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The Southern Electric System

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HL-2183
003324

April 20, 1992

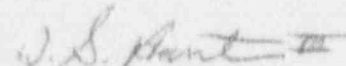
U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

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 Specifications required surveillance. This event occurred at Plant Hatch - units 1 and 2.

Sincerely,



W. G. Hairston, III

MCM/cr

Enclosure: LER 50-321/1992-008

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

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **PLANT HATCH, UNIT 1** DOCKET NUMBER (2) **05000321** PAGE (3) **1** OF **4**

TITLE (4) **PERSONNEL ERROR RESULTS IN MISSED TECHNICAL SPECIFICATIONS REQUIRED 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)
03	24	92	92	008	00	04	20	92	PLANT HATCH, UNIT 2	05000366
										05000

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

OPERATING MODE (9)	1	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL	100	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)	

LICENSEE CONTACT FOR THIS LER (12)

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

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

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

ABSTRACT (16)

On 3/24/92 at 0840 CST, Units 1 and 2 were in the Run mode at a power level of 2436 MWt (100 percent rated thermal power) when it was discovered a weekly representative sample of particulates in the Main Stack (EIS Code WF) effluent had not been collected as required by Unit 1 Technical Specifications (TS) Table 4.15.2-1(B) and Unit 2 TS Table 4.11.2-1(B). A non-licensed Plant Chemistry technician had removed the filter assembly in the sample line of the Main Stack Normal Range Monitoring System (NRM, EIS Code IL), common to both units, and discovered the filter assembly did not contain a particulate filter. The filter assembly should have contained a particulate filter and a charcoal cartridge. The filter assembly was installed in the sample line on 3/17/92, and remained in that sample line until the following weekly scheduled filter replacement on 3/24/92. Consequently, a weekly representative sample of particulates for that week was not collected. On 3/24/92, a particulate filter and a charcoal cartridge were placed in a new filter assembly and the assembly was installed in the Main Stack sample line as required. Review of plant operation and surveillance results prior to and after the week of 3/17/92 indicate it is extremely unlikely gaseous effluent limits were exceeded.

The cause of this event was personnel error. A Chemistry technician responsible for placing a particulate filter and a charcoal cartridge in the filter assembly per procedure 64CH-SAM-005-0S, failed to install the particulate filter. The procedure contributed to the event in that it did not require an independent verification that the particulate filter was installed in the filter assembly. Corrective actions included counseling the involved technician, issuing a Standing Order and revising the procedure.

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TEXT

DESCRIPTION OF EVENT

On 3/24/92 at 0840 CST, Units 1 and 2 were in the Run mode at a power level of 2436 CMWT (100 percent rated thermal power). At that time, it was discovered that a weekly representative sample of particulates in the Main Stack effluent had not been collected from 3/17/92 to 3/24/92, as required by Unit 1 Technical Specifications Table 4.15 2-1(B) and Unit 2 Technical Specifications Table 4.11.2-1(B). These specifications require that the Main Stack (E11S Code WF) effluent be sampled on a continuous basis for particulates and that the samples be analyzed at least weekly. During the time period from 03/17/92 to 03/24/92, both units were operating at rated thermal power.

The Main Stack Normal Range Monitoring, (NRM, E11S Code IL) system monitors gaseous effluents released to the environs from both units via the common Main Stack. A gaseous effluent sample is continuously drawn at a fixed rate of flow through an isokinetic probe. The sample passes through a filter assembly which contains a particulate filter and a charcoal cartridge. The filter assembly is normally replaced each week by a Chemistry technician. The particulate filter and charcoal cartridge are then analyzed isotopically to determine the particulate and iodine radionuclide concentrations released from the Main Stack during the sampling period.

On 03/24/92, a non-licensed Plant Chemistry technician removed the filter assembly in order to perform the weekly analysis per procedure 64CH-SAM-005-0S, "Gaseous Effluents: Sampling." Upon removing the cover of the filter assembly, the technician discovered that the particulate filter was missing. Without the particulate filter in the filter assembly, a representative sample of Main Stack particulate effluent had not been collected for the previous week and could not be analyzed as required by the specifications. Consequently, the surveillance was missed.

An investigation into the event determined that the Chemistry technician responsible for placing the particulate filter and charcoal cartridge in the filter assembly the previous week had failed to insert the particulate filter as required. The filter assembly was installed in the Main Stack sample line on 3/17/92, containing only a charcoal cartridge. The error was not discovered until the following weekly scheduled filter assembly replacement on 3/24/92.

On 3/24/92, a particulate filter and a charcoal cartridge were placed in the filter assembly and the assembly was installed in the Main Stack sample line as required.

CAUSE OF EVENT

The cause of this event was personnel error on the part of a non-licensed Plant Chemistry technician. The technician responsible for changing out the Main Stack effluent sample cartridge on 3/17/92 failed to install a particulate filter in the assembly prior to reinstallation as required.

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A contributing factor to this event was a less than adequate procedure. Procedure 64CH-SAM-005-0S contains a requirement for placing a particulate filter and a charcoal cartridge in the filter assembly prior to installing it in the Main Stack sample line. However, the procedure does not require independent verification of this action.

REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This report is required per 10 CFR 50.73(a)(2)(i) because a condition existed which was prohibited by both units' Technical Specifications. Specifically, a weekly representative Main Stack effluent sample had not been collected and analyzed as required by Unit 1 Technical Specifications Table 4.15.2-1(B) and Unit 2 Technical Specifications Table 4.11.2-1(B).

As previously stated, the Main Stack NRM system monitors gaseous effluents released to the environs from both units via the common Main Stack. A gaseous effluent sample is continuously drawn at a fixed rate of flow through an isokinetic probe. The probe is located high enough in the Main Stack to assure representative sampling. The sample passes through a filter assembly which contains a particulate filter and a charcoal cartridge. The filter assembly is normally replaced each week by a Chemistry technician. The particulate filter and charcoal cartridge are then analyzed isotopically to determine the particulate and iodine radionuclide concentrations released from the Main Stack during the sampling period. The analysis results are then used to compute the yearly dose to the public resulting from the release of radioactive material to the environs.

In this event, a Chemistry technician failed to place a particulate filter in the filter assembly prior to placing the filter assembly in the Main Stack sample line on 3/17/92. As a result, a weekly representative sample of particulates had not been collected and therefore, could not be analyzed as required by the Technical Specifications. However, the particulate concentrations were reviewed for periods in which both units were operating at rated thermal power (which was the case for the week in question) prior to and after the event. The review showed that the particulate releases were extremely low as expected and that no appreciable difference existed between the particulate releases reviewed before and after the events. Also, a review of the offgas post-treatment activity daily checks for both units showed that offgas activity levels remained essentially constant during the period in question. It is therefore reasonable to conclude that the main stack particulate release for the week in question was no higher than the releases occurring prior to and after the event when both units were at rated thermal power.

Based on the above, it is concluded this event did not adversely affect the public's health and safety. This analysis is only applicable when the units are operating at constant power levels.

CORRECTIVE ACTIONS

1. The involved Chemistry technician has been counseled.

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- A Standing Order has been issued by the Manager of Health Physics and Chemistry requiring independent verification when filter assemblies are replaced on both unit's Reactor Building vent, Recombiner Building vent, and Main Stack sample lines. This requirement will be incorporated into procedure 64CH-SAM-005-0S by 6/15/92.
- Since the particulate radionuclide concentrations for the week prior to the event were determined to be conservative from an evaluation of data for a period of 1/1/92 through 3/17/92, these values were used for the week in question for dose rate calculations.

ADDITIONAL INFORMATION

No systems other than the Main Stack Normal Range Monitoring System were affected by this event.

No failed components caused or resulted from this event.

Similar events occurring in the previous two years in which a personnel error directly resulted in missing a Technical Specifications surveillance were reported in the following LERs:

- 50-321/1990-008, dated 05/31/90
- 50-321/1990-019, dated 10/23/90
- 50-366/1990-004, dated 06/15/90
- 50-366/1990-010, dated 11/20/90
- 50-366/1990-011, dated 11/29/90
- 50-366/1990-013, dated 01/18/91
- 50-366/1991-021, dated 12/05/91

Corrective actions resulting from these events included counseling personnel, training personnel, revising procedures, and issuing a clarification to the Technical Specifications. These corrective actions would not have prevented this event because they did not pertain to this activity. Also, counseling or training personnel cannot completely eliminate oversights such as the one that caused this event.