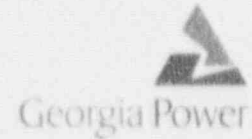


Georgia Power Company
40 Inverness Center Parkway
Post Office Box 1295
Birmingham, Alabama 35201
Telephone 205-877-7279

J. T. Beckham, Jr.
Vice President—Nuclear
Hatch Project



THE SOUTHERN ELECTRIC SYSTEM

HL-2019
002856

January 27, 1992

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 MISSED
TECHNICAL SPECIFICATIONS REQUIRED 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 personnel error which resulted in a missed Technical Specification surveillance. This event occurred at Plant Hatch - Unit 1.

Sincerely,

A handwritten signature in cursive script, appearing to read "J. T. Beckham, Jr.".

J. T. Beckham, Jr.

OCV/cr

Enclosure: LER 50-321/1991-032

cc: (See next page.)

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PDR ADOCK 05000321
S PDR

JE22

U.S. Nuclear Regulatory Commission
January 27, 1992
Page Two

cc: Georgia Power Company
Mr. H. L. Sumner, General Manager - Nuclear Plant
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. Ebnetter, Regional Administrator
Mr. L. D. Wert, Senior Resident Inspector - Hatch

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) PLANT HATCH, UNIT 1	DOCKET NUMBER (2) 05000321	PAGE (3) 1 OF 4
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TITLE (4)
PERSONNEL ERROR RESULTS IN MISSED TECHNICAL SPECIFICATIONS REQUIRED SURVEILLANCE

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)																																																																																																											
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LICENSEE CONTACT FOR THIS LER (12)

NAME STEVEN B. TIPPS, MANAGER NUCLEAR SAFETY AND COMPLIANCE, HATCH	TELEPHONE NUMBER AREA CODE: 912 NUMBER: 367-7851
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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)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (16)

On 12/28/91 at 2230 CST, Unit 1 was in the Run mode at a power level of 2436 CMWT (100% rated thermal power). At that time, it was determined from a routine review of completed surveillance procedure data packages that a daily check of the Unit 1 Torus oxygen concentration had not been performed the previous day as required by Unit 1 Technical Specifications section 4.7.A.5. The check had been performed on 12/26/91 at 2245 CST, but was not performed again until 12/28/91 at 1136 CST. The time between these two consecutive Torus oxygen concentration checks was about 37 hours, exceeding the time allowed by the Unit 1 Technical Specifications (24 hours plus a 25% grace period). When this event was discovered, the required surveillance was current; therefore, no Limiting Conditions for Operation had to be entered.

The cause of this event was personnel error. Licensed Operations personnel performing surveillance procedure 34SV-SUV-019-1S, "Surveillance Checks," on 12/27/91 incorrectly marked the Torus oxygen concentration check as "not required." This error was not caught until after the grace period for performing the surveillance had expired. A review of the complete data package from procedure 34SV-SUV-019-1S for 12/27/91 revealed no other missed surveillances.

Involved personnel were counseled. Additionally, this event will be included in beginning of shift training for Operations shifts.

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PLANT AND SYSTEM IDENTIFICATION

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

DESCRIPTION OF EVENT

On 12/28/91 at 2230 CST, Unit 1 was in the Run mode at a power level of 2436 MWTT (100% rated thermal power). At that time, it was determined from a routine review of completed surveillance procedure data packages that a daily check of the Unit 1 Torus oxygen concentration had not been performed the previous day as required by Unit 1 Technical Specifications section 4.7.A.5. This specification requires that the primary containment (Drywell and Torus, EIIIS Code NH) oxygen concentration be checked daily, i.e., at least once per 24 hours, to ensure it is less than 4% by volume.

Procedure 34SV-SUV-019-1S, "Surveillance Checks," contains the requirement to perform the daily checks of the Unit 1 Drywell and Torus oxygen concentrations. The Torus oxygen concentration check was performed on 12/26/91 at 2245 CST, but was not performed again until 12/28/91 at 1136 CST. On 12/27/91, the check was marked in the surveillance checks data package as "not required"; consequently, it was not performed on that day. Therefore, the time between consecutive oxygen concentration checks was about 37 hours, exceeding the frequency requirements of Unit 1 Technical Specifications section 4.7.A.5. The Drywell oxygen concentration checks were performed all three days as required. When this event was discovered, the Torus oxygen concentration check was current in that it had been performed within the preceding 24 hours. Thus, no Limiting Conditions for Operation had to be entered. A review of the complete data package from procedure 34SV-SUV-019-1S for 12/27/91 revealed no other missed surveillances.

CAUSE OF EVENT

The cause of this event was personnel error. Licensed Operations personnel performing surveillance procedure 34SV-SUV-019-1S on 12/27/91 incorrectly marked the Torus oxygen concentration check as "not required." This error was not caught until after the grace period for performing the surveillance had expired.

The 12/27/91 performance of the surveillance procedure was the last based on two, 12-hour shifts per day. On 12/28/91, a revision was issued to change the procedure based on three, 8-hour shifts per day. The Torus oxygen concentration check went from a night shift activity to a day shift activity as part of this revision. This meant the checks performed on 12/27 and 12/28 would be 12 hours apart instead of the normal 24 hours as the transition from the old shift schedule to the new shift schedule was made. Licensed Operations personnel inappropriately skipped the last night shift (12/27) check and performed the check on the day shift (12/28) as the new revision required. This resulted in approximately 37 hours between consecutive checks during the transition.

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REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This report is required per 10 CFR 50.73(a)(2)(1) because a condition existed which was prohibited by the plant's Technical Specifications. Specifically, the Unit 1 Torus oxygen concentration was not checked daily as required by Unit 1 Technical Specifications section 4.7.A.5. The check was not done on 12/27/91.

In the design basis loss-of-coolant accident (LOCA), the reaction of zirconium metal in the fuel bundles and steam could result in the liberation of hydrogen sufficient to result in a flammable concentration in the primary containment. However, if the oxygen concentration is less than or equal to 4% by volume, there is no possibility of hydrogen combustion following a LOCA. Therefore, the Unit 1 Technical Specifications specify an upper limit of 4% on oxygen concentration during normal operation and require a periodic check of the primary containment's oxygen concentration to ensure this limit is met.

In this event, the Torus oxygen concentration was not checked on 12/27/91 as required by the Unit 1 Technical Specifications. It was checked on 12/26/91 and again on 12/28/91, a difference between consecutive checks of about 37 hours. However, these two checks provided sufficient reason to believe that the torus oxygen concentration was maintained within the 4% limit. Oxygen levels on 12/26/91 and 12/28/91 were well below the 4% limit making it reasonable to assume this was the case on 12/27/91 as well. Therefore, even though the surveillance was not performed in strict compliance with the frequency requirements of the Unit 1 Technical Specifications, Torus oxygen concentration was maintained below the 4% limit. Based on this, it is concluded that this event had no adverse impact on nuclear safety. This analysis is applicable to all power levels.

CORRECTIVE ACTIONS

Involved personnel have been counseled.

Beginning of shift training will be given to the Operations shifts regarding this event. This will be completed by 1/28/92.

ADDITIONAL INFORMATION

No systems other than the Unit 1 primary containment were affected by this event.

No failed components caused or resulted from this event.

There has been one previous event reported in the last two years in which the Unit 1 Torus oxygen concentration check was not performed at the frequency required by the Unit 1 Technical Specifications. This event was reported in LER 50-321/1991-024 dated 11/12/91. That event, in which the check was being

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performed weekly instead of daily, was the result of a misinterpretation of the surveillance requirements. Procedure 34SV-SUV-019-1S was revised to require the check to be performed at the correct frequency, i.e., daily. Corrective action for the previous event could not have prevented this event because the causes of the two events were different.