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HL-1313
1130

October 1, 1990

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

PLANT HATCH - UNIT 1
NRC DOCKET 50-321
OPERATING LICENSE DPR-57
LICENSEE EVENT REPORT
PERSONNEL ERROR RESULTS IN INADEQUATE
PROCEDURE AND MISSED TECHNICAL SPECIFICATION SURVEILLANCE

Gentlemen:

In accordance with the requirements of 10 CFR 50.73(a)(2)(i), Georgia Power Company is submitting the enclosed Licensee Event Report (LER) concerning personnel error which resulted in an inadequate procedure and missed Technical Specification surveillances. This event occurred at Plant Hatch - Unit 1.

Sincerely,

W. G. Hairston, III

JKB/eb

Enclosure: LER 50-321/1990-018

c: (See next page.)

IE22
1/1

c: Georgia Power Company
Mr. H. L. Sumner, General Manager - Nuclear Plant
Mr. J. D. Heidt, Manager Engineering and Licensing - Hatch
NORMS

U.S. Nuclear Regulatory Commission, Washington, D.C.
Mr. F. Rinaldi, Acting Licensing Project Manager - Hatch

U.S. Nuclear Regulatory Commission, Region II
Mr. S. D. Ebneter, Regional Administrator
Mr. L. D. Wert, Senior Resident Inspector - Hatch

NRC Form 366 (9-83) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
PLANT HATCH, UNIT 1	0 5 0 0 0 3 2 1	1 OF 5

TITLE (4)
PERSONNEL ERROR RESULTS IN INADEQUATE PROCEDURE AND MISSED TECHNICAL SPECIFICATION SURVEILLANCE

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQ NUM	REV	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
										0 5 0 0 0
0 9	0 7	9 0	9 0	0 1 8	0 0	1 0	0 1	9 0		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)					
POWER LEVEL	1 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)		
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)		
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below)		
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)			
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)			
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)			

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
S. B. Tipps, Nuclear Safety & Compliance Manager	912	367-7851

COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (16)

On 9/7/90, at approximately 1115 CDT, Unit 1 was in the Run mode at approximately 2436 CMWT (approximately 100 percent of rated thermal power) when non-licensed personnel determined Procedure 34SV-SUV-019-1S, "Surveillance Checks," did not adequately implement the requirements of Unit 1 Technical Specifications Tables 3.2-11 and 4.2-11, items 12 and 15. Specifically, the procedure did not include an instrument check for the Post LOCA Radiation and the Drywell High Range Radiation Monitoring Systems' (EIIS Code IP) recorders. The procedure did, however, include an instrument check of the indicators which provide direct input to the recorders. Upon discovery of the event, an instrument check of the recorders was satisfactorily performed. Procedure 34SV-SUV-019-1S was temporarily revised to include the recorder instrument checks. The deficiency was noted during an ongoing validation of the Commitment Matrix Tracking System.

The cause of the event is personnel error on the part of non-licensed personnel. A procedure writer inadvertently deleted the instrument checks from the procedure in a revision made effective on 12/9/88. Also, during a technical review of the proposed revision, the reviewer failed to identify the error.

Corrective actions include permanently revising the procedure, counseling appropriate personnel, and reviewing the procedure for similar problems. No additional deficiencies were identified.

PLANT AND SYSTEM IDENTIFICATION

Boiling Water Reactor - General Electric
Energy Industry Identification System codes are identified in the text as (EIIS Code XX).

SUMMARY OF EVENT

On 9/7/90, at approximately 1115 CDT, Unit 1 was in the Run mode at approximately 2436 CMWT (approximately 100 percent of rated thermal power) when non-licensed personnel determined Procedure 34SV-SUV-019-1S, "Surveillance Checks," did not adequately implement the requirements of Unit 1 Technical Specifications Tables 3.2-11 and 4.2-11, items 12 and 15. Specifically, the procedure did not include an instrument check for the Post LOCA Radiation and the Drywell High Range Radiation Monitoring Systems' (EIIS Code IP) recorders. The procedure did, however, include an instrument check of the indicators which provide direct input to the recorders. Upon discovery of the event, an instrument check of the recorders was satisfactorily performed. Procedure 34SV-SUV-019-1S was temporarily revised to include the recorder instrument checks. The deficiency was noted during an ongoing validation of the Commitment Matrix Tracking System.

The cause of the event is personnel error on the part of non-licensed personnel. A procedure writer inadvertently deleted the instrument checks from the procedure in a revision made effective on 12/9/88. Also, during a technical review of the proposed revision, the reviewer failed to identify the error.

Corrective actions include permanently revising the procedure, counseling appropriate personnel, and revieving the procedure for similar problems. No additional deficiencies were identified.

DESCRIPTION OF EVENT

On 9/7/90, non-licensed personnel determined Procedure 34SV-SUV-019-1S, "Surveillance Checks," did not fully implement the requirements of Unit 1 Technical Specifications, Tables 3.2-11 and 4.2-11, items 12 and 15. The deficiency was noted during an ongoing validation of the Commitment Matrix Tracking System in which the Technical Specifications are reviewed against the commitment tracking database to ensure each Technical Specifications requirement, as well as the procedure implementing the requirement, is included in the database. The Technical Specifications require that an instrument check be performed once per shift on the Post LOCA Radiation Monitoring System recorders and indicators (item 12) and on the Drywell High Range Radiation Monitoring System recorders and indicators (item 15). Procedure 34SV-SUV-019-1S required a once-per-shift instrument check on each of the indicators but not on the recorders. Specifically, an instrument check was not required to be performed on Post LOCA Radiation recorders 1D11-R622A and B, and the blue pen,

which is dedicated for the radiation parameter of Drywell High Range Radiation/Pressure recorders 1T48-R601A and B. (Procedure 34SV-SUV-019-1S does include an instrument check of the red pen, which is dedicated for the pressure parameter, of recorders 1T48-R601A and B on a once per shift basis).

Upon discovery, a deficiency card was written to document the condition, and procedure 34SV-SUV-019-1S was temporarily revised to include the instrument checks. The instrument checks were satisfactorily performed with no problems being noted.

CAUSE OF THE EVENT

One cause of the event is personnel error on the part of a non-licensed procedure writer. Prior to 12/9/88, Procedure 34GO-SUV-002-1S, "Surveillance Checks," (currently Procedure 345V-SUV-019-1S) contained requirements for performing instrument checks on recorders 1D11-R622A and B, and 1T48-R601A and B. Procedure 34GO-SUV-002-1S correctly specified the frequency and the Technical Specifications reference associated with these instrument checks. However, the upgraded version of the procedure (34SV-SUV-019-1S), which became effective on 12/9/88, did not contain the subject instrument checks. The instrument checks were inadvertently deleted by the procedure writer during the upgrade process.

A second cause of the event is cognitive personnel error on the part of a non-licensed Nuclear Safety and Compliance (NSAC) procedure reviewer. Proposed revisions are reviewed by NSAC personnel to ensure the associated Technical Specifications requirements are adequately addressed. NSAC personnel reviewed the proposed upgraded procedure against approximately 114 Technical Specifications requirements associated with the procedure. During this process, the reviewer verified that the proposed revision included an instrument check of the Post LOCA Radiation Monitoring System indicators and the Drywell High Range Radiation Monitoring System indicators, as required by items 12 and 15 of Unit 1 Technical Specifications Table 4.2-11. However, the reviewer did not realize associated LCO Table 3.2-11 contained operability requirements for the recorders, as well as the indicators. As a result, he did not identify the deficiency and, therefore, did not include an instrument check of the subject recorders.

REPORTABILITY AND SAFETY ASSESSMENT

This report is required pursuant to 10 CFR 50.73(a)(2)(i), because a condition existed which was prohibited by the Technical Specifications. Specifically, an instrument check required by items 12 and 15 of Unit 1 Technical Specifications Tables 3.2-11 and 4.2-11 was not being performed for recorders 1T48-R601A and B, and 1D11-R622A and B.

The Post LOCA Radiation Monitoring System and the Drywell High Range Radiation Monitoring System are redundant systems designed to provide information concerning primary containment radiation levels following an accident. Each of these systems is comprised of two redundant subsystems, each of which contains a detector(s), an indicator(s)/monitor(s), and a recorder. The indicators provide a direct input to the recorders. Because of the redundancy of the systems and their subsystems, drywell radiation levels can be obtained from four different indicators and/or four different recorders.

The purpose of an instrument check of the recorders is to ensure the recorders themselves (as opposed to the detector and indicator/monitor of the channel) are operating correctly, based on a qualitative assessment. A qualitative assessment of the remainder of the instrument channel (that is, the detector(s) and indicator(s)/monitor(s) for each channel) is accomplished via an instrument check of the indicator(s).

In this event, instrument checks of the indicators were being performed in accordance with Procedure 34SV-SUV-019-1S and on a once-per-shift basis, as required by the Technical Specifications. However, an instrument check of Post LOCA Radiation recorders 1D11-R622A and B, and the blue pen (i.e., the radiation parameter) of Drywell High Range Radiation recorders 1T48-R601A and B was not being performed on a once-per-shift basis, as required by the Technical Specifications.

Upon identification of the procedural deficiency and missed surveillance, an instrument check of the subject recorders was performed. The recorders were found to be operating satisfactorily.

Even though an instrument check of the subject instruments was not being performed in strict compliance with the Technical Specifications, Procedure 30AC-OPS-003-0S, "Plant Operations," requires that Control Room recorders be inspected once per shift to assess proper recorder chart operation, abnormal trends, and abnormal operating conditions. This inspection is in addition to the required Technical Specifications instrument checks of selected Control Room recorders. During this inspection, an abnormal indication or trend on Control Room recorders, which includes 1D11-R622A and B, and 1T48-R601A and B, would be reported per procedure to the Shift Supervisor and investigated accordingly. Any gross failures of the recorders would likely be identified during this inspection.

Based on the above information, it is concluded that this event had no adverse impact on nuclear safety. This analysis is applicable to all operating levels.

CORRECTIVE ACTIONS

Upon discovery of the missed surveillance, an instrument check of the recorders was satisfactorily performed.

Procedure 34SV-SUV-019-1S was temporarily revised on 9/7/90 to incorporate the once-per-shift recorder instrument checks. A permanent revision to the procedure will be made effective by 10/31/90.

A review of Procedure 34SV-SUV-019-1S was performed to ensure the instrument checks of indicators and recorders specified in Unit 1 Technical Specifications Tables 3.2-11 and 4.2-11 are adequately addressed in the procedure. No similar problems were noted in the review.

The procedure reviewer was counseled concerning attention to detail when performing reviews. The writer is no longer employed at Plant Hatch and, therefore, could not be counseled.

ADDITIONAL INFORMATION

No systems other than the Post LOCA Radiation Monitoring System and the Drywell High Range Radiation Monitoring System were affected by this event.

Previous similar events in which surveillance requirements of Technical Specifications were not adequately incorporated into plant procedures, resulting in a missed Technical Specifications surveillance, have occurred at Plant Hatch. These events were reported in the following Licensee Event Reports:

50-321/88-19	dated 1/18/89
50-321/89-05	dated 4/21/89
50-321/89-09	dated 9/21/89
50-321/89-11	dated 9/26/89
50-321/89-16	dated 11/30/89
50-321/90-02	dated 2/26/90
50-321/90-03	dated 3/12/90
50-321/90-14	dated 8/17/90
50-366/89-02	dated 3/14/89
50-366/89-06	dated 10/23/89
50-366/89-10	dated 1/2/90

It is noted that corrective actions stemming from a previous similar event should have identified the procedural deficiency. Specifically, corrective actions taken as the result of the event reported in LER 50-366/89-06, dated 10/23/89, included a review of Unit 1 Procedure 34SV-SUV-019-1S to determine whether discrepancies involving instrument checks found in the corresponding Unit 2 procedure also existed in the Unit 1 procedure. One of the discrepancies identified in the Unit 2 procedure was that an instrument check of the radiation parameter of Drywell High Range Pressure/Radiation recorders 2T48-R601A and B were not addressed. However, in performing the review of the Unit 1 procedure, non-licensed personnel overlooked this discrepancy. The individual who performed the review has been counseled concerning the need for attention to detail.