



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

Report Nos.: 50-321/85-22 and 50-366/85-22

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

Docket Nos.: 50-321 and 50-366

License Nos.: DPR-57 and NPF-5

Facility Name: Hatch 1 and 2

Inspection Dates: June 29 - July 26, 1985

Inspection at Hatch site near Baxley, Georgia

Inspectors: <u><i>P. Holmes-Ray</i></u> P. Holmes-Ray, Senior Resident Inspector	<u>8/13/85</u> Date Signed
<u><i>G. Neffelt</i></u> G. Neffelt, Resident Inspector	<u>8/13/85</u> Date Signed
Approved by: <u><i>V. W. Panciera</i></u> V. W. Panciera, Chief, Project Section 2B Division of Reactor Projects	<u>8/13/85</u> Date Signed

SUMMARY

Scope: This inspection involved 179 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: (References listed improperly in safety-related calibration procedures, Paragraph 10; and valve internal parts found missing from a safety system valve, Paragraph 9).

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 QA Manager
- *S. B. Tipps, Superintendent of Regulatory Compliance

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

*Attended exit interview

2. Exit Interview

The inspection scope and findings were summarized on July 26, 1985, with those persons indicated in paragraph 1 above. During the reporting period frequent discussions were held with the General Manager and/or his assistants concerning inspection findings. The licensee acknowledged the findings and took no exception. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspector during this inspection.

3. Licensee Action on Previous Inspection 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 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 1 core spray (CS) system to verify that the lineups were in accordance with licensee requirements for operability and equipment material conditions were satisfactory.

On July 15, 1985, during the walkdown of the Unit 1, train "A", CS system, it was noted by the resident inspector that the southeast diagonal, lowest level (87'), was in a poor state of housekeeping. This radiological area with surface contamination (which required a radiation work permit for entry) had equipment, paper, protective clothing, and used plastic left on the floor. There was also about 1/8 to 1/2 - inches of water covering a portion of the floor and a floor drain. The source of this water was not known. A supervisor from health-physics was notified of this condition and he took action to get the area cleaned up:

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

6. Plant Operations Review (Units 1 and 2)

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

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

7. Technical Specification Compliance (Units 1 and 2)

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

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 the proper condition, that access control and badging was proper, and procedures were followed.

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

9. Review of Nonroutine Events Reported by the Licensee

The following Licensee Event Reports (LERs) were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events which were reported immediately were also reviewed as they occurred to determine that Technical Specifications were being met and that the public health and safety were of utmost consideration. The following LER was considered closed:

Unit 2: 85-10, Rev. 1*

*In-depth review performed.

In 1984, as part of the Unit 2 outage, residual heat removal (RHR) system check valve 2E11-F050B and its bypass valve 2E11-F122B were removed from the system and the check valve replaced. The bypass valve was welded in place on June 15, 1984, and the actuator was installed on June 26, 1984. On July 6, 1984, the check valve was leak tested with the valve lineup signed off showing the bypass valve shut. No leakage was observed. On April 10, 1985, the check valve failed local leak rate testing and the bypass valve was disassembled to aid in leak path determination. At this time the internal parts were found to be missing. There is no record of any maintenance having been performed since the 1984 outage. The conclusion reached is that the valve internals were left out in 1984 and the leak test of the check valve was accomplished with the bypass valve gaged. No record of a maintenance work order (MWO) to remove the operator and internals for the purpose of gaging the bypass valve for the leak test of the newly installed check valve were found. This failure to return the RHR system to its design configuration after maintenance is a violation (366/85-22-01).

10. Procedure Review

During the review of a safety-related calibration procedure (HNP-1-5261, Revision 16, Agastat Timing Relay Calibration) the Resident Inspector was unable to obtain the vendor technical manual from the site document control room using the information provided in the procedure. The licensee was informed of this difficulty and eventually located the vendor technical manual in question in the document control room after a three hour search. The particular problem in this instance was that a unique document control

number was not generated when an additional binder was added to contain newer vendor technical manuals.

Based on the problem encountered locating vendor technical manuals, nine other safety-related calibration procedures were randomly selected. Of these, four vendor technical manuals had similar discrepancies, which were:

<u>Procedure Number</u>	<u>Title</u>	<u>Comment</u>
HNP-1-5251	General Electric Type Self Synchronizing Manual/Automatic Transfer Station	Section G of the procedure cited "S-19238" and procedure reference section cited "S-19239, GEK 9690, Vol X, Part 4." The correct document reference number is "S-19239B, GEK 9690, Vol. X, Part 4A."
HNP-2-5251	(same as above)	Section G of the procedure cited "SX-29461" incorrectly as the document reference number for the vendor technical manual.
HNP-2-5255	General Electric 562 Limiter Calibration	Section G of the procedure cited "S-30698, GEK 9690, Vol. X, Part 3, Signal Conditioners, Tab 5. The correct document reference number is "S-19238, GEK 9690, Vol. X, Part 3, Signal Conditioners, Tab 5."
HNP-2-5273	Model 195-4 Mercoid Level Switch	Section H of the procedure cited "SX-29451, GEK 45778, Vol. X, Part 3, Switches, Tab 7" and the procedure reference section cited "Part 2" for this document reference number. The correct document reference number is "S-30698, GEK 45778, Vol. X, Part 3, Switches, Tab 6."

Therefore, five of the ten vendor technical manuals cited in the safety-related calibration procedures sampled were incorrect. However, this problem appeared to be strictly administrative, because the resident inspector observed that a calibration technician was able to readily locate these technical vendor manuals based on his familiarity with the equipment,

except for the technical vendor manual cited in HNP-1-5261, which was discussed above.

The licensee had previously identified in an internal QA audit letter dated February 19, 1981, that five out of ten calibration procedures had not included a required reference or had an improper reference listed. This QA item was closed out June 9, 1983, by the licensee.

Also, it was noted that the title of HNP-1-5273, Revision 6, "Model 1951-4EV Mercoid and SL400 Robertshaw Level Switch," was for the Model 1951-4EV Mercoid Level Switch and did not apply to the SL400 Robertshaw Level Switch.

This lack of administrative control of technical vendor manuals, which were used in safety-related calibration procedures, is a violation (50-321, 366/85-22-02).