

LICENSEE EVENT REPORT (LER)

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TITLE (4)
PERSONNEL ERRORS CAUSE PROCEDURE ERRORS LEADING TO VIOLATIONS OF TECHNICAL SPECIFICATIONS

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0	2	1988	88	002	00	0	3	1988			0 5 0 0 0

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)									
POWER LEVEL (10) 01010	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Sp. below 1-10-85) - Abstract NRC Form 366A						
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)								

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME J. D. Heidt, Nuclear Licensing Manager - Hatch		AREA CODE 41014	512161-1413510

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

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 (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On 2/19/88 between 0900 CST and 0930 CST, Unit 2 was in the refueling mode of operation at an approximate power level of 0 MWt (approximately 0 percent of rated thermal power). At that time, members of the Procedure Upgrade Program (PUP) determined that some of the surveillance requirements of the Technical Specifications were not met. This is a condition prohibited by the plant's Technical Specifications.

The root cause of this event is cognitive personnel error. Specifically, personnel who were responsible for developing the procedure did not verify that all surveillance requirements were incorporated into the procedure.

Corrective actions for this event included: 1) developing special purpose procedures, 2) performing or scheduling the surveillances, 3) verifying or scheduling verifications of the surveillance results, 4) developing procedure revisions, 5) incorporating the event into the operator training program, and 6) verifying that Unit 1 did not have similar problems.

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A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(i), because a condition existed that was prohibited by the plant's Technical Specifications. Specifically, some of the surveillance requirements associated with the Technical Specifications were not met.

Per the guidance contained in Generic Letter 87-09, a missed surveillance is required to be reported as a condition prohibited by the plant's Technical Specifications.

This report describes two events. In the first event, some of the requirements of Technical Specifications section 4.3.1.2 were not met. In the second event, some of the surveillance requirements associated with Technical Specifications section 3.3.2 were not met.

B. UNIT(S) STATUS AT TIME OF EVENT

1. Power Level/Operating Mode - Events Number 1 and 2

Unit 2 was in the refueling mode of operation for the unit's seventh refueling outage. The Unit 2 reactor parameters were as follows: thermal power was zero, pressure was atmospheric, and reactor coolant temperature was approximately 88 degrees Fahrenheit (°F). There was no fuel in the reactor vessel.

2. Inoperable Equipment - Events Number 1 and 2

There was no inoperable equipment that contributed to this event.

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C. DESCRIPTION OF EVENT

1. Event

Event Number 1

On 2/19/88 at approximately 0930 CST, personnel in the plant Procedure Upgrade Program (PUP) reported that the non-coincidence trip mode of the Reactor Protection System (RPS EIIS Code JC) circuitry was not being tested in accordance with Unit 2 Technical Specifications functional testing requirements. Specifically, PUP personnel reported on Deficiency Card 2-88-818 (as required by the plant's administrative control procedures), that Unit 2 was not in compliance with the following Technical Specifications: 4.9.2.b., 4.9.2.d., 4.3.1.2, Table 4.3.1-1 item 1, and Table 4.3.1-1 item 2.

Section 4.9.2.b requires the performance of a Source Range Monitoring (SRM EIIS Code IG) channel functional test within 24 hours prior to the start of core alterations and at least once per seven days.

Section 4.9.2.d requires verifying that the RPS circuitry "shorting links" have been removed and that the RPS circuitry is in a non-coincidence trip mode within eight hours prior to starting core alterations or shutdown margin demonstrations.

Section 4.3.1.2 requires that the Neutron Monitoring System (NMS EIIS Code IG) logic system functional tests and simulated automatic operation of all channels shall be performed at least once per 18 months and shall include calibration of time delay relays and timers necessary for proper functioning of the trip system.

Table 4.3.1-1 item 1 requires testing of the Immediate Range Monitors (IRM EIIS Code IG) neutron flux high trip and the inoperative trip.

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Table 4.3.1-1 item 2 requires testing of the Average Power Range Monitors (APRM EIIS Code IG) neutron flux upscale trip (15% trip) and the inoperative trip.

On 2/19/88 at approximately 1207 CST, licensed plant operations personnel were notified of the potential deficiency and they initiated a Limited Condition for Operations (LCO 2-88-238). The LCO would ensure that Unit 2 was brought into compliance with applicable Technical Specification requirements prior to reactor core being reloaded (prior to fuel movement).

Plant personnel wrote a special purpose procedure to perform the surveillance requirements. On 2/20/88, the site manager of operations approved the special purpose procedure 34SP-021988-CS-1-2S (SRM Instrument Functional Test for U-2 Reload).

On 2/24/88, Nuclear Safety and Compliance (NSC) personnel were assigned to investigate the event and evaluate the event for reportability requirements. As part of the investigation, the following reference documents were reviewed: 1) Unit 2 Final Safety Analysis Report, Appendix A.22; Regulatory Guide 1.22, "Periodic Testing of Protection System Actuation Functions"; 2) IEEE Standard 279-1971, "Criteria for Protection Systems for Nuclear Power Generating Stations"; and 3) IEEE Standard 338-1971, "Criteria for the Periodic Testing of Nuclear Power Generating Station Protection Systems".

On 2/25/88 at approximately 1820 CST, non-licensed plant operations personnel had performed procedure 34SP-021988-CS-1-2S. The procedure results were acceptable. At 2107 CST, licensed operations personnel removed the LCO. At approximately 2249 CST, fuel movement was in progress to reload the Unit 2 reactor core.

On 2/26/88 at approximately 0015 CST, eight fuel bundles were loaded properly around the four SRM detectors.

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On 3/3/88, the investigation conducted by NSC personnel was complete. As part of the investigation, NSC personnel reviewed the requirements of the Technical Specifications and the associated surveillance procedures against the information contained in the reference documents. Based on the the results of their review, NSC personnel drew the following conclusions:

1. Unit 2 Technical Specifications Section 4.9.2.b requirements were being met by the performance of existing plant procedure 34SV-C51-001-2S (SRM Instrument FT&C).
2. Unit 2 Technical Specifications Section 4.9.2.d requirements were being met by the performance of existing plant procedure 42FH-ERP-014-S (Fuel Movement Operation).
3. Unit 2 Technical Specifications Table 4.3.1-1 item 1.a and 1.b requirements were being met by the performance of existing plant procedure 57SV-H11-001-2S (IRM Functional Test).
4. Unit 2 Technical Specifications Table 4.3.1-1 item 2.a and 2.b requirements were being met by the performance of existing plant procedure 34SV-C51-002-2S (APRM Instrument FT&C).
5. Unit 2 Technical Specifications Section 4.3.1.2 requirements were being partially met by the performance of existing plant procedures 34SV-C51-002-2S (APRM Instrument FT&C), 57SV-H11-001-2S (IRM Instrument Functional Test), and 34SV-C71-004-2S (Reactor Manual Scram Functional Test).

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The investigation found that one set of the relay contacts for relays 2C51-K12A-F (which deactivate relays 2C51-K13A-D) were not being tested by the logic system functional tests. Each 2C51-K13 relay upon receipt of an activation signal from NMS, causes a full RPS logic actuation (full scram signal). This occurs by deactivation of manual scram relays in the manual scram A-1 and B-1 circuitry only when the "shorting links" are removed. The "shorting links" are only removed for reactor core alteration or shutdown margin demonstrations.

Event Number 2

On 2/19/88 at approximately 0900 CST, a member of the plant Procedures Upgrade Program (PUP) determined that plant procedure 57SV-D11-004-2S (Time Response Testing of Reactor Building and Refueling Floor Area Radiation Monitors) did not fully satisfy all the surveillance requirements of the Technical Specifications. Specifically, the procedure did not fully test the isolation system response time for the actuation instrumentation listed in Technical Specifications table 3.3.2-1 items 2a and 2d. A Deficiency Card was generated, as required by the plant's administrative control procedures, to document the condition.

Technical Specifications section 3.3.2 requires that the secondary containment isolation actuation instrumentation channels shown in table 3.3.2-1 be operable with their trip setpoints in accordance with the requirements of table 3.3.2-2 and isolation system response times as outlined in table 3.3.2-3.

The secondary containment isolation actuation instrumentation listed in table 3.3.2-1 items 2a and 2d actuates some (but not all) of the valves in the Primary Containment Isolation System (PCIS EIIS Code JM) valve Group 2 (specifically valve subgroups 6, 10, and 12). The instruments specified in table 3.3.2-1 items 2a and 2d are 2D11-K609 A, B, C, and D and 2D11-K611 A, B, C, and D, respectively. These instruments actuate on a high radiation signal at either the reactor building exhaust vent (2D11-K609) or at the refueling floor exhaust vent (2D11-K611).

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Plant procedure 57SV-D11-004-2S was intended to satisfy the surveillance requirement for testing the isolation system response time associated with these instruments (2D11-K609 and 2D11-K611). PUP personnel determined that the procedure only tested the instrumentation associated with the reactor building and refueling floor air supply and air exhaust fans. The Technical Specifications require that the procedure determine the time from when the monitored parameter (in this case, radiation) exceeds its isolation actuation setpoint at the channel sensor, until the isolation valves (in this case, valve subgroups 6, 10, and 12) travel to their required positions.

After it was determined that the existing response time procedure was inadequate, plant personnel developed a temporary, special purpose procedure, 57SP-0-22-388-IF-1-2S (Reactor Building and Refueling Floor Area Radiation Monitors Time Response Tests), to perform the response time testing. The procedure was written on 2/23/88 and was transmitted to the on site Plant Review Board (PRB) for review on 2/29/88. It was approved for use on 3/3/88.

2. Dates/Times

Event Number 1

<u>Date</u>	<u>Time (CST)</u>	<u>Description</u>
2/19/88	0930	PUP personnel reported that the non-coincidence trip mode of the RPS was not being tested in accordance with Unit 2 Technical Specifications requirements.

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Date	Time (CST)	Description
2/19/88	1207	Licensed operations personnel were notified of the condition and they initiated an LCO to ensure compliance with the applicable Unit 2 Technical Specifications requirements prior to core reload.
2/20/88		Plant personnel developed a special purpose procedure (34SP-021988-CS-1-2S) to perform the surveillance requirements. The site manager of operations approved the special purpose procedure.
2/24/88		NSC personnel were assigned to investigate the event and evaluate it for reportability requirements. Referenced documents were reviewed.
2/25/88	1820	Non-licensed plant operations personnel performed procedure 34SP-021988-CS-1-2S with acceptable results.
	2107	Licensed plant operations personnel removed LCO 2-88-238 since Unit 2 was in compliance with Unit 2 Technical Specifications section 4.3.1.2.
2/25/88	2249	Reactor core reload began.
2/26/88	0015	Eight fuel bundles were loaded properly around the four SRM detectors.
3/9/88		The NSC investigation was completed. The investigation concluded that only one portion of one surveillance requirement was not being met.

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Event Number 2

<u>Date</u>	<u>Time (CST)</u>	<u>Description</u>
2/19/88	0900	Plant personnel in the PUP determined that the plant procedure 57SV-D11-004-2S did not fully incorporate all testing requirements of the applicable Technical Specifications. A Deficiency Card was generated, as required by the plant's administrative control procedures, to document the condition.
2/23/88		Special purpose procedure, 57SP-0-22-388-IF-1-2S was written for temporary use.
2/29/88		The special purpose procedure was sent to the Plant Review Board (PRB) for review and approval.
3/3/88		Special purpose procedure 57SP-0-22-388-IF-1-2S approved for use.

3. Other Systems Affected

Event Number 1

The only system affected by this event was the non-coincidence trip mode of the RPS (i.e., only active when "shorting links" removed).

Unit 1 was not affected by this event since the Unit 1 "shorting links" are not required to be removed by Unit 1 Technical Specifications.

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Event Number 2

No systems, other than a portion of the PCIS valve Group 2 isolation system, were affected by this event. The PCIS system provides containment isolation and has no other secondary functions.

4. Method of Discovery - Event Number 1 and 2

The events were discovered as part of the PUP. This is a long term program to upgrade all plant procedures. For surveillance procedures, the PUP includes a technical review to ensure that these procedures properly address all Technical Specifications requirements. The procedures had not yet been through the PUP.

5. Operator Actions

Event Number 1

Operations personnel performed the following actions:

1. Processed the reported deficiency card as required by the plant's administrative control procedure.
2. Initiated an LCO to ensure Unit 2 compliance before fuel load.
3. Performed procedure 34SP-021988-CS-1-2S.

MSC personnel performed the following action:

1. Investigated event and reported per 10 CFR 50.73 requirements.

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Event Number 2

No operator actions were required in this event.

6. Auto/Manual Safety System Response - Event Number 1 and 2

No manual or automatic safety systems actuations occurred, nor were any required to occur.

D. CAUSE OF EVENT

1. Immediate Cause

Event Number 1

The immediate cause for the missed Logic System Functional Testing (LSFT) of the non-coincidence trip mode of RPS is procedure inadequacy. Specifically, no plant procedure tested the non-coincidence trip mode of RPS every 18 months as required by Unit 2 Technical Specifications.

Event Number 2

The immediate cause of the missed surveillance testing for the isolation system response times associated with instruments 2D11-K609 and 2D11-K611 is procedure inadequacy. Specifically, the procedure did not incorporate all the applicable Technical Specification requirements.

2. Root/Intermediate Cause

Event Number 1

The root cause for this LSFT not being performed was cognitive personnel error. Specifically, plant personnel who developed the surveillance procedures did not correctly incorporate all of the Technical Specifications requirements.

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Event Number 2

The root cause of the event is cognitive personnel error on the part of non-licensed plant personnel. Specifically, the individuals responsible for developing the surveillance procedure did not verify that all the requirements of the Technical Specifications were properly incorporated into the surveillance procedure.

Plant Nuclear Safety and Compliance (NSC) personnel attempted to determine a possible cause for the procedure inadequacy. The procedure history files were researched and it was determined that the error existed in the procedure since the original revision (Revision 0 circa 1978).

E. ANALYSIS OF EVENT

Event Number 1

The "shorting links" are only removed for reactor core alterations or shutdown margin demonstrations. Unit 2 Technical Specifications requires all control rods be fully inserted prior to reactor core alterations, and shutdown margin demonstrations are usually only performed in start-up mode operations.

Since the LSFT (missed surveillance) was performed on 2/25/88 and the surveillance results were satisfactory, it is concluded that at all times, the logic system was capable of performing its intended safety function.

Based on the above information, it is concluded that this event had no adverse impact on nuclear safety. Additionally, since the only time the logic train is inoperable is when "shorting links" are removed, it is believed that the consequences of the event would not be more severe under other power conditions.

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Event Number 2

The instrumentation section of the Technical Specifications describes requirements that ensure the effectiveness of the instrumentation used to assure the safe operation of the plant and mitigate the consequences of accidents. For isolation systems, this is done by prescribing the operability requirements, trip set points, and response times for isolation of the reactor systems.

Plant personnel determined that the PCIS valve Group 2, subgroups 6, 10 and 12 valves had been demonstrated operable by other plant procedures. Specifically, plant procedure 42SV-SUV-031-2S (Reactor Building Isolation System FT) provides instructions for performing the logic system functional testing on the logic circuitry for these valve groups. This testing verifies that the logic works correctly and this testing is performed every 18 months (every refueling cycle).

Additionally, plant procedure 34SV-SUV-008-2S (Primary Containment Isolation Valve Operability) verifies that the valves are demonstrated as operable. This testing is also performed every refueling cycle.

These two procedures demonstrated that the valves and associated logic were capable of performing their intended safety functions.

However, since the isolation response times were not specifically verified to comply with Technical Specification requirements, a review was performed of the valves in subgroups 6, 10, and 12 to determine the safety consequences if the valves did not respond to the actuation signal within the required response time. This review disclosed several key factors which further demonstrate why this event had no adverse impact on nuclear safety.

Many of the valves are normally closed. As such, under normal conditions, they need no response time to fulfill their isolation function. In addition, most of the valves are designed to fail in the closed direction. Those valves which are normally open (they may or may not fail closed) are on sampling systems which both take suction from, and exhaust back into, the primary containment. The sampling systems are typically closed loop systems and are fully enclosed in the reactor building.

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If any of the valves were open when called upon to isolate and they exceeded their response time requirements, the excess process flow from the primary containment would be channeled: 1) back into the primary containment, or 2) directly to the Standby Gas Treatment System (SGTS EIIS Code BH), or 3) to the reactor building atmosphere which is eventually processed by the SGTS.

Thus, any excess process flow which would be released due to exceeding the isolation system response times would be very low and would be processed by SGTS prior to its discharge from the plant. Finally, it should be noted that valve subgroups 6, 10, and 12 close on a reactor building or refueling floor high exhaust radiation signal in order to isolate any probable sources of radiation. This conservative "anticipatory trip" will provide assurance that the secondary containment and SGTS can perform their functions.

Based on the above information, it is concluded that this event had no adverse impact on nuclear safety. Additionally, while this event occurred while Unit 2 was in refueling, the above analysis is applicable to all power levels and operating modes.

In the event that performance of special purpose procedure 57SP-0-22-388-IF-1-2S demonstrates that the isolation system instrumentation response time requirements of the Technical Specifications are not met, a revision to this LER will be initiated. The revision will discuss the impact of the event for the as found response times.

F. CORRECTIVE ACTIONS

Corrective actions for Event Number 1 included:

1. Special purpose procedure 34SP-021988-CS-1-2S was developed to bring Unit 2 into compliance with Unit 2 Technical Specifications section 4.3.1.2 requirements.

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2. The special purpose procedure was performed and the surveillance results were satisfactory.
3. PUP personnel will include the Technical Specification section 4.3.1.2 requirement to perform an LSFT on the non-coincidence trip mode of RPS into a plant procedure. It is anticipated that plant procedure 34SV-C51-002-2S will be revised to include this required surveillance. The procedure revision is currently scheduled for completion by approximately 5/1/88.
4. The event was reviewed to determine if any additional corrective actions are required relative to the personnel errors that occurred. It was determined that the personnel errors (in procedure development) occurred so far in the past that the best corrective action would be to include the event in the operations training programs. The event will be included as a lesson learned.
5. Plant personnel reviewed the Unit 1 Technical Specifications in light of this event to determine if a similar problem existed. Based on the results of the review, it was determined that Unit 1 did not have this problem since the shorting links are not required to be removed. As such, the Unit 1 RPS logic is not configured to have a non-coincidence mode of operation.

Corrective actions for Event Number 2 included:

1. Developing a revision to plant procedure 57SV-D11-004-2S. The revision to the procedure will incorporate the applicable response time test requirements.
2. Procedure 57SV-D11-004-2S will not be revised for final approval before the unit will start up from the current refueling outage. As such, a special purpose procedure was written on 2/23/88. This procedure, 57SP-0-22-388-IF-1-2S (Reactor Building and Refueling Floor Area Radiation Monitors Time Response Tests), will perform the response time testing. The procedure received its final approval on 3/3/88. The procedure will be used to satisfy the response time testing requirements of the Technical Specifications. This testing will occur prior to the start up of the unit at the end of the current refueling outage. It is anticipated that the unit will startup by approximately 3/17/88.

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3. In the event that the performance of the special purpose procedure demonstrates that the isolation system instrumentation response time requirements of the Technical Specifications are not met, a revision to this LER will be initiated. The revision will discuss any additional actions that are required.
4. Plant personnel reviewed the Unit 1 Technical Specifications in light of this event to determine if a similar problem existed. Based on the results of the review, it was determined that Unit 1 did not have this problem since there is no comparable requirement for response time testing in the Unit 1 Technical Specifications.

G. ADDITIONAL INFORMATION

1. FAILED COMPONENT(S) IDENTIFICATION

No components failed and contributed to these events.

2. PREVIOUS SIMILAR EVENTS

There have been previous events where surveillance requirements have not been fully met. The vents were reported in the following LERs: 50-321/1986-002 Rev 1 (dated 1/6/86), 50-321/1986-008 Rev 1 (dated 1/31/86), 50-321/1986-014 Rev 1 (dated 4/3/86), 50-321/1986-041 (dated 10/10/86), 50-366/1986-004 (dated 1/31/86), 50-366/1986-006 (dated 3/20/86), 50-366/1986-016 (dated 8/7/86), 50-366/1986-025 (dated 10/23/86), 50-321/1987-003 (dated 1/9/87), 50-366/1987-011 (dated 9/2/87), 50-366/1987-016 (dated 12/31/87), and 50-321/1988-001.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

While these LERs describe events where surveillance requirements were not fully met, the events were caused for different reasons. These included: 1) inadequate procedures, 2) incorrect interpretations of Technical Specifications requirements, 3) failure to include sources or equipment into procedures, 4) failure to follow all administrative controls for procedure development, 5) failure to update procedures, 6) inadequate technical reviews of procedures or Technical Specifications, and 7) incorrect assumptions relative to completion of work tasks.

The corrective actions for these events included: 1) developing new procedures, 2) providing correct interpretations of Technical Specifications, 3) leak testing sources, 4) revising procedures, 5) counseling personnel, 6) performing reviews, 7) emphasizing personnel responsibilities for procedure implementations, 8) continuing to implement PUP, 9) strengthening administrative controls, 10) revising Technical Specifications, 11) developing design changes, 12) verifying equipment was operable, and 13) verifying that other surveillance requirements were satisfactory.

The long term corrective actions to prevent these sorts of events is PUP. In the event reported in LER 50-333/1988-002, it was PUP personnel who identified the procedure inadequacy. This detection testifies to the effectiveness of the program. While the event is reportable per the requirements of 10 CFR 50.73, long term corrective actions were in progress to detect and correct procedure deficiencies. PUP will continue to review plant procedures against their respective Technical Specifications requirements to identify problems. Based on the results of these reviews, appropriate corrective actions will be performed to correct any noted deficiencies.

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Georgia Power

the southern electric system

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March 18, 1988

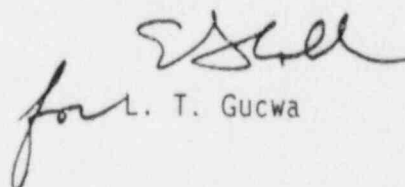
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

PLANT HATCH - UNIT 2
NRC DOCKET 50-366
OPERATING LICENSE NPF-5
LICENSEE EVENT REPORT
PERSONNEL ERRORS CAUSE PROCEDURE ERRORS
LEADING TO VIOLATIONS OF TECHNICAL SPECIFICATIONS

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 an event where some surveillance requirements were not met. The event occurred at Plant Hatch - Unit 2.

Sincerely,


for L. T. Gucwa

LGB/lc

Enclosure: LER 50-366/1988-002

c: (see next page)

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March 18, 1988
Page Two

c: Georgia Power Company

Mr. J. T. Beckham, Jr., Vice President - Plant Hatch
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