

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE C J 11		CAUSE CODE A 12		CAUSE SUBCODE D 13		COMPONENT CODE Z Z Z Z Z Z 14						COMP. SUBCODE Z 15		VALVE SUBCODE Z 16			
LER/RO REPORT NUMBER 8 1 17		EVENT YEAR 8 1 21 22		SEQUENTIAL REPORT NO. 0 0 7 24 26		OCCURRENCE CODE / 27		REPORT TYPE L 30		REVISION NO. 0 32							
ACTION TAKEN H 18		FUTURE ACTION Z 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 22 37 40		ATTACHMENT SUBMITTED Y 23 41		NPRD-4 FORM SUB. N 24 42		PRIME COMP. SUPPLIER Z 25 43		COMPONENT MANUFACTURER Z 9 9 9 26 44 47	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of these two events has been attributed to a lack of com-
11 munication among personnel who collect and analyze reactor coolant.
12 These persons have been instructed on the proper location for reactor
13 coolant sampling. Reactor coolant was sampled on 1/26/81 and found
14 that no limits were exceeded.

FACILITY STATUS		% POWER		OTHER STATUS		METHOD OF DISCOVERY		DISCOVERY DESCRIPTION	
1	5	H	0	0	0	N/A			Laboratory Observation
7	8	9	10	11	12	13	14	15	16
ACTIVITY CONTENT		RELEASED OF RELEASE		AMOUNT OF ACTIVITY				LOCATION OF RELEASE	
1	6	2	2	N/A					N/A
7	8	9	10	11	12	13	14	15	16
PERSONNEL EXPOSURES		NUMBER		TYPE		DESCRIPTION			
1	7	0	0	0	2	N/A			
7	8	9	10	11	12	13	14	15	16
PERSONNEL INJURIES		NUMBER		DESCRIPTION					
1	8	0	0	0	N/A				
7	8	9	10	11	12	13	14	15	16
LOSS OF OR DAMAGE TO FACILITY		TYPE		DESCRIPTION					
1	9	2	N/A						
7	8	9	10	11	12	13	14	15	16
PUBLICITY		ISSUED		DESCRIPTION				NRC USE ONLY	
2	0	N	N/A						
7	8	9	10	11	12	13	14	15	16

NAME OF PREPARER

W.H. Rogers	Health Physics Superintendent
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PHONE: 912-367-7781

LER # 50-366/1981-007
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

NARRATIVE REPORT FOR LER 50-366/1981-007

On January 24th and 25th, 1981 while the unit was in cold shutdown the reactor coolant sample was taken from the fuel pool sample line. The technician taking the sample was filling in on the weekend for the technician that normally takes the samples. No communication occurred between the 2 technicians. The supervisor on duty was aware that the sample location had changed from the fuel pool to the RHR loop that was in service for the reactor vessel. The normal sample point, the reactor coolant sample line, was out of service. The reactor water clean up system was not in service so a sample could not be taken from either. Several days earlier the RHR loop had been started up and the fuel was being transferred from the fuel pool to the reactor vessel. When all fuel is in the fuel pool, reactor coolant samples are taken from the fuel pool sample lines. The last time the technician had sampled for reactor coolant he had taken the sample from the fuel pool sample lines which was correct at that time.

The samples were taken without incident and the data reviewed. During the ensuing conversation the technician noted the sample came from the fuel pool not the RHR loop. As a result the sample was pulled from the RHR loop on January 26, 1981 and no limits were exceeded. There were 2 violations of section 4.4.4.c because the conductivity was not checked every 24 hours which is required when the continuous recording conductivity monitor is inoperable. There were no effects upon public health and safety due to this event.

No previous LER has been issued for this violation on Unit 2 although several have been issued on Unit 1. This series of events has never occurred before and the persons involved have been re-instructed on proper communications, its value and effectiveness.