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> HL-1440 000195

January 15, 1991

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

> PLANT HATCH - UNIT 2 NRC DOCKET 50-366 OPERATING LICENSE NPF-5 LICENSEE EVENT REPORT PERSONNEL ERROR CAUSES PROCEDURAL INADEQUACY AND MISSED TECHNICAL SPECIFICATIONS 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 a condition which existed that was prohibited by the plant Technical Specifications. This event occurred at Plant Hatch - Unit 2.

Sincerely,

W.S. Hunt - It

W. G. Hairston, III

SWR/CT/rw

Enclosure: LER 50-366/1990-014

c: (See next page.)



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c: <u>Georgia Power Company</u> 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. K. Jabbour, 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

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PLANT AND SYSTEM IDENTIFICATION

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

SUMMARY OF EVENT

On 12/19/90, at approximately 1400 CST, Unit 2 was in the Run mode at an approximate power level of 2436 CMWt (approximately 100% rated thermal power). At that time personnel from the Safety Audit and Engineering Review Department were auditing compliance with Technical Specifications surveillance requirements. It was found that channel check surveillances on reactor water level instruments 2B21-N680A/B/C/D (EIIS Code JM) required by Unit 2 Technical Specifications Table 4.3.2-1 item 6.a. had not been performed during the last Unit 2 refueling outage. These channel checks are required to be performed once per shift during all operating conditions, but were not performed when the reactor was in operating condition 4 or 5. Review of the maintenance history for these four level instruments since 1987 revealed a reliable performance record.

The cause of this event was a deficient procedure caused by personnel error.

Corrective actions for this event included counseling the responsible personnel, revising the affected procedure, checking corresponding Unit 1 requirements, and performing a line-by-line review of the subject procedure. The first three actions are complete. The procedure review will be completed by 3/31/91.

DESCRIPTION OF EVENT

On 12/19/90, at approximately 1400 CST, personnel from the Safety Audit and Engineering Review Department were conducting a routine audit of Technical Specifications surveillances. At that time it was discovered that procedure 34SV-SUV-019-2S, "Surveillance Checks," contained an error regarding the applicable operating conditions under which a channel check was required to be performed on reactor water level instruments 2B21-N68OA/B/C/D (EIIS Code JM). Three separate Technical Specifications govern the surveillance requirements and applicable operating conditions for these instruments. Technical Specifications Table 4.3.1-1 item 4. requires a channel check to be performed when in operating conditions 1 and 2; Technical Specifications Table 4.3.2-1 item 1.a.1. requires a channel check to be performed when in operating conditions 1, 2, and 3; and Technical Specifications Table 4.3.2-1 item 6.a. requires a channel check to be performed when in operating conditions 3, 4, and 5. Therefore, the surveillance on these instruments is required in all operating conditions. However, contrary to the requirements of the Trannical Specifications, the procedure required the channel check to be performed only in operating conditions 1, 2, and 3. A subsequent spot check of the surveillance history of this procedure revealed that the channel check had not been performed during the last Unit 2 refueling outage when the reactor was in conditions 4 and 5.

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CAUSE OF EVENT

TEXT

The cause of the event is personnel error. Prior to Revision 4 of this procedure, the Technical Specifications requirement to perform the surveillance was correctly stated in the procedure. However, when Revision 4 was initiated in October 1989, the requirement to perform the channel check in operating conditions 4 and 5 was inappropriately deleted as part of an editorial correction, having been mistaken for a typographical error. The individual who deleted the requirement did not consult the Technical Specifications to ascertain the correct applicable operating conditions. The revision was further reviewed by two personnel from the Nuclear Safety and Compliance department as it was being processed, but they overlooked the error also.

REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This event is reportable per 10 CFR 50.73(a)(2)(i)(B) because a condition existed which is prohibited by the plant's Technical Specifications. Specifically, channel check surveillances required to be performed on reactor water level instruments 2B21-N680A/B/C/D by Technical Specifications Table 4.3.2-1 item 6.a. were not performed in operating conditions 4 and 5.

These reactor water level instruments provide a trip signal to automatically isolate the shutdown cooling system while in operating conditions 3, 4, and 5 in the event that reactor water level decreases to or below Level 3. Review of Deficiency Card and maintenance history showed that none of these four instruments has had a deficiency or a maintenance work order written against it since 1987. Only one corrective maintenance work order has been initiated against the corresponding level detectors in this time frame and this condition did not affect operability. Furthermore, there are four such instruments, and the design of their respective trip logic circuits is fail-safe.

Based on the above analysis, it is concluded that this event had no adverse impact on nuclear safety. Since the surveillance was performed while the reactor was in conditions 1, 2, and 3, the analysis is applicable to operating conditions 4 and 5.

CORRECTIVE ACTIONS

- Three individuals who were responsible for the procedure error have been counseled regarding the need to consult primary source documents any time changes are made to a procedure which implements Technical Specifications. This action is complete.
- Procedure 34SV-SUV /19-2S has been revised to correct the error in operating condition applicability with respect to instruments 2B21-N68OA/B/C/D. This action is complete.

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- 3. The channel check requirements for Unit 1 were reviewed. It was determined that Unit 1 Technical Specifications do not require the channel check to be performed when in operating conditions 4 and 5. However, as a conservative measure, and to maintain consistency between units, the corresponding Unit 1 procedure, 34SV-SUV-019-1S, "Surveillance Checks," has been revised to require the channel check to be performed under all operating conditions. This action is complete.
- Procedure 34SV-SUV-019-2S will be subjected to a line-by-line review to assure that it correctly implements the Technical Specifications it references. This action will be complete by 3/31/91.

ADDITIONAL INFORMATION

- 1. Other Systems Affected: No other systems were affected by this event.
- Previous Similar Events: Events in which less than adequate revisions to procedures have caused violations of Technical Specifications requirements in the past two years were reported in the following LERs:

50-321/89-09, dated 09/21/89 50-321/90-02, dated 02/26/90 50-321/90-03, dated 03/12/90 50-321/90-14, dated 08/08/90 50-321/90-18, dated 10/01/90 50-366/89-02, dated 03/14/89 50-366/89-06, dated 10/23/89

Corrective actions resulting from the previous similar events included counseling of involved personnel, revisions to appropriate procedures, a review of an amendment involved in a previous similar event, and a review of a sample of surveillance procedures to ensure compliance with Technical Specifications surveillance requirements. The revisions to procedures would not have prevented this event since an erroneous revision caused the event. Counseling personnel would not have prevented this event since the personnel involved in this event are unique to this event. The review of a sample of surveillance procedures would not have prevented this event because the erroneous procedure revision which caused this event occurred after the sample review was completed.

Failed Components Identification: No failed components contributed to this event.