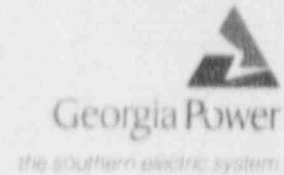


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J. T. Beckham, Jr.  
Vice President - Nuclear  
Hatch Project



December 21, 1992

Docket No. 50-366

HL-3091  
004597

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

PLANT HATCH - UNIT 2  
LICENSEE EVENT REPORT  
MISSED TECHNICAL SPECIFICATIONS  
ACTION STATEMENT

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 less than adequate procedure which resulted in a missed Technical Specifications action statement. This event occurred at Plant Hatch - Unit 2.

Sincerely,

J. T. Beckham, Jr.

OCV/cr

Enclosure: LER 50-366/1992-027

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

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## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) PLANT HATCH, UNIT 2										DOCKET NUMBER (2) 05000366		PAGE (3) 1 of 6					
TITLE (4) MISSED TECHNICAL SPECIFICATIONS ACTION STATEMENT																	
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)						
12	02	92	92	027	00	12	21	92			05000						
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)															
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)(vi)			OTHER (Specify in Abstract below)						
		20.405(a)(1)(iii)			X 50.73(a)(2)(i)			50.73(a)(2)(vii)(A)									
		20.405(a)(1)(iv)			50.73(a)(2)(ii)			50.73(a)(2)(vii)(B)									
		20.405(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(x)									
LICENSEE CONTACT FOR THIS LER (12)																	
NAME										TELEPHONE NUMBER							
STEVEN B. TIPPS, MANAGER NUCLEAR SAFETY AND COMPLIANCE, HATCH										AREA CODE		367-7851					
912																	
COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)																	
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRC			
X	IL	RIS	V115	NO													
SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH		DAY		YEAR	
YES (If yes, complete EXPECTED SUBMISSION DATE)										X NO							

## ABSTRACT (16)

On 12/2/92 at 0720 CST, Unit 2 was in the Run mode at a power level of 2436 CMWT (100 percent rated thermal power). At that time, a Chemistry department technician reported that there was no sample flow in the reactor building ventilation exhaust sampling system as is required by Unit 2 Technical Specifications table 3.3.6.10-1. The licensed shift supervisor then requested Instrument and Control technicians to take measures necessary to start at least one sampling system sample pump. This action was carried out immediately. Subsequent investigation revealed that the sample pumps had been deenergized the previous night as part of a surveillance on the sampling system. An auxiliary pump had been connected in preparation for deenergizing the main sample pumps, but due to miscommunication, the auxiliary pump was not turned on. The total time the sampling flow was interrupted was approximately ten and one half hours.

The root causes of this event are less than adequate communications and a less than adequate procedure. Less than adequate communications resulted in unsatisfactory interdepartmental coordination of a work activity. An inadequate procedure, as well as poor communications, resulted in the licensed shift supervisor being unaware of the effects of the procedure on the sample pumps.

Corrective actions for this event include revising the surveillance procedure used to functionally test the sampling system's radiation monitors and discussing the event with affected personnel during regularly scheduled departmental training meetings.

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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 12/2/92 at 0720 CST, Unit 2 was in the Run mode at a power level of 2436 CMWT (100 percent rated thermal power). At that time, a nonlicensed Chemistry department technician reported to the licensed shift supervisor that there was no flow in the reactor building ventilation exhaust sampling system (EIIIS Code IL) as required by Unit 2 Technical Specifications 3.3.6.10. The system was immediately restored to normal operation. Subsequent investigation revealed that the sampling system had been removed from service and proper compensatory actions had not been taken as a result of miscommunications which occurred during a surveillance begun on the previous day, 12/01/92.

On 12/1/92 at approximately 0950 CST, Unit 2 was in the Run mode at 100 percent rated thermal power. At that time, Instrument and Control technicians (I&C techs) began performance of surveillance procedure 57SV-D11-022-2S, "REACTOR BUILDING VENT RADIATION MONITOR CHANNEL FUNCTIONAL TEST AND CALIBRATION." This procedure requires temporarily removing the reactor building ventilation exhaust sampling system from service so that a calibration may be performed on its noble gas activity monitor. Unit 2 Technical Specifications table 3.3.6.1C-1, item 2 requires this system to be operable at all times when releases are being made through the reactor building vent. If this condition is not met, Action Statement 105 requires a grab sample of the effluent to be taken and analyzed every day. Accordingly, the licensed shift supervisor initiated Limiting Condition for Operation 2-92-991 to initiate the grab sampling and to track implementation of the corrective action. The required sampling was initiated immediately, and the first sample was completed by 1325 CST.

In addition to disabling the noble gas activity monitor, the surveillance requires temporarily disabling both of the system's sample pumps. This normally lasts only ten to fifteen minutes. Unit 2 Technical Specifications Action Statement 107 requires that when sampling flow is interrupted, an auxiliary method of establishing sampling flow and analysis must be initiated. Consequently, a Chemistry foreman directed that an auxiliary sample pump be connected to the appropriate instrument taps in preparation for the auxiliary sampling. This action was completed by approximately 1330 CST. The auxiliary pump was not turned on at that time, however, because the operating main sample pump was still on line, drawing flow through the particulate filters. The Chemistry foreman communicated the Technical Specifications requirements relative to interruption of sample flow to the I&C techs. The Chemistry foreman was not required to take any other action at that time, and attended to other duties while waiting for notification that the main sample pump had been turned off.

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During the performance of the surveillance, difficulty was encountered in calibrating the count rate meter which is part of the vent radiation sample panel. Therefore, by the end of their shift, the I&C techs had not yet reached the step in the procedure which would have turned off the main sample pump. Subsequently, they turned the work over to the next shift who prepared to remove a faulty component from the sample panel for repair. Removing the component from the sample panel resulted in both sample pumps being disabled. However, the requirement to notify the Chemistry department upon removing the sample pumps from service was apparently not communicated during the shift turnover briefing.

Before the faulty component could be removed, the surveillance procedure directed the I&C techs to inform the licensed shift supervisor that the system would be affected. When they did, the shift supervisor observed that an LCO had been written earlier that day against the reactor building ventilation exhaust sampling system. This was the LCO which required daily grab sampling for noble gas activity. When the I&C techs briefed the shift supervisor on the effects of the procedure, the shift supervisor did not understand from their conversation that both sample pumps would be deenergized and that all sample flow would be interrupted for several hours. Moreover, the surveillance procedure does not state that all sample flow will be interrupted. Thus the shift supervisor concluded that the existing LCO was sufficient to cover the work which was about to be done on the sampling system. The shift supervisor therefore relied upon the previously written LCO, and authorized performance of the surveillance procedure.

At approximately 2100 CST on 12/1/92, the faulty component was removed from the sample panel with the result that both sample pumps were disabled. However, this shift of I&C techs was unaware of the need to notify the Chemistry department that sampling had been interrupted, and therefore they did not do so. Operations personnel in the Main Control Room were aware that work was being done on the sample panels during the shift and so they expected to receive annunciators associated with the reactor building ventilation exhaust sampling system. Therefore, when the pumps were deenergized causing the high/low flow annunciator to actuate, operations personnel believed the annunciator was merely the result of instrumentation work and was not a valid alarm requiring corrective action. Moreover, the LCO mentioned above required the involvement of Chemistry department personnel, leading operations personnel to conclude that the Chemistry department was already aware of the work on the sampling system. On these bases, operations personnel did not call the Chemistry department for additional action as is normally required by the annunciator response procedure.

On 12/2/92 at approximately 0720 CST, a Chemistry technician went to perform a regularly scheduled surveillance in which the iodine and particulate filter cartridges are replaced. When he arrived at the sample panels he observed that no flow or vacuum was present. He also noted that the auxiliary pump was connected to the system, but was not turned on. Since electronic test equipment was still connected to one of the sample panels, he contacted a Chemistry department supervisor to ask about the situation. The Chemistry supervisor, in turn, contacted the Main Control Room and asked if the high/low flow annunciator

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was illuminated. When the shift supervisor replied that it was illuminated, the Chemistry supervisor realized that the Technical Specifications Action Statement requiring auxiliary sampling had not been carried out. The Chemistry supervisor explained this to the shift supervisor who immediately requested that one of the main sample pumps be energized. This was done at once, restoring sample flow and placing the plant in compliance with the requirement to provide continuous sampling flow through the iodine and particulate filters. The total time that sample flow was interrupted was about ten and one half hours.

CAUSE OF EVENTS

The root causes of this event are less than adequate communications and a less than adequate procedure. Less than adequate communications occurred when the I&C techs turned over their work activity to the oncoming shift of I&C techs. Because the first shift of I&C techs did not gain a full understanding of the sampling flow requirements from their previous communication with the Chemistry foreman, they did not emphasize to the oncoming shift the need to contact the Chemistry department when the operating main sample pump was turned off. As a result, Chemistry department personnel were not notified when the pump was turned off, and therefore they did not start the auxiliary sample pump.

Less than adequate communications also occurred when the I&C techs briefed the licensed shift supervisor. The shift supervisor did not understand from his conversation with the I&C techs that both sample pumps were to be deenergized simultaneously. Had he understood this, the appropriate notifications to the Chemistry department could have been made.

Procedure 57SV-D11-022-2S was less than adequate in that it does not state that all sampling flow will be terminated when the procedure is carried out. Therefore, when the licensed shift supervisor reviewed the procedure during his conversation with the I&C techs, the effects of the procedure were not apparent to him.

REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This report is required per 10 CFR 50.73(a)(2)(i) because Unit 2 entered a condition which is prohibited by the Technical Specifications. Specifically, Unit 2 Technical Specifications table 3.3.6.10-1 item 2 requires that Action Statement 107 be carried out to implement a means of establishing auxiliary sample flow in cases where continuous sampling of the reactor building ventilation system effluent is interrupted. Because of miscommunication, this auxiliary sample flow was not established, and sample flow was interrupted for about ten and one half hours.

The purpose of the reactor building ventilation exhaust sampling system is to monitor the effluent from the reactor building ventilation system for content of radioactive iodine, noble gases and particulates. The reactor building ventilation exhaust sampling system consists of particulate and iodine filters,



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noble gas activity monitors, sample pumps, and the necessary piping, heaters, and valves to draw a portion of the ventilation exhaust through the system and return it to the reactor building vent stack. In the event that excessive levels of noble gas activity are detected in the effluent, the system provides annunciation in the Main Control Room. The particulate and iodine filters are not monitored by any automated device and thus do not have any automatic safety function or annunciation. The particulate and iodine filters are replaced on a weekly basis, and the old filters are analyzed for the radionuclide content which has accumulated over the seven-day sampling period. The results of the analysis are incorporated in the Semi-annual Radioactive Effluent Release Report.

In this event, both of the main sample pumps were deenergized for a period of approximately ten and one half hours. During this time, therefore, no sample of reactor building vent exhaust was being drawn across the particulate and iodine filters. Since the sample flow was interrupted for a period of about ten and one half hours, this represents a reduction in total filter exposure time of less than seven percent. This is not sufficient to have had significant impact on the results of the radionuclide analysis under conditions of normal radiological release.

If an accident involving release of radioactive materials into the secondary containment had occurred during the time the sample pumps were deenergized, it would have had no effect on the plant's automatic response (since the filters do not have an automatic function or alarm). The sampling system's noble gas monitor provides an input to a recorder which may be used during an accident to provide information pertinent to offsite dose calculations. However, in the event that the sampling system had been inoperable during an event involving a radiological release, other monitors would have been available for use. Operators are directed to these other monitors by procedure 73EP-EIP-018-0S, "PROMPT OFFSITE DOSE ASSESSMENT." No other radiation monitoring equipment was affected by the event.

Based on this analysis, it is concluded that this event had no adverse impact on nuclear safety. This analysis is applicable to all power levels.

CORRECTIVE ACTIONS

1. Procedure 57SV-D11-022-2S has been revised to clarify the effects of removing one or both sample pumps from service. This revision provides assurance that all involved personnel understand the various Technical Specifications requirements which must be satisfied when the reactor building ventilation exhaust sampling equipment is removed from service. The procedure has been approved for validation and will be issued for use after the next regularly scheduled performance of the surveillance. This will occur by 3/31/93. The Unit 1 exhaust sampling system is designed differently such that the surveillance does not require the user to deenergize both sample pumps. Therefore, the Unit 1 procedure does not require revision.

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2. This event will be discussed with personnel from the Maintenance, Operations, and Chemistry departments in regularly scheduled departmental training meetings. This action will be completed by 3/31/93.

ADDITIONAL INFORMATION

1. Other Affected Systems: No systems were affected other than those mentioned in this report.
2. Previous Similar Events: Events reported in the past two years which involved missed Technical Specifications Action Statements are described in the following LERs:

50-366/1990-013, dated 1/14/91,  
50-366/1991-021, dated 12/4/91,  
50-366/1992-004, dated 4/30/92,  
50-366/1992-011, dated 8/14/92.

Corrective actions for these events included issuing a departmental standing order on the conduct of gaseous sampling activities, conducting departmental training, revising procedures, issuing a departmental directive on chart recorder operability, counseling personnel, testing affected equipment, replacing failed components, and implementing a design change. These actions could not have prevented this event because they could not have had any effect on verbal communications. The procedure which was involved in this event was not involved in any of the previous events.

3. Failed Components Identification:

Master Parts List Number: 2D11-K636A  
Manufacturer: Victoreen  
Type: Logarithmic Count Rate Meter  
Model Number: 842-11  
EIIIS System Code: IL  
EIIIS Component Code: RIS  
Root Cause Code: X  
Reportable to NPRDS: No