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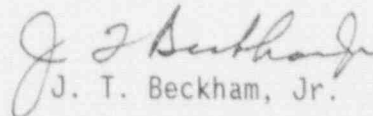
U.S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, D.C. 20555

PLANT HATCH - UNIT 2  
NRC DOCKET 50-366  
OPERATING LICENSE NPF-5  
LICENSEE EVENT REPORT  
LESS THAN ADEQUATE COMMUNICATION AND PERSONNEL ERROR  
RESULTS IN MISSED TECHNICAL SPECIFICATIONS 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 less than adequate communications and a personnel error which resulted in missed Technical Specifications surveillances. This event occurred at Plant Hatch - Unit 2.

Sincerely,

  
J. T. Beckham, Jr.

OCV/cr

Enclosure: LER 50-366/1992-022

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 E. I. HATCH, UNIT 2										DOCKET NUMBER (2) 05000366		PAGE (3) 1 OF 6		
TITLE (4) LESS THAN ADEQUATE COMMUNICATION AND PERSONNEL ERROR RESULT IN MISSED TECH SPECS 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)			
11	13	92	92	022	00	12	07	92			05000			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)												
4		20.402(b)				20.405(c)				50.73(a)(2)(iv)		73.71(b)		
POWER LEVEL		000				20.405(a)(1)(i)				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 STEVEN B. TIPPS, MANAGER NUCLEAR SAFETY AND COMPLIANCE, HATCH										TELEPHONE NUMBER AREA CODE 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)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)										<input checked="" type="checkbox"/> NO				
ABSTRACT (16)														

On 11/13/92, at 1225 CST, Unit 2 was in a refueling outage in Cold Shutdown. The core had been reloaded and the reactor vessel head installed. At that time, nonlicensed Instrument & Controls (I & C) personnel notified the Unit 2 licensed shift supervisor that functional tests required by the Technical Specifications for five Analog Transmitter Trip System (ATTS) trip units had not been performed at the required frequency. Technical Specifications table 3/4.3.3-1 requires that trip units 2B21-N690D and F, 2B21-N691B and D, and 2B21-N685B be functionally tested every 30 days with a 25 percent grace period. The instruments were last functionally tested on 10/1/92. The subsequent surveillance was required to be performed by 11/7/92. However, by 11/13/92, it had not been performed. The instruments were declared inoperable, and the appropriate limiting condition for operation was entered. The functional tests were then performed and satisfactorily completed by 1433 CST. The instruments were declared operable and the LCO was terminated at 1440 CST. The causes of this event were less than adequate communication and personnel error. The functional tests were started on 11/1/92; but, they were terminated due to the Safety Parameter Display System being inoperable. The need to resolve the condition and complete the tests was not adequately communicated to I & C supervision during shift turnover. The surveillances were, therefore, not completed. Additionally, the I & C surveillance coordinator failed to ensure that the tests were completed prior to the due date lapsing. Corrective actions include counseling personnel and revising procedures.

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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).

DESCRIPTION OF EVENT

On 11/13/92, at 1225 CST, Unit 2 was in a refueling outage in Cold Shutdown. The core had been reloaded and the reactor vessel head installed. At that time, nonlicensed Instrument & Controls (I & C) personnel notified the Unit 2 licensed shift supervisor that functional tests required by the Technical Specifications for five Analog Transmitter Trip System (ATTS, EIIS Code JE) trip units had not been performed at the required frequency. Technical Specifications table 3/4.3.3-1 requires that trip units 2B21-N690D and F, 2B21-N691B and D, and 2B21-N685B be functionally tested every 30 days with a 25 percent grace period. The instruments were last functionally tested on 10/1/92. The subsequent surveillance was due to be performed by 11/7/92. However, on 11/13/92 during a routine review of a surveillance tracking log, I & C personnel identified that the surveillance had not been performed.

Since the surveillance had been missed, the trip units were declared inoperable. Trip unit 2B21-N690D provides a reactor vessel low pressure injection permissive for the Residual Heat Removal - Low Pressure Coolant Injection (RHR - LPCI, EIIS Code BO) system and the Core Spray (CS, EIIS Code BM) system. Trip unit 2B21-N690F provides an input to the trip system associated with the automatic closure of the Reactor Recirculation System (EIIS Code AD) pump discharge valves. Trip units 2B21-N691B and D provide a reactor water low level signal to actuation systems for the CS system, the RHR-LPCI system, and the Automatic Depressurization System (ADS, EIIS Code SB). Additionally, the CS actuation system provides input to the initiation logic for the Emergency Diesel Generators (EDG, EIIS Code EK). Trip unit 2B21-N685B provides a reactor water level permissive input to the control logic for the Residual Heat Removal System (RHR, EIIS Code BO) - Containment Spray Mode and the Suppression Pool Cooling mode.

With these instruments inoperable, the Technical Specifications require that the CS system and the LPCI system be declared inoperable. With these systems inoperable and the reactor in condition 4 or 5, Technical Specifications section 3.5.3.1 requires that all activities with the potential for draining the reactor vessel be suspended and that one subsystem of the LPCI system be returned to operable status within four hours. Consequently, Limiting Condition for Operation (LCO) 2-92-949 was initiated to track resolution of the problem and the implementation of the Technical Specifications required action statements.

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The surveillances were satisfactorily completed by 1433 CST, on 11/13/92, via performance of the appropriate sections of procedures 57SV-SUV-012-2S, "ATTS Panel 2H11-P926 Channel Functional Test and Calibration," and 57SV-SUV-014-2S, "ATTS Panel 2H11-P928 Channel Functional Test and Calibration." No problems were found with the instrumentation during the tests. Consequently, the LCO was terminated at 1440 CST.

CAUSE OF EVENT

The causes of the event were less than adequate communication and cognitive personnel error on the part of nonlicensed I & C personnel. On 11/1/92, an attempt was made to perform the functional tests. One of the functional tests was started; however, it was terminated when the technicians realized that the Safety Parameter Display System (SPDS, EIIS Code IQ) was out of service. The test procedure includes verifying that the output of the trip unit is properly displayed on SPDS. The technician believed that the procedure could not be completed with SPDS out of service and, thus, the test was terminated. The other four functional tests also included a check of SPDS; thus, it was concluded that they in turn could not be performed. The I & C foreman noted in the shift log that the tests were not completed due to SPDS being out of service, expecting the I & C supervisors on the day shift to resolve the problem. However, it is apparent that the day shift personnel did not ascertain from the log entry the need for the tests to be performed by any specific date. Consequently, no actions were taken to complete the surveillances.

By 11/7/92, the due date plus grace period (also known as the late date) had arrived. The plant Technical Specifications surveillance coordinator issued a printout of surveillances which had late dates of 11/7/92. The department surveillance coordinator typically reviews the printout to ensure that his department's surveillances are complete. During an outage, many of the I & C department surveillances are deferred because many of the instruments are not required to be operable for the plant conditions existing during the outage. Procedures 57SV-SUV-012-2S and 57SV-SUV-014-2S contain many such instruments. In particular, the procedures implement functional tests for a total of 53 trip units, of which only six are required to be performed in the Cold Shutdown or Refueling modes. Therefore, most of the trip unit surveillances addressed by these procedures had been deferred at the time of this event. When the department surveillance coordinator received the aforementioned surveillance printout, he assumed that the trip unit surveillances listed for these two procedures were not required to be performed for the plant conditions existing and, thus, had been deferred. Consequently, he did not check the printout to ensure all surveillances for the trip units which were required to be operable for the existing plant conditions had been performed.



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A contributing factor to this event was less than adequate procedures. The SPDS portion of the functional test procedures was not required to be completed in order to implement the Technical Specifications surveillance requirement for the ATTS instruments. The SPDS portion of the tests could have been marked as not applicable and the tests then completed. In such situations, the procedures typically direct the technician to do so. However, these two procedures, 57SV-SUV-012-2S and 57SV-SUV-014-2S, did not contain any such directions, resulting in the technician terminating the test upon realizing that the portion of the test associated with SPDS could not be completed.

REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This report is required pursuant to 10 CFR 50.73 (a)(2)(i)(B) because a condition existed that was contrary to the Technical Specifications. Specifically, trip units 2B21-N690D and F, 2B21-N691B and D, and 2B21-N685B were not functionally tested at the frequency required by Technical Specifications table 3/4.3.3-1, items 1.a, 1.c, 2.b, 2.c, 2.d, and 2.e. This table requires that the instruments be functionally tested once per 30 days with a 25 percent or seven day grace period. Contrary to this requirement, 43 days after the previous surveillance, the functional tests had not been performed.

In this event, the trip units were functionally tested six days after the required frequency plus grace period had lapsed. In a practical sense, it is conservative to assume that an instrument is inoperable based solely on a required surveillance being missed. It is more a matter of the operability of the instrument not being verified. Such was the case in this event. On 11/13/92, the trip units were verified to be operable by successful completion of the required functional tests. Consequently, had the instruments been called upon to perform their intended safety function, they would have functioned as designed.

However, had the five trip units actually been rendered inoperable as a result of this event, the intended safety function of the instrumentation would still not have been defeated due to the redundancy and independence in the design of ATTS and the associated trip systems. Specifically, trip units 2B21-N691B and D comprise only two of four channels of the trip systems providing automatic initiation of the CS system, the RHR-LPCI system, the EDG system, and of the trip systems providing a permissive for automatic initiation of ADS on a low reactor water level condition. Had these two trip units been rendered inoperable, the design of the trip systems is such that the remaining operable channels would be capable of effecting an automatic initiation of both divisions of the CS system, the RHR-LPCI system, the EDG system and of providing a permissive signal to ADS.

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Regarding trip unit 2B21-N685B, failure of this trip unit would be inconsequential. This instrument provides an interlock to the "B" division of the RHR - Containment Spray mode and Suppression Pool Cooling mode such that these modes can only be initiated (a manual action) when adequate reactor core cooling exists as demonstrated by the reactor water level being greater than two thirds core height. It is possible for the trip unit to fail in two ways: either failing to enforce the interlock allowing the containment cooling modes to be manually initiated even though adequate core cooling does not exist or failing such that the interlock is enforced preventing manual initiation of these modes even though adequate core cooling does exist. In either case, the failure is inconsequential. In the former case, administrative controls dictate when to initiate these modes of the RHR system and specifically require that adequate core cooling be assured prior to doing so. Consequently, had the trip unit failed to enforce the interlock when core cooling was inadequate, the administrative controls would have been sufficient to prevent premature initiation of these modes of RHR system operation. In the latter case, the function of the interlock can be overridden by use of a keylock switch if necessary. Use of the keylock switch is again administratively controlled to assure that the interlock is not overridden indiscriminately. Consequently, had the trip unit failed such that the interlock was enforced even though adequate core cooling existed, administrative controls would have allowed use of the keylock override switch only after adequate core cooling was verified which would then allow manual initiation of the Containment Spray mode and the Suppression Pool Cooling mode of the RHR system. Additionally, the "A" division of the RHR system would be unaffected by a failure of trip unit 2B21-N685B and, therefore, its associated permissive interlock would have functioned as designed.

Trip unit 2B21-N690D comprises one of four channels of the trip systems providing a low reactor pressure permissive for CS and RHR-LPCI injection. Had it failed, the other three channels would have been sufficient to produce the permissive signal.

Trip unit 2B21-N690F comprises one of four channels of the trip systems providing a close signal to the Reactor Recirculation system pump discharge valves on low reactor pressure. The RHR-LPCI system injects to the vessel via the Reactor Recirculation system. These valves automatically close to direct RHR-LPCI flow to the reactor in the event of a Loss of Coolant Accident when reactor pressure decreases to less than or equal to 425 psig. Had 2B21-N690F failed, the other three channels would have been unaffected and would have been capable of initiating the closure signal.

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

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CORRECTIVE ACTIONS

The I & C surveillance coordinator and the I & C foreman were both counseled regarding their responsibility for ensuring that the surveillances are completed by the required due dates and the need to take appropriate actions if they cannot be performed by the required due dates.

The aforementioned procedures will be revised to include actions to take when SPDS is inoperable. Other procedures were identified as having the same inadequacy and, likewise, will be revised. The revisions will be made effective by 3/31/93.

ADDITIONAL INFORMATION

No systems other than those previously identified in this report were involved in this event.

One similar event has occurred in the previous two years in which a missed surveillance resulted from a failure to communicate or from failing to ensure or confirm that a surveillance was completed. This event was reported in LER 50-321/92-19, dated 8/4/92. This event involved a single procedure which contained more than one task, a system operability test and an Inservice Inspection Test (IST), which is common with plant procedures. The operability test had been performed as a functional test following maintenance. The IST portion of the procedure (a Technical Specifications surveillance activity) had come due. The licensed shift supervisor noted that the operability test had been performed previously and erroneously assumed that the IST portion of the procedure had also been completed. As such, he documented on a surveillance task sheet, which is used for tracking surveillances, that the IST was completed even though it had not been. Consequently, the surveillance was missed. Corrective actions for the event included counseling the shift supervisor. This individual was not involved with the event addressed in this report. Consequently, the corrective action could not have prevented this event.

No failed components either contributed to or resulted from this event.