

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



Georgia Power

the southern electric system

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

HL-2041
002926

February 6, 1992

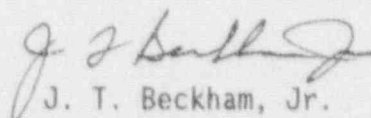
U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

PLANT HATCH - UNIT 1
NRC DOCKET 50-321
OPERATING LICENSE DPR-57
LICENSEE EVENT REPORT
PERSONNEL ERRORS RESULT IN
MISSED TECHNICAL SPECIFICATION SURVEILLANCES

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 errors which resulted in missed Technical Specification surveillances. This event occurred at Plant Hatch - Unit 1.

Sincerely,


J. T. Beckham, Jr.

JKB/cr

Enclosure: LER 50-321/1992-002

cc: (See next page.)

9202100259 920206
PDR ADDCK 05000321
S PDR

JE 22/11

U.S. Nuclear Regulatory Commission

February 6, 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. Ebner, Regional Administrator
Mr. L. D. Wert, Senior Resident Inspector - Hatch

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) PLANT HATCH, UNIT 1	BUCKET NUMBER (2) 05000321	PAGE (3) 1 OF 5
-------------------------------------------------	--------------------------------------	----------------------------------

TITLE (4)
PERSONNEL ERRORS RESULT IN MISSED TECHNICAL SPECIFICATION SURVEILLANCES

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	BUCKET NUMBER(S)
01	15	92	92	002	00	02	06	92		05000
										05000

OPERATING MODE (9) **1**

POWER LEVEL **00**

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)

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)(ix)	

SEE CONTACT FOR THIS LER (12)

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

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRPDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (16)	MONTH	DAY	YEAR

ABSTRACT (16)

On 1/15/92, at 1200 CST, Unit 1 was in the Run mode at 2436 CMWT (approximately 100 percent of rated thermal power). Licensed personnel were preparing a revision to procedure 34SV-SUV-019-1S, "Surveillance Checks," and noted that in two separate instances the procedure required instrument checks to be performed less frequently than that required by the Unit 1 Technical Specifications. Specifically, Unit 1 Technical Specifications table 4.2-11, item 7 requires an instrument check to be performed on the Suppression Chamber water temperature parameters of temperature recorders 1T47-R611 and R612 once per shift. Also, Unit 1 Technical Specifications table 4.1-1, item 8 requires an instrument check to be performed on Average Power Range Monitor (APRM) indicators LC51-K605A through F once per shift. However, for each of these instrument checks, procedure 34SV-SUV-019-1S required they be performed daily rather than once per shift resulting in missed Technical Specification surveillances.

A deficiency card was written and on-shift licensed personnel were notified. The instrument checks were then performed or verified to be current. The cause of the events was cognitive personnel error, on the part of licensed personnel. Specifically, individuals made incorrect changes to procedure 34SV-SUV-019-1S while using the editorial correction process. Corrective actions include performing the instrument checks, revising the procedure, and counseling personnel.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)	
		YEAR	SEQ NUM	REV		
PLANT HATCH, UNIT 1	05000321	92	002	00	2	OF 5

TEXT

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 1/15/92, at 1200 CST, Unit 1 was in the Run mode at 2436 CMWT (approximately 100 percent of rated thermal power). Licensed personnel were preparing a revision to procedure 34SV-SUV-019-1S, "Surveillance Checks," and noted that in two separate instances the procedure required instrument checks to be performed less frequently than that required by the Unit 1 Technical Specifications. Specifically, Unit 1 Technical Specifications table 4.2-11, item 7 requires an instrument check to be performed on the Suppression Chamber (EIIIS Code BS) water temperature parameters of temperature recorders 1T47-R611 and R612 once per shift. Also, Unit 1 Technical Specifications table 4.1-1, item 8 requires an instrument check to be performed on Average Power Range Monitor (APRM, EIIIS Code IG) indicators 1C51-K605A through F once per shift. However, for each of these instrument checks, procedure 34SV-SUV-019-1S required that they be performed daily rather than once per shift resulting in missed Technical Specifications surveillances.

Upon identification of the condition, a deficiency card was written and on-shift licensed personnel were notified. At 1305 CST, on 1/15/92, licensed personnel performed an instrument check of the temperature recorders applicable instruments; no problems were identified during the check. An instrument check of APRMs 1C51-K605A through F had been successfully performed earlier on day shift at 0945 CST and, therefore, it was not necessary to repeat it. Procedure 34SV-SUV-019-1S was temporarily revised on 1/15/92 per procedure 10AC-MGR-003-0S, "Preparation and Control of Procedures," to correct the instrument check frequencies and was issued prior to the next instrument check.

CAUSE OF EVENT

The cause of the event was cognitive personnel error on the part of licensed personnel. In the case involving the instrument check of the temperature recorder, licensed personnel failed to confirm the Technical Specifications required frequency prior to making the change. Specifically, the instrument check frequency was changed in conjunction with changing the frequency of the Suppression Chamber water temperature surveillance. Unit 1 Technical Specifications section 4.7.A.1.a requires that the Suppression Chamber water temperature be monitored once per day during normal operating conditions. Data is required to be taken and a calculation made in performing this surveillance. Procedure 34SV-SUV-019-1S requires the water temperature surveillance to be performed once per shift because the data is also needed in performing the once per shift instrument check required by Unit 1 Technical Specifications table 4.2-11, item 7. Personnel believed that the temperature surveillance frequency in the procedure was incorrect since it did not correspond with the Technical Specifications requirement. On 12/12/91, using the editorial correction process

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)	
		YEAR	SEQ NUM	REV		
PLANT HATCH, UNIT 1	05000321	92	002	00	3	OF 5

TEXT

addressed in 10AC-MGR-003-05, the water temperature surveillance frequency was changed to daily to reflect the Technical Specifications required frequency. At that time, it was erroneously assumed that the frequency required by the Technical Specifications for the instrument check was the same as that for the temperature surveillance and was, therefore, also changed to daily.

Also, a cognitive personnel error was committed by licensed personnel in that the editorial correction process was inappropriately used to implement the change to the procedure. This process is intended to be used exclusively for correcting typographical errors that cannot affect the performance of the procedure and allow procedure changes without requiring the normal procedure reviews. In this event, personnel justified use of the process because they believed that the temperature surveillance frequency in the procedure was an obvious mistake since it was more frequent than that required by the Technical Specifications. However, subsequent evaluation revealed that in order to perform the instrument check the data from the temperature surveillance was required. Thus, the temperature surveillance had to be performed once per shift. This change affected the performance of the procedure, and was not a typographical error or obvious mistake. Consequently, the editorial correction process was inappropriate for this change and due to the absence of the usual procedure reviews, the deficient condition was not identified prior to the change being issued.

Regarding the APRM instrument checks, on 1/12/92, licensed personnel inadvertently changed the frequency in procedure 34SV-SUV-019-1S from once per shift to daily while making editorial corrections to the procedure. Since the change was made using the editorial change process, it was not subjected to the normal review process; and, therefore, the mistake was not identified and corrected prior to the change being issued.

REPORTABILITY AND SAFETY ASSESSMENT

This report is required pursuant to 10 CFR 50.73(a)(2)(i)(B) because a surveillance procedure resulted in two instrument checks being performed on a less frequent basis than that required by the Technical Specifications. This constitutes a condition prohibited by the Technical Specifications and is therefore reportable.

The APRM system is designed to prevent fuel damage by generating a scram trip signal at a predetermined power level in the event of an abnormal operational transient. The system is comprised of six separate APRM channels, each having a Main Control Room indicator (1C51-K605A, B, C, D, E, and F). The qualitative instrument check is performed by verifying that all six APRM indicators are reading within three divisions of each other. In this event, from 1/12/92 to 1/15/92, the instrument check was being performed daily instead of once per shift as required by the Technical Specifications.

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)	
		YEAR	SEQ NUM	REV		
PLANT HATCH, UNIT 1	05000321	92	002	00	4	OF 5

TEXT

A review of the Deficiency Card database and the Maintenance Work Order history database showed that for this time period no problems were identified during the APRM instrument checks and furthermore that no problems were experienced with the APRMs that could have been identified by an instrument check. A failed relay was found during this time period during performance of procedure 57SV-C51-005-1S, "LPRM Calibration." The relay functions to provide annunciation in the Main Control Room when a Local Power Range Monitor fails downscale. An instrument check of the APRMs could not have identified the relay failure. Based on this information, it was concluded that the failure to perform the instrument check at the required frequency had no adverse impact on nuclear safety.

The Suppression Chamber provides the heat sink for the energy release following a postulated rupture in the reactor system. It also provides a heat sink for the Safety Relief Valve (SRV, EIS Code SB) discharge in the event of a postulated pressure transient in the reactor system. Temperature limits are placed on the Suppression Chamber water volume to ensure that the steam loads from a primary system rupture or an SRV actuation can be adequately condensed. Temperature monitoring instrumentation provides the capability to monitor the Suppression Chamber temperature. A qualitative instrument check is performed by verifying that the applicable temperature recorder outputs are reading within six degrees of each other. In this event, from 12/12/91 to 1/15/92, the instrument check was being performed daily instead of once per shift as required by the Technical Specifications.

A review of the Deficiency Card database and the Maintenance Work Order history database showed for this time period that no problems were experienced with the Suppression Chamber temperature instrumentation. Based on this information, it was concluded that a failure to perform the instrument check at the required frequency had no adverse impact on nuclear safety.

This safety assessment applies to all operating conditions.

CORRECTIVE ACTIONS

Procedure 34SV-SUV-019-1S was temporarily revised on 1/15/92 to correct the instrument check frequencies.

Personnel involved in this event will be counseled by 2/10/92 regarding attention to detail and compliance with administrative controls.

Procedures 34SV-SUV-019-1S and 2S were reviewed for similar conditions. No other problems were noted during the review.

Procedure 34SV-SUV-019-1S is being permanently revised to reflect the correct Technical Specifications frequencies. The revision will be made effective by 2/28/92.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)	
		YEAR	SEQ NUM	REV		
PLANT HATCH, UNIT 1	05000321	92	002	00	5	OF 5

TEXT

ADDITIONAL INFORMATION

No systems other than the APRM system and the Suppression Chamber temperature monitoring instrumentation were affected by this event.

No similar events have occurred in the previous two years in which a procedure change made via the editorial correction process has resulted in a missed Technical Specifications surveillance.

No failed components contributed to this event.