliance is mandatory (Paragraph 13.2) and that, if an approved procedure cannot be performed as written, stop and change the procedure. On July 14, 1983, Procedures HNP-2-9402 and HNP-2-9207 were not being followed verbatim nor was the event stopped, and the procedures were not changed.

2. Procedure, HNP-2-9402, "Control Rod Scram Testing", requires, in step E.17, return of the scrammed rod to its initial position prior to scramming the next rod. On July 14, 1983, the rods scrammed from the time test panel (2H11-P610) were not being returned to their initial position prior to scramming the next rod.

3. Procedure, HNP-2-9207, "Control Rod Movement", Paragraph D.4 and Data Sheet 1 requires notch control for rods identified with an asterisk. This asterisk was on all rod groups moved during the shutdown of July 14, 1983, up to the point where the reactor manual scram was initiated, and these movements were not conducted by notch control.

4. Procedure, HNP-2-9207, "Control Rod Movement", Paragraph E.5 requires that rod movement be stopped if proper operation of the Rod Sequence Control System (RSCS) is not confirmed. On July 14, 1983, rod movement was continued even though the RSCS was circumvented and therefore inoperative.

B. Technical Specification 3.1.4.1 requires that Rod Worth Minimizer (RWM) to be operable or a second licensed operator or other qualified member of the technical staff to be present at the reactor console to verify compliance with the prescribed control rod pattern.

Contrary to the above, on July 14, 1983, after bypassing the RWM, a second person did not verify compliance with the prescribed rod pattern. As a consequence, the rod insertion sequence was violated as evidenced by Control Rod 42-39 at notch 12 versus the required notch 48.

C. Technical Specification 3.1.4.1 requires that the Rod Sequence Control System (RSCS) be operable in Operation Condition 1 when thermal power is below 20%.

Contrary to the above, on July 14, 1983, while in Operation Condition, with thermal power below 20%, the RSCS was not operational in that is was not performing its intended function of notch control. The required notch control was circumvented by use of the Emergency In Switch and the scram switches on the scram time test panel.

RESPONSE:

Admission or Denial of the Alleged Violation: The violation did occur. While the violation occurred within the general context of the violation as stated, personnel and operators involved in the events always felt they were operating within the bounds of approved procedures.

Reason for Violation: Operating personnel failed to adequately follow procedures. Personnel used group discussion to make a "consensus decision" regarding action to be taken for reducing reactor power. In fact, these actions did not comply with the "intent" and "scope" of existing procedures. However, personnel and operators were not aware that actions taken were "outside" of analyzed conditions.

Georgia Power Company performed an indepth critique of this incident immediately following the event and an additional evaluation the following day with the personnel involved. The results of those critiques and actions taken as well as the impact of the events, are provided as follows:

A. Description of Event:

1. Unit 2 was being maintained at approximately 150 MWE during startup from a refueling outage. Scram time testing and air ejector trouble shooting had been in progress. Condenser vacuum suddenly began decreasing and the turbine was quickly unloaded and tripped. The operator began rapidly inserting rods to reduce power level as vacuum continued to decrease. It became apparent to the control room staff that unless power could be quickly decreased to within the limit of the mechanical vacuum pump so that it could be placed in service, vacuum would soon reach the reactor feed pump low vacuum trip point resulting in a loss of feedwater flow to the vessel, causing a reactor transient and possibly a challenge to a safety system. The cause of the vacuum decrease was not known. The reactor core isolation cooling (RCIC) system was inoperative at the time and the high pressure coolant injection (HPCI) system was operable, as allowed by Technical Specifications.

B. Operator Actions Taken:

1. In order to reduce reactor power with the fastest possible control rod insertion rate, the rod worth minimizer (RWM) was bypassed, as allowed by Technical Specifications. A second operator was assigned to verify rod movements as required. It is now clear, however, that the functional requirement of the Technical Specification was not being met. Rod movement was being made from the front panel of the operating console at this time. Operators started the insertion of control rods to reduce power due to the vacuum problem.

2. At one point the insertion of control rods was made by the use of the Emergency In (Rod In) switch to reduce reactor power. The use of this switch did not meet the intent of Emergency In use and did result in the Rod Sequence Control System (RSCS) not being used to control rod movement by notch control below 20% of power as required.

3. When the operators reached groups of control rods that were of low rod worth (low effect on reactor power) in the rod insertion sequence, a shift technical advisor (STA) suggested that instead of manually inserting those control rods, that they could be scrammed (rapid insertion), resulting in a quicker insertion rate and reactor power level decrease. It was noted that the control rod scram time test panel was set up to do this as a part of normal startup testing requirements. While such action is allowed with the reactor at power, it is only allowed for one control rod to be scrammed, then returned to its original position before the next rod is tested.

4. A collective discussion between the licensed operators in the control room resulted in a decision to proceed in that manner in order to prevent loss of the reactor feed pump. Vacuum at the time was approximately 1/2 inch above trip point. It was at this point control rod movement activities were prescribed to be completed in a manner contrary to procedures and requirements. Personnel involved failed to be aware that such control rod movement was not approved by existing procedures because the control rod that was scrammed was not to be returned to its original position before the next rod was scrammed. Involved personnel did not address the concern of conducting an operation outside of the bounds of analyzed conditions. Because of the failure to address such concerns, a possible "control rod drop accident" condition was not considered.

5. After the decision to scram control rods to effect rapid reactor power reduction was made, a plant operator continued to insert rods at the reactor panel while two additional operators proceeded to the scram timing panel with the rod sequence sheets to insert rods with the individual scram switches. When the front panel operator observed rods going in, he stopped inserting and verified further insertions from the scram panel. Personnel involved believed these actions complied with the two person verification requirements for rod movement with the RWM system bypassed.

6. After rod insertion in this manner, it was found that one rod was in an "out of sequence" position at notch 12. The vacuum pump was placed in service and vacuum stabilized at a low level. Because of the out of sequence condition, the reactor was manually scrammed (shutdown) as required by rod movement procedures.

7. Although their actions were incorrect, the involved plant operators actions were reasoned through and deliberate. During the critique the involved personnel became aware of the factors that had led them to incorrect conclusions.

It should be obvious from the above discussion that the operator actions were not performed to provide for the generation of electric power, because the turbine was already disconnected, but were done in the interest of reactor safety. The actions taken were intended to avoid or limit a transient on the reactor.

C. Impact of Events

1. The intent of the operators to reduce reactor power for existing conditions was in itself proper, but the means of doing so were not within approved procedures or analysis.

2. The bypassing of the RWM and the assignment of a second operator to verify rod movement was in itself proper, but the failures to maintain this double verification and the movement of control rods from two different locations at the time of rod movement from the scram time test panel did not meet requirements.

3. The use of the scram time test panel to scram more than one control rod was improper and not within analyzed conditions as was the use of the emergency in switch, but had limited impact due to the low worth of the rods involved.

4. While not mitigating the seriousness of the events and the possible effects had other high worth rods been involved, the health and safety of the public were not affected by these events.

Corrective Steps Which Have Been Taken and Results Achieved: The following corrective actions were taken as the result of these events:

1. The Unit 2 reactor was placed in cold shutdown.

2. Individuals involved with the event were removed from licensed duties [Operations Superintendent, Operations Supervisor on Shift (OSOS), Reactor Operator, Shift Technical Advisor (STA)]. Individuals were trained in the significance of the event and were allowed to assume licensed duties only after review by plant management.

3. Plant management conducted a session with Operations Supervisors to emphasize GPC's commitment to following procedures and to operation within analyzed regions. The role of the OSOS in management of the plant was clarified.

4. Results of the management investigation and proposed corrective actions were discussed with USNRC Region II personnel and their concurrence was obtained for Unit 2 restart.

5. Standing orders were issued for the control of the following activities:

   A. Operation of emergency rod in switch. (This has since been placed in procedures HNP-1&2-9207.)

   B. Rod worth minimizer bypass controls. (This has since been placed in procedures HNP-1&2-9207.)

   C. Requirement for Plant Manager approval of SRO procedure changes. (This has since been placed in procedure HNP-9.)

6. Licensed operators and STA's were briefed on shift duties and detailed discussions were held in the following areas:

   A. Description of the July 14 event;
   B. Lessons learned from the event;
   C. Operational philosophy;
   D. Corrective actions to be taken for this event;
   E. The need to avoid "consensus decisions".

7. Involved operating and STA personnel were counseled by GPC Power Generation Management.

8. Supervisors and above viewed a GPC Power Generation presentation made by Mr. J. T. Beckham, Jr., Vice President and General Manager Nuclear Generation, on this event.

9. HNP-1&2-9207, Rod Movement Procedures, were revised to clarify the use of emergency rod in switch and bypassing of rod worth minimizer.

10. HNP-1&2-9402, Scram Time Testing Procedures, were reviewed in detail to assure they did not require revision.

11. Training was provided in the following areas:

    A. A control room management course was presented to licensed operations supervisory personnel, SRO's, and selected Site Management personnel.

    B. A special seminar and discussion of the NRC position regarding plant operations were presented by Mr. Paul Bemis of the USNRC. This presentation was presented to licensed personnel and other site personnel.

    C. The manager of the Core Analysis section of Southern Company Services presented a lecture on Final Safety Analysis Report (FSAR) transient and accident analyses, procedure compliance, and the consequences of operations outside of analyzed areas. This was presented to licensed control room supervisors.

    D. Site personnel were retrained in procedure compliance through the use of Departmental Directives.

    E. GPC site personnel attended a taped lecture by H. C. Nix, Plant Hatch General Manager, on operating philosophy and procedure compliance.

Corrective Steps Which Will Be Taken to Avoid Future Violations: In addition to steps already listed, the following ongoing actions have been taken:

1. Simulator training now stresses the lessons learned from this event.

2. Special "FSAR Analyzed Regions of Operation" topics are now being presented to licensed operators and STA's in training classes.

3. Training for STA's now stresses the role of the STA in the control room and Reactor Engineer duties for overview and standback approach.

4. The following training is planned to re-emphasize periodically the attitudes desired in the operation of the plant:

   A. Long Term (Repetitive) Seminars - The Georgia Power philosophy of operation of Plant Hatch will be presented to licensed personnel and site mangement personnel who may be involved in decision making activities regarding the day-to-day operation of Plant Hatch. This will be done as a forum to provide for the free exchange of thoughts in the specific areas of: 1) why group decisions are not appropriate for operation; 2) system operation outside of the intent of existing procedures; 3) operation outside of procedures; and 4) lines of responsibility and authority in the control room during periods of non-routine operation. Other items which may be identified in the future can be added to assure that the desired operational philosophy is instilled in the appropriate personnel. This forum will be conducted on a schedule such that affected personnel are re-exposed to the desired attitudes on an annual basis.

   B. Notable industry personnel will also be utilized in seminars on a long term basis.

C. As part of the long term training the subject of plant operating philosophy will be in new employee training and annual retraining.

5. There are presently several activities performed by site management to monitor and evaluate shift activities on an on-going basis. The General Manager and Deputy General Manager, as well as the Operations Manager, make random audits of shift operations. This is complemented by the Duty Officer who generally observes night shift turnover activities and by management audits that require an assessment of backshift activities once per week. During outages, different members of management are assigned to the back shifts for audits and/or coordination functions. QA performs back shift audits periodically.

Date When Full Compliance Will Be Achieved: Compliance with requirements was achieved on July 14, 1983, with the conclusion of the Unit 2 reactor shutdown. By August 31, 1983, full compliance with long-term actions committed to in our July 18, 1983 response to this event was achieved.

Special Concerns: Those special concerns and questions expressed in the Proposed Imposition of Civil Penalties Notice have been addressed as follows:

1. Has the Georgia Power Company's (GPC) policy of "safety first" been compromised by improper plant "running" without proper consideration of overall plant safety? It has always been GPC's policy to operate and maintain the Plant Hatch reactors in a safe manner. While decisions made regarding the July 14, 1983, events were incorrect, they were never made with the intent, nor knowledge, to compromise safety. Those actions taken are isolated events and are contrary to the general operating policy of both GPC and its operators. To assure full understanding of the GPC policy, actions listed in the "Corrective Steps Which Have Been Taken" section of this response were completed. Additionally, site personnel were presented an August 22, 1983, memo from J.H. Miller, President, that defines the right, obligations and requirements with respect to providing for the safety of and standards of performance for all Plant Hatch personnel. Also, as a result of this event, QA has increased the frequency of their operations

audits. The QA Department participates in a rotation program which currently includes a licensed (SRO) power generation engineer to better facilitate their audit process. Safety Review Board members are receiving additional classroom and simulator training in order to better assess the operation of the plant in their reviews and audits. These actions reflect GPC's and its operators' policy to always place safety first.

2. Has the GPC's policy of strict adherence to approved operating procedures been compromised at Plant Hatch by individual supervisors and managers and has an effective system of audits been implemented to assure compliance with policy? As stated, GPC believes that the actions carried out in the course of the July 14, 1983 events were taken with the mistaken belief that existing procedures allowed these actions. Managers, Superintendents and Supervisors have been reminded of the need to monitor plant activities and to assure procedure compliance. The existing procedure "Self Audit" program has been re-emphasized to all site departments to improve the quality of procedures. Procedure self-audits will assure that existing procedures are reviewed on a timely basis and should result in improved procedures.

3. Is each operations supervisor fully aware of his/her individual responsibilities for making decisions? The additional training steps, counseling and presentations discussed in the "Corrective Steps which Have Been Taken" section of this response have assured that supervisors have been fully trained and understand their responsibilities.

4. Is the role and the authority of the shift technical advisor (STA) clear to them and to each operations supervisor? As part of an on-going program, training for STA's now stresses the role of the STA in the control room. STA's and operations supervisors understand the role and authority of STA's.

5. Is each licensed operator aware of the importance of adherence to Technical Specifications and knowledgeable of approved interpretations of those specifications? Licensed personnel and STA's were provided a copy of the failure to follow Rod Movement Procedures as related to the July 14, 1983 event. This was presented in Departmental Directive 0-83-14. With the additional training completed to date, licensed operators are fully aware of the importance of complying with Technical Specifications and the GPC policy for such compliance and fully understand the intent and interpretation of these specifications.

Additional Improvements

In addition to our response in accordance with 10 CFR 2.201 and in addition to the Special Concerns expressed by the NRC in their Proposed Imposition of Civil Penalties Notice, GPC has made other general plant operations and management improvements since the July 14, 1983 event. Some of these are:

A. A program to hold formal shift meetings at the start of each shift has been implemented. These meetings address concerns with the operation of the units and proposed actions to resolve problem areas.

B. A new position of a supervisor whose function is to control maintenance activities during outages has been added to relieve the Shift Supervisors from the paper work duties of maintenance activities. This action allows full attention to be directed towards current unit operations.

C. An improved interface between departments has been achieved, resulting in better support of the Operations Department by other departments. This interface results in maintenance and engineering support being provided directly to Operations at the time of operational needs rather than an after the fact support. Further, it defines the responsibility of the Operations Supervisor and the support to be given him.

D. The daily work schedule meeting has been moved to 8:30 a.m. rather than the 2:00 p.m. meeting time. This results in problems with unit operations being addressed in a more timely manner. Resolution of problems are proposed and carried out with the full support of all departments.

E. Selected superintendents now attend the work schedule meetings. This results in more fully supervised problem resolutions.

F. Department informational meetings are now held monthly. These meetings have improved communications between departments, resulting in more active involvement between the departments. Training efforts and operating philosophy are passed on to all levels of plant personnel. These actions have resulted in a better awareness by all personnel which leads to safe plant operations.

G. Managers are becoming more involved in the day to day operations of the plant, resulting in better supervision of plant operations and activities.

Georgia Power

Georgia Power Company recognizes and concurs with the NRC's concerns as set forth in the Notice and in the enforcement conferences. We have responded and intend to continue to respond to this event in a manner which will ensure that safety will be the foremost concern of all involved with Plant Hatch. We believe the actions documented in this letter evidence such a prompt and extensive response. As previously noted, Georgia Power Company is enclosing payment of the proposed civil penalty. However, for the reasons previously given, and based on the actions presented herein, we respectfully request that NRC reconsider and reduce the civil penalty.

J. T. Beckham, Jr. states that he is Vice President of Georgia Power Company and is authorized to execute this oath on behalf of Georgia Power Company, and that to the best of his knowledge and belief the facts set forth in this letter are true.

GEORGIA POWER COMPANY

By: _____

J. T. Beckham, Jr.

Sworn to and subscribed before me this 25th day of January, 1984.

William E. Brunson

Notary Public Notary Public, Georgia, State at Large
My Commission Expires Aug. 26, 1985

DLT/mw

Enclosure

xc: H. C. Nix, Jr.
Senior Resident Inspector
J. P. O'Reilly, (NRC-Region II)

(3)

UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

FEB 14 1984

Docket No. 50-366
License No. NPF-5
EA 83-86

Georgia Power Company
ATTN: Mr. R. J. Kelly
Executive Vice President
P.O. Box 4545
Atlanta, GA 30302

Gentlemen:

This letter acknowledges receipt of your letter dated January 25, 1984 and your check in the amount of $100,000 as payment in full for the civil penalty proposed by the NRC on December 27, 1983.

In that letter, you admitted that the violations described in the Notice of Violation occurred, but also requested that the NRC reduce the penalty to no more than $64,000. The NRC has carefully evaluated your response and determined that reduction of the fine is not warranted.

Your primary argument is that you should be assessed no more than the base penalty of $64,000 for a Severity Level II violation because the reasons given for escalating the penalty to $100,000 are not among the five factors identified in 10 CFR Part 2, Appendix C for adjusting the base penalty. Although the NRC relies primarily on the five factors to determine whether a base penalty should be escalated, the NRC has discretion under Appendix C to escalate a penalty for other reasons, when appropriate.

In this particular case, several violations of your technical specifications occurred. Each violation could have been considered separately and a separate civil penalty assessed for each. However, to focus on the fundamental underlying causes of the event, the violations were grouped into one problem area. Because of the circumstances of this event, including the fact that several licensed personnel collectively decided to take actions not covered by approved procedures that resulted in violation of several technical specifications, the NRC used its discretion to escalate the base civil penalty for this problem to emphasize the significance of the event. The use of such discretion was appropriate under the circumstances. Had you not taken extensive, prompt corrective action, an even stronger enforcement sanction would have been taken for this very significant violation.

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Accordingly, I find no basis for reducing the penalty. Your corrective actions will be examined during future inspections.

Sincerely,

Richard C. DeYoung, Director
Office of Inspection and Enforcement

cc:
J. T. Beckham, Vice President and
General Manager-Nuclear Generation
H. C. Nix, Site General Manager
C. E. Belflower, Site QA Supervisor

DOCKET REPORT	TO DATE	FROM DATE	FIND-INGS	DEVIATION/ SEVERITY	SEVERITY SUPPLEMENT	TEXT
050003218201	011582	011282	1	-	-	-
050003218202	012082	122181	1	-	-	-
050003218203	012982	012882	1	-	-	-
050003218204	021182	020882	1	-	-	-
050003218205	021282	020882	2	5	1	FAILURE TO FOLLOW APPROVED PHYSICAL SECURITY PLAN
050003218206	021282	021182	1	-	-	-
003218207	022682	022282	2	5	1	ENVIRONMENTAL TECHNICAL SPECIFICATION 5.6 REQUIRES DETAILED WRITTEN PROCEDURES, INCLUDING APPLICABLE CHECK LISTS AND INSTRUCTIONS, SHALL BE PREPARED AND FOLLOWED FOR ALL ACTIVITIES INVOLVED IN IMPLEMENTING THE ENVIRONMENTAL TECHNICAL SPECIFICATIONS. LICENSEE PROCEDURE HNP-7650 REQUIRES ALL DATA AND RESULTS GENERATED AT THE PLANT SITE BE REVIEWED IN A TIMELY MANNER. CONTRARY TO THE ABOVE, LICENSEE PROCEDURE HNP-7650 WAS NOT ADHERED TO IN THAT NUMEROUS DATA SHEETS WERE NOT REVIEWED FOR ONE AND TWO MONTHS. IN ONE CASE A REVIEW OF A DATA SHEET WAS NOT MADE FOR ONE YEAR.
050003218208	031982	030282	1	-	-	-
050003218209	030182	012182	2	5	1	10CFR50, APPENDIX B, CRITERION V, REQUIRES ACTIVITIES AFFECTING QUALITY SHALL BE PRESCRIBED BY DOCUMENTED INSTRUCTIONS, PROCEDURES, OR DRAWINGS, OF A TYPE APPROPRIATE TO THE CIRCUMSTANCES AND SHALL BE ACCOMPLISHED IN ACCORDANCE WITH THESE INSTRUCTIONS, PROCEDURES, OR DRAWINGS. PLANT PROCEDURE HNP-822, MATERIAL INSPECTION REQUEST, STEP 6.1.A REQUIRES A TWO PART QC HOLD TAG BE ATTACHED TO MATERIAL TO BE INSPECTED. CONTRARY TO THE ABOVE, ON JANUARY 21, 1982, QC HOLD TAGS WERE NOT ATTACHED AS REQUIRED TO APPROXIMATELY 100 SPARE JOHNSON PUMP PARTS IN THE WAREHOUSE.
050003218209	030182	012182	2	D		PARAGRAPH 3.4.5.2 OF THE FINAL SAFETY ANALYSIS REPORT STATES THAT THE WITHDRAWAL SPEED CONTROL VALVE IS SET TO GIVE A CONTROL ROD A SHIM WITHDRAWAL SPEED OF 3 INCHES PER SECOND. THIS WITHDRAWAL SPEED CORRESPONDS TO A NOMINAL FULL CORE WITHDRAWAL TIME OF 48 SECONDS. CONTRARY TO THE ABOVE, THE UNIT

DOCKET REPORT	TO DATE	FROM DATE	FIND-INGS	DEVIATION/ SEVERITY	SEVERITY SUPPLEMENT	TEXT
050003218209	030182	012182	2	D		WAS STARTED UP ON JUNE 4, 1981, FOLLOWING A REFUEL ING OUTAGE WITH EIGHT CONTROL ROD DRIVE WITHDRAWAL TIMES OUTSIDE OF THE ACCEPTANCE BAND OF 40-60 SEC ONDS.
050003218209	030182	012182	2	5	1	TECHNICAL SPECIFICATION 6.8.1 REQUIRES THAT WRITTE N PROCEDURES SHALL BE ESTABLISHED, IMPLEMENTED AND MAINTAINED COVERING THE APPLICABLE PROCEDURES REC OMMENDED IN APPENDIX "A" OF REGULATORY GUIDE 1.33, REVISION 2, FEBRUARY 1978 AND SURVEILLANCE AND TE ST ACTIVITIES OF SAFETY-RELATED EQUIPMENT. CONTRA RY TO THE ABOVE, ON JUNE 14, 1981, PLANT PROCEDURE HNP-801 WAS NOT FOLLOWED IN THAT A NONCONFORMANCE REPORT WAS NOT ISSUED WHEN EIGHT CONTROL ROD DRIV E MECHANISMS WERE UNABLE TO SATISFY THE ACCEPTANCE CRITERIA STATED IN HNP-1-9404, CONTROL ROD DRIVE TIMING. CONTRARY TO THE ABOVE TECHNICAL SPECIFICA TION, PLANT PROCEDURE HNP-2-3410, SURVEILLANCE OF THE RCIC STEAM LINE DELTA P INSTRUMENTS, WAS NOT P ROPERLY MAINTAINED OR REVIEWED IN THAT AN INCORREC T +142 INCH VALVE EXISTED IN STEP F.2.0 OF THE PRO CEDURE FOR SETTING THE RCIC HIGH STEAM FLOW ISOLAT ION SETPOINT FOR THE INBOARD ISOLATION VALVE. CON TRARY TO THE ABOVE TECHNICAL SPECIFICATION, PLANT PROCEDURE HNP-820, PLANT RECORDS MANAGEMENT, PARAG RAPH E.2 WAS NOT FOLLOWED IN THAT PLANT RECORDS ON CONTROL ROD DRIVE TESTS WERE NOT FORWARDED TO THE DOCUMENT CONTROL SECTION SUBSEQUENT TO COMPLETION OF CONTROL ROD TESTING ON JUNE 14, 1981. ON FEBRU ARY 2, 1982, THE RECORDS OF ONLY 15 OF 137 RODS TE STED WERE IN DOCUMENTATION. THE REMAINING RECORDS WERE LOCATED IN AN ENGINEER'S DESK DRAWER.
050003218210	031282	031082	2	5	1	TECHNICAL SPECIFICATION SECTION 6.8.1.F REQUIRES W RITTEN PROCEDURES TO BE ESTABLISHED, IMPLEMENTED A ND MAINTAINED COVERING THE FIRE PROTECTION PROGRAM IMPLEMENTATION. (1) ON MARCH 12, 1982, WITH UNIT 1 IN OPERATION, THREE WELDING PERMITS WERE FOUND IN UNIT 1 WHICH WERE ISSUED FOR MORE THAN ONE SHIF T. THIS IS CONTRARY TO GEORGIA POWER COMPANY PROC EDURE HNP-555, CONTROL OF IGNITION SOURCES, SECTIO N E.4. (2) ON MARCH 12, 1982, THE UNIT 1 REACTOR BUILDING HVAC EQUIPMENT ROOM CONTAINED AN ACCUMULA TION OF COMBUSTIBLE MATERIAL CONSISTING OF CONTAMI NATED FILTERS, NEW FILTERS, CARDBOARD BOXES, AND M ISCELLANEOUS DEBRIS WHICH HAD NOT BEEN REVIEWED BY

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050003218210	031282	031082	2	5	1	THE SENIOR REGULATORY SPECIALIST AND A STORAGE PERMIT HAD NOT BEEN ISSUED. THIS IS CONTRARY TO GEORGIA POWER COMPANY'S PROCEDURE HNP-559, CONTROL OF TRANSIENT COMBUSTIBLES, SECTION F.
050003218211	040282	032982	2	5	1	TECHNICAL SPECIFICATION 6.8.1 REQUIRES THAT WRITTEN PROCEDURES BE ESTABLISHED, IMPLEMENTED AND MAINTAINED COVERING THE APPLICABLE PROCEDURES RECOMMENDED IN APPENDIX "A" OF REGULATORY GUIDE 1.33. REGULATORY GUIDE 1.33, APPENDIX "A" STATES IN PART THAT RADIATION PROTECTION PROCEDURES SHOULD BE PROVIDED. PROCEDURE HNP-8005, REVISION 12, SECTION I, RADIATION OCCURRENCE REPORTS, PARAGRAPH 1.(B)(2) REQUIRES ACTION TO BE TAKEN TO ENSURE THE REPORTED EVENT DOES NOT RECUR. CONTRARY TO THE ABOVE, RADIATION PROTECTION PROCEDURES WERE NOT ESTABLISHED, IMPLEMENTED AND MAINTAINED IN THAT THE ACTION DESIGNATED TO CORRECT MISUSE OF PERSONNEL DOSIMETRY BY AN INDIVIDUAL ON NOVEMBER 3, 1981, WAS NOT PERFORMED. SPECIFICALLY, THE PRESCRIBED NOTIFICATION OF ALL EMPLOYEES ON OCCURRENCE REPORT 81-19A WAS NOT PERFORMED.
050003218212	032082	030282	2	5	1	TECHNICAL SPECIFICATION 6.8.1 REQUIRES THAT PROCEDURES CONTROLLING THE OPERATION OF SAFETY-RELATED SYSTEMS BE IMPLEMENTED. PLANT PROCEDURE HNP-1-1117, RHR SERVICE WATER, DATA PACKAGE 1, REQUIRES THAT THE MOTOR COOLING WATER SHUTOFF VALVES BE LOCKED OPEN AND THE STATUS OF THE VALVES BE DOUBLE VERIFIED. CONTRARY TO THE ABOVE, ON MARCH 1, 1982, THE MOTOR COOLING WATER INLET VALVE FOR "A" RESIDUAL HEAT REMOVAL (RHR) SERVICE WATER PUMP WAS FOUND BY THE INSPECTOR NOT LOCKED OPEN AS REQUIRED BY THE HNP-1-1117 PROCEDURE (THE VALVE WAS LATER DETERMINED TO BE OPEN).
050003218213	050482	042882	1	-	-	-
050003218214	042082	032182	1	-	-	-
050003218215	050582	050482	2	3	1	FAILURE TO CONTROL ACCESS TO THE PROTECTED AREA.
050003218216	060482	060182	1	-	-	-
050003218217	051382	041982	1	-	-	-

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050003218219	052582	042182	2	4	1	TECHNICAL SPECIFICATION 3.10.B REQUIRES THAT FUEL SHALL NOT BE LOADED INTO THE REACTOR CORE UNLESS A LL CONTROL RODS ARE FULLY INSERTED. CONTRARY TO T HE ABOVE, AND AS REPORTED BY THE LICENSEE, FUEL WA S LOADED INTO THE CORE WITHOUT ALL CONTROL RODS FU LLY INSERTED ON TWO OCCASIONS: 1) TWENTY TWO (22) FUEL BUNDLES WERE LOADED ON 5/16/82 WITH CONTROL R OD 10-23 WITHDRAWN. 2) TWO (2) FUEL BUNDLES WERE LOADED ON 5/17/82 WITH CONTROL ROD 10-31 WITHDRAWN .
050003218220	062182	052682	2	4	1	FAILURE TO MAINTAIN COOLING WATER ISOLATION VALVE IN A LOCKED OPEN CONDITION ON 1D PLANT SERVICE WAT ER PUMP, AT THE INTAKE STRUCTURE. THIS IS A REPEA T OF SIMILAR ITEM IN REPORT 82-12.
050003218221	070982	070882	1	-	-	-
050003218222	072282	071882	1	-	-	-
050003218223	072382	072182	1	-	-	-
050003218224	073082	072682	2	4	1	FAILURE TO PROVIDE QA INDOCTRINATION TO ALL NON QA PERSONNEL AND FAILURE TO PROVIDE SPECIALIZED INST RUCTION TO PLANT OPERATORS, MAINTENANCE PERSONNEL, TEST PERSONNEL, QC AND HEALTH PHYSICS PERSONNEL I N THEIR AREAS OF QA PROGRAM IMPLEMENTATION AS REQU IRED BY 10CFR50, APPENDIX B, CRITERION II AND THE LICENSEE'S ACCEPTED QA PROGRAM. FAILURE TO PROVIDE A SCHEDULED PREPLANNED LECTURE SERIES BASED ON EVALUATION OF ANNUAL WRITTEN LICEN SED OPERATOR EXAMINATION AS REQUIRED BY 10CFR55, A PPENDIX A.
050003218225	072682	062282	2	4	1	FAILURE OF PLANT LICENSED OPERATOR TO CONTROL PLAN T PRESSURE PRIOR TO SRV LIFTING ON A SCRAM WITH MS IV CLOSURE. FAILURE TO POST FIRE WATCHES FOR AN EXTENDED PERIO D IN ACCORDANCE WITH TECHNICAL SPECIFICATION REQUI REMENTS WHEN INADEQUATE FIRE BARRIERS WERE FOUND T O EXIST.
050003218226	081382	080982	1	-	-	-
050003218227	081982	081882	1	-	-	-

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050003218228	082782	072782	1	-	-	-
050003218229	090382	083082	1	-	-	-
050003218230	100182	092882	1	-	-	-
050003218231	092382	092082	1	-	-	-
050003218232	092882	082882	2	5	1	FAILURE TO FOLLOW HPCI SURVEILLANCE PROCEDURE. HPCI PUMP DISCHARGE VALVE WAS CYCLED AT POWER RATHER THAN IN COLD SHUTDOWN CONDITIONS. FAILURE OF LICENSEE PERSONNEL TO PROPERLY FRISK WHEN ENTERING THE CONTROL ROOM. INSPECTOR FOUND FRISKER TURNED OFF AND UNPLUGGED. FAILURE TO NOTIFY NRC WITHIN 1 HOUR AS REQUIRED BY 50.72 ON INOPERABLE SBGT SYSTEMS ON UNIT 1 AND ECCS ACTUATIONS ON UNIT 2 (TWO EXAMPLES).
050003218233	102982	102582	1	-	-	-
050003218234	110582	110182	1	-	-	-
050003218235	102882	092882	1	-	-	-
050003218236	120682	113082	4	4	1	ENVIRONMENTAL TECHNICAL SPECIFICATION 5.3.2.2 REQUIRES THAT AUDITS OF FACILITY ACTIVITIES SHALL BE PERFORMED AT LEAST ONCE A YEAR UNDER THE COGNIZANCE OF THE SRB TO ENSURE CONFORMANCE OF FACILITY OPERATION OF ALL PROVISIONS OF THE ENVIRONMENTAL TECHNICAL SPECIFICATIONS (ETS). ETS-3.2, TABLE 3.2-1, SPECIFIES THE PERFORMANCE OF AN ANALYTICAL PROGRAM. CONTRARY TO THE ABOVE, AUDITS OF THE ANALYTICAL PROGRAM WERE NOT PERFORMED IN 1980, 1981, AND 1982, THROUGH DECEMBER 6, 1982.
050003218236	120682	113082	4	D		OCOM-IN A LETTER DATED DECEMBER 30, 1982, NRC REGION II ISSUED A NOTICE OF VIOLATION TO THE GEORGIA POWER COMPANY. THE NOTICE IDENTIFIED A VIOLATION OF ENVIRONMENTAL TECHNICAL SPECIFICATION 5.3.2.2, DISCLOSED DURING NRC INSPECTION NOS. 50-321/81-24 AND 50-366/81-24, FOR HAVING FAILED TO CONDUCT AUDITS OF ITS ANALYTICAL PROGRAM. GEORGIA POWER COMPANY RESPONDED TO THE NRC CITATION IN A LETTER DATED DECEMBER 30, 1981, DESCRIBING CERTAIN CORRECTIVE AND PREVENTIVE ACTION TAKEN OR PLANNED. THE FOLLOWING STATEMENT WAS INCLUDED IN THIS LETTER: BY A

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050003218236	120682	113082	4	D		PRIL 1, 1982, GEORGIA POWER COMPANY WILL DEVELOP A PROGRAM TO PROVIDE FOR ANNUAL QA AUDITS OF CONTRACTOR ACTIVITIES RELATED TO THE ENVIRONMENTAL MONITORING. IMPLEMENTATION OF THIS PROGRAM WILL BEGIN IN APRIL 1982. CONTRARY TO THE ABOVE, AS OF DECEMBER 6, 1982, THE LICENSEE HAD NOT DEVELOPED A PROGRAM TO PROVIDE FOR ANNUAL QA AUDITS OF CONTRACTOR ACTIVITIES RELATED TO THE ENVIRONMENTAL MONITORING.
050003218237	111982	111682	1	-	-	-
0003218238	111982	111682	2	4	1	CONTRARY TO TECHNICAL SPECIFICATIONS 6.8.1.C AND 6.8.2, THE SURVEILLANCE TEST PROCEDURE HNP-1-3952-E, REV. 13, FOR TYPE "C" LEAK RATE TESTS DID NOT CONTAIN DETAILED VALVE POSITIONS FOR ALL TEST CONNECTIONS, VENT VALVES, DRAIN VALVES AND BLOCK VALVES ASSOCIATED WITH LEAK RATE TESTS. A SUPPLEMENTARY DOCUMENT WAS USED TO ASSIST IN DETERMINING VALVE ALIGNMENTS WHICH IS NOT A PART OF THE APPROVED TEST PROCEDURE.
050003218239	112082	102882	1	-	-	-
050003218240	111982	111582	1	-	-	-
050003218241	121682	121382	2	5	1	CONTRARY TO TECHNICAL SPECIFICATION 6.8.2, PROCEDURE CHANGES WERE NOT APPROVED, ISSUED AND CONTROLLED IN ACCORDANCE WITH PLANT PROCEDURE. HNP-9 IN THAT ON DECEMBER 14, 1982, AN UNAPPROVED, UNCONTROLLED CHANGE TO PLANT PROCEDURE HNP-6914 WAS BEING USED FOR QUALIFICATION OF CLASS 1 PIPE WELDERS.
050003218242	121582	121382	2	4	1	CONTRARY TO 10CFR50, APPENDIX "B", CRITERION XVI AND I, AND THE ACCEPTED QA PROGRAM (FSAR 17.2.16 AND 17.2.1), THE QA DEPARTMENT DOES NOT EFFECTIVELY ASSURE CONFORMANCE TO QUALITY STANDARDS IN THAT IT DOES NOT ASSURE PROMPT CORRECTION OF CONDITIONS ADVERSE TO QUALITY. SPECIFICALLY ONE ITEM WIRITEN IN 1978, TWO ITEMS WRITTEN IN 1979, SEVEN ITEMS WRITTEN IN 1980 AND SEVEN ITEMS WRITTEN IN 1981 STILL REMAIN OPEN. ALL THESE ITEMS WERE IDENTIFIED BY THEIR QA AUDIT SYSTEM. CONTRARY TO 10CFR50, APPENDIX "B", CRITERION V, THE ACCEPTED QA PROGRAM (FSAR 17.2.5) AND LICENSEE PROCEDURES QA-05-06 AND QA-05-01, SIX AUDIT FINDING

DOCKET REPORT	TO DATE	FROM DATE	FIND-INGS	DEVIATION/ SEVERITY	SEVERITY SUPPLEMENT	TEXT
050003218242	121582	121382	2	4	1	S WERE NOT RESPONDED TO WITHIN THE REQUIRED 30 DAY TIME PERIOD.
050003218242	121582	121382	2	5	1	CONTRARY TO THE ACCEPTED QA PROGRAMS, ENDORSEMENT OF ANSI N 45.2.23, THE LICENSEE DID NOT UPDATE QUALIFICATIONS OF 4 OF 5 LEAD AUDITORS ANNUALLY.
050003218243	121982	112082	1	-	-	-
050003218244	121082	120682	1	-	-	-
050003218301	012183	011883	2	4	1	CONTRARY TO TECHNICAL SPECIFICATION 6.8.1.A, PROCEDURES FOR REPAIR OF RECIRC AND RHR PIPING WERE NOT FOLLOWED IN THAT (1) ON JANUARY 18, 1983, NUMEROUS PIECES OF .035" DIAMETER STAINLESS WELDING MATERIAL UP TO APPROXIMATELY 50 FT. IN LENGTH WERE LEFT SCATTERED OVER THE DRYWELL AFTER COMPLETION OF WELD REPAIRS, (2) ON JANUARY 19, 1983, STEPS 17, 18 AND 21 OF PROCEDURE HNP-1-10174 HAD NOT BEEN SIGNED OFF. STEPS 19, 20 AND 23 HAD TO BE SIGNED OFF, AND (3) ON JANUARY 19, 1983, PT INSPECTION HAD BEEN PERFORMED IN ACCORDANCE WITH SCS PROCEDURE H/F/V-600 AND UT WAS BEING PERFORMED IN ACCORDANCE WITH LMI PROCEDURE UT-38 IN LIEU OF THE PROCEDURES REQUIRED BY HNP-1-10174.
050003218302	012183	122082	1	-	-	-
050003218303	020383	012983	1	-	-	-
050003218304	021183	020783	2	5	1	CONTRARY TO 10CFR50.72(A)(1), THE LICENSEE DID NOT NOTIFY THE NRC OPERATIONS CENTER WITHIN ONE HOUR FOLLOWING A LIQUID RELEASE OF I-131 FROM CHEMICAL WASTE SAMPLE TASK "A" WHICH EXCEEDED TECHNICAL SPECIFICATIONS AND 10CFR20, APPENDIX "B", TABLE II, COLUMN 2, LIMITS. THE RELEASE CONCENTRATION WAS 8.5X10-7 MICROCURIES PER MILLILITER; THE LIMIT IS 3.0X10-7 MICROCURIES PER MILLILITER. A 30-DAY LER WAS SUBMITTED AS REQUIRED BY TECHNICAL SPECIFICATIONS.
050003218305	022583	022283	1	-	-	-
050003218306	103182	070181	1	-	-	-
050003218307	022683	012283	2	4	1	CONTRARY TO TECHNICAL SPECIFICATION 6.8.1, ON FEBR

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050003218307	022683	012283	2	4	1	UARY 23, 1983, THE INSPECTOR DISCOVERED THAT: 1. PROCEDURE HNP-1-1500, WAS NOT BEING PROPERLY IMPLEMENTED IN THAT: A. ADJUSTABLE WRENCHES ABOUT (10 INCHES IN LENGTH) WERE ATTACHED TO THE KEYS OF KEY LOCK SWITCHES C61-S34A & B IN SUCH A WAY AS TO HOLD THE SWITCHES AGAINST THE SPRING RETURN. THIS ACTION OVERRIDES A HIGH REACTOR PRESSURE (840 PSI.) SHUTTING SIGNAL TO THE 2" VENT VALVES 1T48-F340 & 1T48-F341. HNP-1-1500 IN NO WAY AUTHORIZES THE ACTION OF USING A MECHANICAL OVERRIDE ON THE KEY LOCK SWITCHES. B. THE SHIFT FOREMAN'S (NOW KNOWN AS SHIFT SUPERVISOR) PERMISSION WAS NOT OBTAINED PRIOR TO OVERRIDE WITH SWITCHES C61-S34A & B AS REQUIRED BY HNP-1-1500, SECTION G NOTE. 2. PROCEDURE HNP-34, RULES FOR PERFORMING PROCEDURES, WAS NOT BEING IMPLEMENTED IN THAT: A. PARAGRAPH B.2., STATES THAT VERBATIM COMPLIANCE IS MANDATORY. HNP-1-1500 WAS NOT BEING PERFORMED VERBATIM AS STATED ABOVE. B. PARAGRAPH B.3., STATES THAT IF THE PROCEDURE CAN NOT BE PERFORMED AS WRITTEN STOP AND CHANGE THE PROCEDURE. HNP-1-1500 WAS NOT STOPPED OR CHANGED SUCH THAT VERBATIM COMPLIANCE COULD BE MET. C. PARAGRAPH B.4., STATES TO NOTIFY YOUR IMMEDIATE SUPERVISOR OF ANY PROCEDURE PROBLEMS. THIS WAS NOT DONE IN THAT THE SHIFT SUPERVISOR DID NOT KNOW ABOUT THE UNAUTHORIZED USE OF MECHANICAL OVERRIDE OR THAT THE OVERRIDE WAS IN PROGRESS. 3. PROCEDURE HNP-9, WAS NOT IMPLEMENTED IN THAT NO SRO CHANGE NOR PRB REVIEW OF A PROCEDURE CHANGE WAS OBTAINED AS REQUIRED BY HNP-9. THE USE OF THE WRENCHES TO OVERRIDE SPRING FORCE ON SWITCHES CONSTITUTES AN UNAUTHORIZED PROCEDURE CHANGE. 4. PROCEDURE HNP-1-1500 WAS NO PROPERLY MAINTAINED IN THAT THE SECTION G NOTE, STATED THAT THE SWITCHES C61-S34A & B WERE TO OVERRIDE A LOCA SIGNAL. THESE SWITCHES DO NOT OVERRIDE A LOCA SIGNAL.
050003218307	022683	012283	2	5	1	CONTRARY TO TECHNICAL SPECIFICATION 6.8.1 AND HNP-1-1117, ON FEBRUARY 18, 1982, THE DIVISION II MANUAL ISOLATION VALVE WAS FOUND BY THE INSPECTOR TO BE UNLOCKED AND ON FEBRUARY 24, 1982, ALL FOUR (2 PER LOOP) RHR SERVICE WATER STRAINERS WERE FOUND BY THE INSPECTOR TO BE ON LINE.
050003218308	032583	031483	1	-	-	

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050003218309	032583	031483	2	3	1	10CFR50, APPENDIX "B", CRITERIA V, X AND XVIII, AS IMPLEMENTED BY HATCH'S SAR SECTION 17.2.5, 17.2.10 AND 17.2.18, REQUIRE ACTIVITIES AFFECTING QUALITY ARE PRESCRIBED BY DOCUMENTED INSTRUCTIONS, ACTIVITIES CONCERNING SAFETY-RELATED SYSTEMS BE INSPECTED TO VERIFY CONFORMANCE WITH DOCUMENTED INSTRUCTIONS AND DRAWINGS, AND AUDITS ARE TO BE PERFORMED TO VERIFY COMPLIANCE WITH APPLICABLE REGULATIONS AND LICENSE REQUIREMENTS. CONTRARY TO THE ABOVE, THE ADMINISTRATIVE AND MANAGERIAL CONTROL SYSTEMS IN EFFECT IN THE AREAS OF PROCEDURES INSPECTIONS, AND AUDITS WITH REGARD TO RESTORATION OF CABLE TRAY SYSTEMS TO DESIGN STANDARDS AFTER REPAIRS AND/OR MODIFICATIONS ARE INADEQUATE IN THAT MANY CABLE TRAY DISCREPANCIES (SUCH AS, CABLE TRAY COVERS REMOVED, KAOWOOL AND FIRE STOPS IN TRAY SYSTEMS REMOVED, AND CABLE TRAY HOLD DOWN CLAMPS MADE INEFFECTIVE) EXIST THROUGH OUT THE PLANT. THESE ADMINISTRATIVE AND MANAGERIAL CONTROL SYSTEMS HAVE BEEN INEFFECTIVE IN THAT DOCUMENTATION FOR TRACKING PURPOSES AND SUBSEQUENT RESOLUTION FOR THESE CABLE TRAY DISCREPANCIES DO NOT EXIST.
050003218310	032683	022783	1	-	-	-
050003218311	041583	041183	1	-	-	-
050003218312	042883	042483	2	4	1	FAILURE TO IDENTIFY INDIVIDUALS ENTERING THE PA, UNAUTHORIZED INDIVIDUALS WITHIN THE PA AND ESCORT UNABLE TO MAINTAIN CONTACT.
050003218313	042383	032683	2	4	1	FAILURE TO TAKE CONTROL ROOM VENTILATION SYSTEM FILTER BED SAMPLED AS REQUIRED BY TECHNICAL SPECIFICATIONS 4.12.A.2.A.
050003218314	050583	042683	1	-	-	-
050003218315	052083	042483	2	4	1	CONTRARY TO TECHNICAL SPECIFICATIONS 6.8.1, PROCEDURES HNP-1-1117 & HNP-1-3358, WERE NOT PROPERLY IMPLEMENTED IN THAT VALVE X42-F073D (SEAL WATER TO "D" RHR SERVICE WATER PUMP) AND VALVE Z43-F300C (ISOLATION TO CABLE SPREADING ROOM SPRINKLER MULTIMATIC VALVE) WERE NOT LOCKED IN POSITION AS REQUIRED BY THE RESPECTIVE PROCEDURES.
050003218316	060883	060683	1	-	-	-

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050003218317	052783	052383	2	4	1	10CFR20.301, SPECIFIES AUTHORIZED METHODS FOR DISPOSAL OF LICENSED MATERIAL AND PROHIBITS DISPOSAL BY OTHER MEANS. ONE AUTHORIZED METHOD IS BY TRANSFER TO AN AUTHORIZED RECIPIENT PURSUANT TO THE SPECIFIC LICENSE REQUIREMENTS OF THE RECIPIENT. CONTRARY TO THE ABOVE, ON MARCH 22, 1983, THE LICENSEE DISPOSED OF NINE, NINETY-SIX CUBIC FOOT METAL BOXES OF COMPACTED RADIOACTIVE WASTE, BY TRANSFER FOR LAND BURIAL TO CHEM-NUCLEAR SYSTEMS, INC., WHOSE SOUTH CAROLINA LICENSE (NO. 097) DOES NOT AUTHORIZE RECEIPT OF LIQUID WASTE FOR LAND BURIAL. ONE BOX (HNP-83-321) CONTAINED APPROXIMATELY FIVE QUARTS OF FREE STANDING LIQUID.
050003218318	062083	052083	1	-	-	-
050003218319	070883	070583	1	-	-	-
050003218320	072083	062183	1	-	-	-
050003218321	081283	080883	2	4	1	10CFR20.201(B) REQUIRES THE LICENSEE TO PERFORM SURVEYS AS NECESSARY TO DEMONSTRATE COMPLIANCE WITH 10CFR20.106 WHICH LIMITS THE RELEASE OF RADIOACTIVITY IN UNRESTRICTED AREAS TO CONCENTRATIONS IN APPENDIX B, TABLE II AND TO EVALUATE THE EXTENT OF RADIATION HAZARDS THAT MAY BE PRESENT. CONTRARY TO THE ABOVE, FAILURE TO PROPERLY EVALUATE AND TAKE CORRECTIVE ACTION IN REGARD TO A SYSTEMATIC CONCENTRATIONS IN GROUNDWATER SAMPLES COLLECTED DURING AN AUGUST 1982 SAMPLING OF MONITORING WELLS. THIS FAILURE RESULTED IN AN OVERSTATEMENT OF TRITIUM CONENTRATIONS IN THE GROUND WATER.
050003218322	081083	081083	1	-	-	-
050003218323	080583	080283	1	-	-	-
050003218324	081983	081783	1	-	-	-
050003218326	093083	092683	1	-	-	-
050003218327	093083	082083	1	-	-	-
050003218328	093083	092683	1	-	-	-

DOCKET REPORT	TO DATE	FROM DATE	FIND-INGS	DEVIATION/ SEVERITY	SEVERITY SUPPLEMENT	TEXT
050003218329	101483	101183	1	-	-	-
050003218330	103183	100183	2	4	1	FAILURE TO SET FIRE WATCHES WHEN PORTIONS OF THE F IRE PROTECTION SYSTEM WAS INOPERABLE AS REQUIRED B Y TECHNICAL SPECIFICATIONS 3.13.1 ACTION 1 FOR UNI T 1 AND 3.7.6.2 ACTION 2 FOR UNIT 2.
050003218331	111883	111483	1	-	-	-
050003218333	120183	112983	1	-	-	-
050003218335	121683	112183	1	-	-	-
050003218336	122283	121983	1	-	-	-

DOCKET REPORT	TO DATE	FROM DATE	FIND-INGS	DEVIATION/ SEVERITY	SEVERITY SUPPLEMENT	TEXT
050003668201	011582	011282	1	-	-	-
050003668202	012082	122181	1	-	-	-
050003668203	012982	012882	1	-	-	-
050003668204	021182	020882	1	-	-	-
050003668205	021282	020882	2	5	1	FAILURE TO FOLLOW APPROVED PHYSICAL SECURITY PLAN
050003668206	021282	021182	1	-	-	-
50003668207	022682	022282	2	5	1	ENVIRONMENTAL TECHNICAL SPECIFICATION 5.6 REQUIRES DETAILED WRITTEN PROCEDURES, INCLUDING APPLICABLE CHECK LISTS AND INSTRUCTIONS, SHALL BE PREPARED AND FOLLOWED FOR ALL ACTIVITIES INVOLVED IN IMPLEMENTING THE ENVIRONMENTAL TECHNICAL SPECIFICATIONS. LICENSEE PROCEDURE HNP-7650 REQUIRES ALL DATA AND RESULTS GENERATED AT THE PLANT SITE BE REVIEWED IN A TIMELY MANNER. CONTRARY TO THE ABOVE, LICENSEE PROCEDURE HNP-7650 WAS NOT ADHERED TO IN THAT NUMEROUS DATA SHEETS WERE NOT REVIEWED FOR ONE AND TWO MONTHS. IN ONE CASE A REVIEW OF A DATA SHEET WAS NOT MADE FOR ONE YEAR.
050003668208	031982	030282	2	5	1	CONTRARY TO CRITERION V OF APPENDIX B TO 10CFR50, ACTIVITIES AFFECTING QUALITY WERE NOT ACCOMPLISHED IN ACCORDANCE WITH DOCUMENTED PROCEDURES AND DRAWINGS IN THAT THE CB&I WELDING QA SUPERVISOR HAD SIGNED OFF THE FITUP ON WELD B-4 ON DRAWING R56 AND ONE MEMBER OF THE JOINT WAS CUT SQUARE IN LIEU OF THE REQUIRED 15 DEGREE LEVEL IN VIOLATION OF CB&I QA MANUAL, SECTION 8, PARAGRAPH 8.5.3.
50003668209	030182	012182	2	5	1	10CFR50, APPENDIX B, CRITERION V, REQUIRES ACTIVITIES AFFECTING QUALITY SHALL BE PRESCRIBED BY DOCUMENTED INSTRUCTIONS, PROCEDURES OR DRAWINGS, OF A TYPE APPROPRIATE TO THE CIRCUMSTANCES AND SHALL BE ACCOMPLISHED IN ACCORDANCE WITH THESE INSTRUCTIONS, PROCEDURES OR DRAWINGS. PLANT PROCEDURE HNP-822, MATERIAL INSPECTION REQUEST, STEP 6.1.A REQUIRES A TWO PART QC HOLD TAG BE ATTACHED TO MATERIAL TO BE INSPECTED. CONTRARY TO THE ABOVE, ON JANUARY 21, 1982, QC HOLD TAGS WERE NOT ATTACHED AS REQUIRED TO APPROXIMATELY 100 SPARE JOHNSON PUMP PARTS IN THE WAREHOUSE.

DOCKET REPORT	TO DATE	FROM DATE	FIND-INGS	DEVIATION/ SEVERITY	SEVERITY SUPPLEMENT	TEXT
050003668209	030182	012182	2	5	1	TECHNICAL SPECIFICATION 6.8.1, REQUIRES THAT WRITTEN PROCEDURES SHALL BE ESTABLISHED, IMPLEMENTED AND MAINTAINED COVERING THE APPLICABLE PROCEDURES RECOMMENDED IN APPENDIX "A" OF REGULATORY GUIDE 1.33, REVISION 2, FEBRUARY 1978 AND SURVEILLANCE AND TEST ACTIVITIES OF SAFETY-RELATED EQUIPMENT. CONTRARY TO THE ABOVE TECHNICAL SPECIFICATION, PLANT PROCEDURE HNP-2-3410, SURVEILLANCE OF THE RCIC STEAM LINE DELTA P INSTRUMENTS, WAS NOT PROPERLY MAINTAINED OR REVIEWED IN THAT AN INCORRECT +142 INCH VALVE EXISTED IN STEP F.2.0 OF THE PROCEDURE FOR SETTING THE RCIC HIGH STEAM FLOW ISOLATION SETPOINT FOR THE INBOARD ISOLATION VALVE.
050003668209	030182	012182	2	4	1	TECHNICAL SPECIFICATION 3.3.2, REQUIRES THAT THE ISOLATION ACTUATION INSTRUMENTATION CHANNELS IN TABLE 3.3.2-1 BE OPERABLE WITH TRIP SETPOINTS CONSISTENT WITH THE VALVES SHOWN IN TABLE 3.3.2-2. IF NOT OPERABLE, THE CHANNEL MUST BE RESTORED TO OPERABLE STATUS WITHIN 2 HOURS OR THE AFFECTED SYSTEM IS ISOLATED. CONTRARY TO THE ABOVE, THE ISOLATION ACTUATION INSTRUMENTATION SETPOINT FOR THE HIGH STEAM FLOW ISOLATION SIGNAL OF THE RCIC INBOARD ISOLATION VALVE WAS NOT SET GREATER THAN OR EQUAL TO 300% OF RATED FLOW AS REQUIRED BY TABLE 3.3.2-2 ITEM 5.A. THE SYSTEM WAS NOT ISOLATED AND DECLARED INOPERABLE AS REQUIRED BY TABLE 3.3.2-2 ITEM 5.A. THIS CONDITION HAD EXISTED WITH THE LICENSEE'S KNOWLEDGE FOR APPROXIMATELY TWO AND ONE HALD YEARS UNTIL PROPERLY ADJUSTED ON JANUARY 11, 1982. CONTRARY TO THE ABOVE TECHNICAL SPECIFICATION, THE ISOLATION ACTUATION SETPOINT FOR THE RCIC INBOARD SYSTEM LINE ISOLATION VALVE WAS ERRONEOUSLY SET TO A NON CONSERVATIVE VALVE ON JANUARY 28, 1982 DUE TO THE LICENSEE'S FAILURE TO PROPERLY IMPLEMENT A CHANGE TO PROCEDURE HNP-2-3410, RCIC STEAM LINE DELTA P INSTRUMENT FUNCTIONAL TEST AND CALIBRATION. TECHNICAL SPECIFICATION 6.9.1.8.I, REQUIRES WHEN PERFORMANCE OF COMPONENTS REQUIRES REMEDIAL ACTION OR CORRECTIVE MEASURES TO PREVENT OPERATION IN A MANNER LESS CONSERVATIVE THAN ASSUMED IN THE ACCIDENT ANALYSES, SAFETY ANALYSIS REPORT OR TECHNICAL SPECIFICATION BASES THAT IT BE REPORTED TO THE REGIONAL OFFICE WITHIN 24 HOURS. CONTRARY TO THE ABOVE, THE EXISTENCE OF A NON-CONSERVATIVE SETTING FOR THE RCIC INBOARD STEAM LINE ISOLATION VALVE TRIP

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050003668209	030182	012182	2	4	1	SETPOINT WAS NOT REPORTED PROMPTLY TO THE REGIONAL OFFICE WITHIN 24 HOURS AS REQUIRED WHEN IT WAS DISCOVERED IN THE FALL OF 1979 AND AGAIN ON JANUARY 11, 1982 (TWO EXAMPLES).
050003668210	031282	031082	1	-	-	-
050003668211	040282	032982	2	5	1	TECHNICAL SPECIFICATION 6.8.1, REQUIRES THAT WRITTEN PROCEDURES BE ESTABLISHED, IMPLEMENTED AND MAINTAINED COVERING THE APPLICABLE PROCEDURES RECOMMENDED IN APPENDIX "A" OF REGULATORY GUIDE 1.33. REGULATORY GUIDE 1.33, APPENDIX "A" STATES IN PART THAT RADIATION PROTECTION PROCEDURES SHOULD BE PROVIDED. PROCEDURE HNP-8005, REVISION 12, SECTION I, RADIATION OCCURRENCE REPORTS, PARAGRAPH 1.(B)(2) REQUIRES ACTION TO BE TAKEN TO ENSURE THE REPORTED EVENT DOES NOT RECUR. CONTRARY TO THE ABOVE, RADIATION PROTECTION PROCEDURES WERE NOT ESTABLISHED, IMPLEMENTED AND MAINTAINED IN THAT THE ACTION DESIGNATED TO CORRECT MISUSE OF PERSONNEL DOSIMETRY BY AN INDIVIDUAL ON NOVEMBER 3, 1981, WAS NOT PERFORMED. SPECIFICALLY, THE PRESCRIBED NOTIFICATION OF ALL EMPLOYEES ON OCCURRENCE REPORT 81-19A WAS NOT PERFORMED.
050003668212	032082	030282	1	-	-	-
050003668213	050482	042882	1	-	-	-
050003668214	042082	032182	1	-	-	-
050003668215	050582	050482	2	3	1	FAILURE TO CONTROL ACCESS TO THE PROTECTED AREA.
050003668216	060482	060182	1	-	-	-
050003668217	051382	041982	1	-	-	-
050003668219	052582	042182	1	-	-	-
050003668220	062182	052682	2	4	1	FAILURE TO RECOGNIZE LCO CONDITION ON "A" RESIDUAL HEAT REMOVAL TRAIN AND HALT FUEL LOADING IN ACCORDANCE WITH TECHNICAL SPECIFICATION 3.9.12.A.
050003668221	072382	072182	1	-	-	-
050003668222	073082	072682	2	4	1	FAILURE TO PROVIDE QA INDOCTRINATION TO ALL NON QA

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050003668222	073082	072682	2	4	1	PERSONNEL AND FAILURE TO PROVIDE SPECIALIZED INSTRUCTION TO PLANT OPERATORS, MAINTENANCE PERSONNEL, TEST PERSONNEL, QC AND HEALTH PHYSICS PERSONNEL IN THEIR AREAS OF QA PROGRAM IMPLEMENTATION AS REQUIRED BY 10CFR50, APPENDIX B, CRITERION II AND THE LICENSEE'S ACCEPTED QA PROGRAM. FAILURE TO PROVIDE A SCHEDULED PREPLANNED LECTURE SERIES BASED ON EVALUATION OF ANNUAL WRITTEN LICENSED OPERATOR EXAMINATION AS REQUIRED BY 10CFR55, APPENDIX A.
050003668223	072282	071882	1	-	-	-
050003668224	072682	062282	2	4	1	FAILURE TO POST FIRE WATCHES FOR AN EXTENDED PERIOD IN ACCORDANCE WITH TECHNICAL SPECIFICATION REQUIREMENTS WHEN INADEQUATE FIRE BARRIERS WERE FOUND TO EXIST.
050003668225	081382	080982	1	-	-	-
050003668226	082782	072782	1	-	-	-
050003668227	090382	083082	1	-	-	-
050003668228	100182	092882	1	-	-	-
050003668229	092382	092082	1	-	-	-
050003668230	092882	082882	2	5	1	FAILURE OF LICENSEE PERSONNEL TO PROPERLY FRISK WHEN ENTERING THE CONTROL ROOM. INSPECTOR FOUND FRISKER TURNED OFF AND UNPLUGGED. FAILURE TO NOTIFY NRC WITHIN 1 HOUR AS REQUIRED BY 50.72 ON INOPERABLE SBGT SYSTEMS ON UNIT 1 AND ECCS ACTUATIONS ON UNIT 2 (TWO EXAMPLES).
050003668231	102982	102582	1	-	-	-
050003668232	110582	110182	1	-	-	-
050003668233	102882	092882	2	4	1	INADEQUATE SURVEILLANCE PROCEDURES. LOGIC TESTS ON HPCI, RCIC, ADS, RPS, SBGT, CS, PCIS AND CONTAINMENT PURGE AND INERTING SYSTEMS WERE FOUND NOT TO BE COMPLETE FROM SENSOR TO ACTIVATED DEVICE AS REQUIRED BY TECHNICAL SPECIFICATIONS.
050003668234	120682	113082	4	4	1	ENVIRONMENTAL TECHNICAL SPECIFICATION 5.3.2.2 REQU

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050003668234	120682	113082	4	4	1	IRES THAT AUDITS OF FACILITY ACTIVITIES SHALL BE P ERFORMED AT LEAST ONCE A YEAR UNDER THE COGNIZANCE OF THE SRB TO ENSURE CONFORMANCE OF FACILITY OPER ATION OF ALL PROVISIONS OF THE ENVIRONMENTAL TECHN ICAL SPECIFICATIONS (ETS). ETS-3.2, TABLE 3.2-1, SPECIFIES THE PERFORMANCE OF AN ANALYTICAL PROGRAM . CONTRARY TO THE ABOVE, AUDITS OF THE ANALYTICAL PROGRAM WERE NOT PERFORMED IN 1980, 1981, AND 198 2, THROUGH DECEMBER 6, 1982.
050003668234	120682	113082	4	D		OCOM-IN A LETTER DATED DECEMBER 30, 1982, NRC REGI ON II ISSUED A NOTICE OF VIOLATION TO THE GEORGIA POWER COMPANY. THE NOTICE IDENTIFIED A VIOLATION OF ENVIRONMENTAL TECHNICAL SPECIFICATION 5.3.2.2, DISCLOSED DURING NRC INSPECTION NOS. 50-321/81-24 AND 50-366/81-24, FOR HAVING FAILED TO CONDUCT AUD ITS OF ITS ANALYTICAL PROGRAM. GEORGIA POWER COMP ANY RESPONDED TO THE NRC CITATION IN A LETTER DATE D DECEMBER 30, 1981, DESCRIBING CERTAIN CORRECTIVE AND PREVENTIVE ACTION TAKEN OR PLANNED. THE FOLL OWING STATEMENT WAS INCLUDED IN THIS LETTER: BY A PRIL 1, 1982, GEORGIA POWER COMPANY WILL DEVELOP A PROGRAM TO PROVIDE FOR ANNUAL QA AUDITS OF CONTRA CTOR ACTIVITIES RELATED TO THE ENVIRONMENTAL MONIT ORING. IMPLEMENTATION OF THIS PROGRAM WILL BEGIN IN APRIL 1982. CONTRARY TO THE ABOVE, AS OF DECEM BER 6, 1982, THE LICENSEE HAD NOT DEVELOPED A PROG RAM TO PROVIDE FOR ANNUAL QA AUDITS OF CONTRACTOR ACTIVITIES RELATED TO THE ENVIRONMENTAL MONITORING .
050003668235	111982	111682	1	-	-	-
050003668236	111982	111682	1	-	-	-
50003668237	112082	102882	2	5	1	FAILURE TO FOLLOW PROCEDURE. VALVE LINEUP FOR RHR SERVICE WATER STRAINER VALVES 2E11-F116B AND 2E11 -F117B WAS IMPROPER IN THAT BOTH VALVES SHOULD HAV E BEEN LOCKED SHUT BUT F116B WAS UNLOCKED AND F117 B WAS OPEN.
050003668238	111982	111582	1	-	-	-
050003668239	121082	120682	1	-	-	-
050003668240	121582	121382	2	4	1	CONTRARY TO 10CFR50, APPENDIX "B", CRITERION XVI A

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050003668240	121582	121382	2	4	1	ND I, AND THE ACCEPTED QA PROGRAM (FSAR 17.2.16 AN D 17.2.1), THE QA DEPARTMENT DOES NOT EFFECTIVELY ASSURE CONFORMANCE TO QUALITY STANDARDS IN THAT IT DOES NOT ASSURE PROMPT CORRECTION OF CONDITIONS A DVERSE TO QUALITY. SPECIFICALLY ONE ITEM WIRTTEN IN 1978, TWO ITEMS WRITTEN IN 1979, SEVEN ITEMS WR ITTEN IN 1980 AND SEVEN ITEMS WRITTEN IN 1981 STIL L REMAIN OPEN. ALL THESE ITEMS WERE IDENTIFIED BY THEIR QA AUDIT SYSTEM.
						CONTRARY TO 10CFR50, APPENDIX "B", CRITERION V, TH E ACCEPTED QA PROGRAM (FSAR 17.2.5) AND LICENSEE P ROCEDURES QA-05-06 AND QA-05-01, SIX AUDIT FINDING S WERE NOT RESPONDED TO WITHIN THE REQUIRED 30 DAY TIME PERIOD.
050003668240	121582	121382	2	5	1	CONTRARY TO THE ACCEPTED QA PROGRAMS, ENDORSEMENT OF ANSI N 45.2.23, THE LICENSEE DID NOT UPDATE QU ALIFICATIONS OF 4 OF 5 LEAD AUDITORS ANNUALLY.
050003668241	121982	112082	1	-	-	-
050003668301	012183	011883	1	-	-	-
050003668302	012183	122082	2	5	1	IMPROPER REPORTING OF LOW FIRE SUPPRESSION WATER S YSTEM TANK LEVELS. THE REQUIRED 24 HOUR TELEPHONE REPORT OF TECHNICAL SPECIFICATION 3.7.6.1 WAS NOT MADE WHEN FIRE SUPPRESSION WATER SYSTEM TANKS FEL L BELOW TECHNICAL SPECIFICATION LIMITS.
050003668303	020383	012983	1	-	-	-
050003668304	021183	020783	2	5	1	CONTRARY TO 10CFR50.72(A)(1), THE LICENSEE DID NOT NOTIFY THE NRC OPERATIONS CENTER WITHIN ONE HOUR FOLLOWING A LIQUID RELEASE OF I-131 FROM CHEMICAL WASTE SAMPLE TASK "A" WHICH EXCEEDED TECHNICAL SPE CIFICATIONS AND 10CFR20, APPENDIX "B", TABLE II, C OLUMN 2, LIMITS. THE RELEASE CONCENTRATION WAS 8. 5X10-7 MICROCURIES PER MILLILITER; THE LIMIT IS 3. 0X10-7 MICROCURIES PER MILLILITER. A 30-DAY LER W AS SUBMITTED AS REQUIRED BY TECHNICAL SPECIFICATIO NS.
050003668305	022583	022283	1	-	-	-
050003668306	103182	070181	1	-	-	-

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050003668307	022683	012283	1	-	-	-
050003668308	032583	031483	2	4	1	10CFR50, APPENDIX "B", CRITERION V, AS IMPLEMENTED BY FSAR SECTION 17.2.5, REQUIRES THE LICENSEE TO ACCOMPLISH ACTIVITIES AFFECTING QUALITY IN ACCORDANCE WITH PRESCRIBED PROCEDURES. CONTRARY TO THE ABOVE, THE LICENSEE DID NOT REVISE PROCEDURE HNP-2-3801, REV. 17, IN ACCORDANCE WITH THE REQUIREMENTS OF THE PRESCRIBED PROCEDURE, PROCEDURE HNP-9. PROCEDURE WRITING, USE AND CONTROL", REQUIRED THAT ALL REVISIONS TO A PROCEDURE BE ENTERED ON A "PROCEDURE REVISION REQUEST FORM" INDICATING THE REASON FOR THE PROPOSED CHANGE. HOWEVER, STANDBY DIESEL SERVICE WATER PUMP VIBRATION ACCEPTANCE CRITERIA WERE CHANGED IN PROCEDURE HNP-2-3801, REV. 17, WITHOUT ENTERING THE REASON ON A PROCEDURE REVISION REQUEST FORM.
050003668309	032583	031483	2	3	1	10CFR50, APPENDIX "B", CRITERIA V, X AND XVIII, AS IMPLEMENTED BY HATCH'S SAR SECTION 17.2.5, 17.2.10 AND 17.2.18, REQUIRE ACTIVITIES AFFECTING QUALITY ARE PRESCRIBED BY DOCUMENTED INSTRUCTIONS, ACTIVITIES CONCERNING SAFETY-RELATED SYSTEMS BE INSPECTED TO VERIFY CONFORMANCE WITH DOCUMENTED INSTRUCTIONS AND DRAWINGS, AND AUDITS ARE TO BE PERFORMED TO VERIFY COMPLIANCE WITH APPLICABLE REGULATIONS AND LICENSE REQUIREMENTS. CONTRARY TO THE ABOVE, THE ADMINISTRATIVE AND MANAGERIAL CONTROL SYSTEMS IN EFFECT IN THE AREAS OF PROCEDURES INSPECTIONS, AND AUDITS WITH REGARD TO RESTORATION OF CABLE TRAY SYSTEMS TO DESIGN STANDARDS AFTER REPAIRS AND/OR MODIFICATIONS ARE INADEQUATE IN THAT MANY CABLE TRAY DISCREPANCIES (SUCH AS, CABLE TRAY COVERS REMOVED, KAOWOOL AND FIRE STOPS IN TRAY SYSTEMS REMOVED, AND CABLE TRAY HOLD DOWN CLAMPS MADE INEFFECTIVE) EXIST THROUGH OUT THE PLANT. THESE ADMINISTRATIVE AND MANAGERIAL CONTROL SYSTEMS HAVE BEEN INEFFECTIVE IN THAT DOCUMENTATION FOR TRACKING PURPOSES AND SUBSEQUENT RESOLUTION FOR THESE CABLE TRAY DISCREPANCIES DO NOT EXIST.
050003668310	032683	022783	1	-	-	-
050003668311	041583	041183	1	-	-	-
050003668312	042883	042483	2	4	1	FAILURE TO IDENTIFY INDIVIDUALS ENTERING THE PA, U

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050003668312	042883	042483	2	4	1	NAUTHORIZED INDIVIDUALS WITHIN THE PA AND ESCORT U NABLE TO MAINTAIN CONTACT.
050003668313	042383	032683	1	-	-	-
050003668314	050583	042683	1	-	-	-
050003668315	052083	042483	1	-	-	-
050003668316	060883	060683	2	5	1	TECHNICAL SPECIFICATION 6.8.1.C, REQUIRES THAT PRO CEDURES BE IMPLEMENTED FOR SURVEILLANCE OF SAFETY-RELATED EQUIPMENT. PARAGRAPH G OF THE APPLICABLE PROCEDURE FOR TECHNICAL SPECIFICATION REQUIREMENTS 4.4.8, REQUIRES IN PART THAT, FOR FLAW INDICATION S FOUND DURING INSERVICE INSPECTION AND REPORTED O N AN INDICATION NOTIFICATION FORM, SUFFICIENT NOND ESTRUCTIVE TEST EXPERTISE ADEQUATELY RESOLVE NECES SARY REPAIR WORK TO ELIMINATE THE FLAW INDICATION OR PROVE INSIGNIFICANT THE SOURCE OF THE INDICATIO N. CONTRARY TO THE ABOVE, ON APRIL 28, 1982, PRO EDURE HNP-904 WAS NOT PROPERLY IMPLEMENTED IN THAT THE LIQUID PENETRANT INSPECTION FOR WELD 2E11-1RH -20-RS-1BC/2G21-1RWCU-6D-1 WAS ACCEPTED WITHOUT NE CESSARY REPAIR WORK TO ELIMINATE OR PROVE INSIGNIF ICANT ROUGH CONDITIONS IN THE WELD EDGES WHICH HEL D EXCESS PENETRANT POSSIBLY MASKING SIGNIFICANT IN DICATIONS.
050003668317	052783	052383	2	4	1	10CFR20.301, SPECIFIES AUTHORIZED METHODS FOR DISP OSAL OF LICENSED MATERIAL AND PROHIBITS DISPOSAL B Y OTHER MEANS. ONE AUTHORIZED METHOD IS BY TRANSF ER TO AN AUTHORIZED RECIPIENT PURSUANT TO THE SPEC IFIC LICENSE REQUIREMENTS OF THE RECIPIENT. CONTR ARY TO THE ABOVE, ON MARCH 22, 1983, THE LICENSEE DISPOSED OF NINE, NINETY-SIX CUBIC FOOT METAL BOXE S OF COMPACTED RADIOACTIVE WASTE, BY TRANSFER FOR LAND BURIAL TO CHEM-NUCLEAR SYSTEMS, INC., WHOSE S OUTH CAROLINA LICENSE (NO. 097) DOES NOT AUTHORIZE RECEIPT OF LIQUID WASTE FOR LAND BURIAL. ONE BOX (HNP-83-321) CONTAINED APPROXIMATELY FIVE QUARTS OF FREE STANDING LIQUID.
050003668318	062083	052083	1	-	-	-
050003668319	070883	070583	1	-	-	-

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050003668320	072083	062183	2	5	1	10CFR50, APPENDIX B, CRITERION V, AS IMPLEMENTED BY THE HATCH UNIT 2 FSAR, PARAGRAPH 17.2.5 REQUIRES THAT ACTIVITIES AFFECTING QUALITY SHALL BE ACCOMPLISHED IN ACCORDANCE WITH DOCUMENTED INSTRUCTIONS, PROCEDURES, OR DRAWINGS. ADDITIONALLY, HATCH UNIT 2 FSAR, PARAGRAPH 8.3.1.5 AND HATCH UNIT 2 PROCEDURE HNP-6921 REQUIRE THAT ELECTRICAL CABLES BE COLOR CODED AT APPROXIMATELY 10 FOOT INTERVALS. CONTRARY TO THE ABOVE, PROCEDURES WERE NOT FOLLOWED IN THAT SEVERAL CABLES LOCATED IN WEST CABLEWAY TRAYS, NUMBERS ESS-I 2MB5297 AND 8, AND ESS-I 2ABA7-01 2343 NOT COLOR CODED.
0003668322	081283	080883	2	4	1	10CFR20.201(B) REQUIRES THE LICENSEE TO PERFORM SURVEYS AS NECESSARY TO DEMONSTRATE COMPLIANCE WITH 10CFR20.106 WHICH LIMITS THE RELEASE OF RADIOACTIVITY IN UNRESTRICTED AREAS TO CONCENTRATIONS IN APPENDIX B, TABLE II AND TO EVALUATE THE EXTENT OF RADIATION HAZARDS THAT MAY BE PRESENT. CONTRARY TO THE ABOVE, FAILURE TO PROPERLY EVALUATE AND TAKE CORRECTIVE ACTION IN REGARD TO A SYSTEMATIC CONCENTRATIONS IN GROUNDWATER SAMPLES COLLECTED DURING AN AUGUST 1982 SAMPLING OF MONITORING WELLS. THIS FAILURE RESULTED IN AN OVERSTATEMENT OF TRITIUM CONENTRATIONS IN THE GROUND WATER.
050003668323	071683	071483	2	2	1	TECHNICAL SPECIFICATION 6.8.1 STATES THAT PROCEDURES SHALL BE WRITTEN, APPROVED AND IMPLEMENTED FOR REACTOR OPERATIONS. CONTRARY TO THE ABOVE, ON JULY 14, 1983, CONTROL ROD MANIPULATIONS WERE CONDUCTED IN VIOLAITON OF WRITTEN AND APPROVED PROCEDURES, RESULTING IN CONTROL ROD PATTERNS OUTSIDE THOSE ANALYZED FOR THE ROD DROP ACCIDENT DESCRIBED IN FSAR CHAPTER 15.1.38. THESE MANIPULATIONS WERE IMPROPERLY ACCOMPLISHED BY SCRAMMING CONTROL RODS FROM THE SCRAM TIME TEST PANEL (2H11-P610) AND INSERTING CONTROL RODS USING THE EMERGENCY IN SWITCH INSTEAD OF THE APPROVED PROCEDURAL METHOD OF INSERTING CONTROL RODS IN NOTCH CONTROL FORM THE MAIN CONTROL PANEL (2H11-P603). TECHNICAL SPECIFICATION 3.1.4.1 REQUIRES THE ROD WORTH MINIMIZER (RWM) TO BE OPERABLE OR A SECOND LICENSED OPERATOR OR OTHER QUALIFIED MEMBER OF THE TECHNICAL STAFF TO BE PRESENT AT THE REACTOR CONSOLE TO VERIFY COMPLIANCE WITH THE PRESCRIBED CONTROL ROD PATTERN. CONTRARY TO THE ABOVE, ON JULY 14,

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050003668323	071683	071483	2	2	1	1983, AFTER BYPASSING THE RWM, A SECOND PERSON DID NOT VERIFY COMPLIANCE WITH THE PRESCRIBED ROD PATTERN. AS A CONSEQUENCE, THE ROD INSERTION SEQUENCE WAS VIOLATED AS EVIDENCED BY CONTROL ROD 42-39 AT NOTCH 12 VERSUS THE REQUIRED NOTCH 48. TECHNICAL SPECIFICATION 3.1.4.2 REQUIRES THAT THE ROD SEQUENCE CONTROL SYSTEM (RSCS) BE OPERABLE IN OPERATION CONDITION 1 WHEN THERMAL POWER IS BELOW 20%. CONTRARY TO THE ABOVE, ON JULY 14, 1983, WHILE IN OPERATION CONDITION 1, WITH THERMAL POWER BELOW 20%, THE RSCS WAS NOT OPERATIONAL IN THAT IT WAS NOT PERFORMING ITS INTENDED FUNCTION OF NOTCH CONTROL. THE REQUIRED NOTCH CONTROL WAS CIRCUMVENTED BY USE OF THE EMERGENCY IN SWITCH AND THE SCRAM SWITCHES ON THE SCRAM TIME TEST PANEL.
050003668324	080583	080283	1	-	-	-
050003668325	081983	081783	1	-	-	-
050003668327	081083	081083	1	-	-	-
050003668328	093083	092683	1	-	-	-
050003668329	093083	082083	2	4	1	TECHNICAL SPECIFICATION 6.5.1.6.A REQUIRES THAT THE PLANT REVIEW BOARD (PRB) SHALL BE RESPONSIBLE FOR REVIEW OF ALL PROCEDURES REQUIRED BY TECHNICAL SPECIFICATION 6.8 AND CHANGES THERETO. TECHNICAL SPECIFICATION 4.5.2 REQUIRES THAT THE AUTOMATIC DEPRESSURIZING SYSTEM (ADS) SHALL BE DEMONSTRATED OPERABLE BY MANUALLY OPENING EACH ADS VALVE AND OBSERVING THAT EITHER; (1) THE CONTROL VALVE OR BYPASS VALVE POSITION RESPONDS ACCORDINGLY, OR (2) THERE IS A CORRESPONDENCE CHANGE IN THE MEASURED STEAM FLOW. CONTRARY TO THE ABOVE, FROM APRIL 1, 1982, UNTIL JULY 8, 1983, THE TECHNICAL SPECIFICATION REQUIRED METHOD FOR ADS OPERATION VERIFICATION WAS NOT USED. THE PROCEDURE DID PROVE OPERABILITY BY TAILPIPE PRESSURE SENSORS TO INDICATE OPENING OF THE RELIEF VALVE; HOWEVER, THE TECHNICAL SPECIFICATIONS DO NOT RECOGNIZE THIS METHOD. ON APRIL 1, 1982, THE PRB APPROVED A CHANGE TO PROCEDURE HNP-2-3901 (REV. 7) THAT DELETED THE TECHNICAL SPECIFICATION REQUIRED METHOD FOR ADS OPERABILITY VERIFICATION AND SUBSTITUTED ANOTHER METHOD FOR VERIFICATION. ON SEPTEMBER 7, 1982 (REV. 8), AUGUST 10, 1982 (RE

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050003668329	093083	082083	2	4	1	V. 9), OCTOBER 4, 1982 (REV. 10), AND ON JUNE 14, 1983 (REV. 11, A GENERAL REVISION OF THE PROCEDURE), THE PRB APPROVED THE PROCEDURE WITHOUT THE REQU IRED METHOD OF ADS VERIFICATION.
050003668330	093083	092683	1	-	-	-
050003668331	101483	101183	1	-	-	-
050003668332	103183	100183	1	-	-	-
050003668333	111883	111483	1	-	-	-
050003668335	120183	112983	1	-	-	-
050003668337	121683	121383	1	-	-	-
050003668338	121683	112183	2	-	-	-
050003668339	122283	121983	1	-	-	-