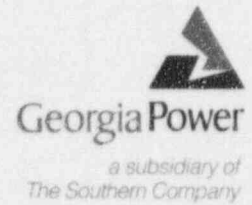


Georgia Power Company
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J. T. Beckham, Jr.
Vice President - Nuclear
Hatch Project

November 12, 1996



Docket No. 50-321

HL-5266

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

Edwin I. Hatch Nuclear Plant - Unit 1
Licensee Event Report
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 a personnel error which resulted in missed Technical Specifications surveillances.

Sincerely,

J. T. Beckham, Jr.

OCV/eb

Enclosure: LER 50-321/1996-013

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. B. L. Holbrook, Senior Resident Inspector - Hatch

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NRC FORM 366 (5-92)		U.S. NUCLEAR REGULATORY COMMISSION																																	APPROVED OMB NO. 3150-0104 EXPIRES: 5/31/95 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNB87714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.																											
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FACILITY NAME (1) Edwin I. Hatch Nuclear Plant - Unit 1																																	DOCKET NUMBER (2) 0 5 0 0 0 3 2 1									PAGE (3) 1 OF 5																				
TITLE (4) Personnel Error Results In Missed Technical Specifications Surveillances																																																														
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 NAME Plant Hatch, Unit 2												DOCKET NUMBER(S) 0 5 0 0 0 3 6 6																							
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OPERATING MODE (9) 1									THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 2 : (Check one or more of the following) (11)																																																					
POWER LEVEL (10) 1 0 0									20.402(b)															20.405(c)															50.73(a)(2)(iv)												73.71(b)											
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									20.405(a)(1)(ii)															50.36(c)(2)															50.73(a)(2)(vi)												OTHER (Specify in Abstract below and in Text, NRC Form 366A)											
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NAME Steven B. Tipps, Nuclear Safety and Compliance Manager, Hatch																																	TELEPHONE NUMBER (include area code) 9 1 1 2 3 6 7 - 7 8 5 1																													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																																														
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-space typewritten lines) (16)																																																														
<p>On 10/22/96 at 1325 EDT, Unit 1 and 2 were in the Run mode, both at a power level of 2558 CMWT (100 percent rated thermal power). At that time, personnel determined that the periodic channel functional test of the Reactor-Mode-Switch-in-Shutdown control rod block function required by Unit 1 and Unit 2 Technical Specifications Surveillance Requirements (SRs) 3.3.2.1.6 had not been performed. These surveillance requirements were added to the Specifications as part of the Improved Technical Specifications and became effective on 7/13/95. They were required by SR 3.0.1 to be performed the first time the mode switch was placed in the Shutdown position after the new requirements became effective. During a review of conditional surveillance requirements, Operations personnel determined that no procedures existed to perform the channel functional test required by SR 3.3.2.1.6 and that the test had not been performed as required. Since the units were not in a mode in which this control rod block function was required to be operable, no actions were required to be taken; however, Operations personnel initiated Required Action Sheets 1-96-322 and 2-96-242 as tracking mechanisms to ensure the surveillance is completed or the required actions taken when each unit enters the mode in which this function is required to be operable.</p> <p>This event was caused by personnel error. Responsible personnel failed to ensure procedures to perform the surveillance tests were in place. Personnel have been made aware of their error and its consequences and mechanisms have been initiated to ensure the tests are performed or actions taken.</p>																																																														

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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TEXT (If more space is required, use additional copies of NRC Form 366A)(17)

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor

Energy Industry Identification System codes appear in the text as (EIS Code XX).

DESCRIPTION OF EVENT

On 10/22/96 at 1325 EDT, Unit 1 and 2 were in the Run mode, both at a power level of 2558 CMWT (100 percent rated thermal power). At that time, Operations personnel determined that the periodic channel functional test of the Reactor-Mode-Switch-in-Shutdown control rod block function required by Unit 1 and Unit 2 Technical Specifications Surveillance Requirements (SRs) 3.3.2.1.6 had not been performed. These surveillance requirements were added to the Unit 1 and Unit 2 Technical Specifications effective 7/13/95 as part of the Plant Hatch Technical Specifications Improvement Program; they are required to be performed once every 18 months. The Reactor-Mode-Switch-in-Shutdown control rod block function is required by Unit 1 and Unit 2 Limiting Conditions for Operation 3.3.2.1 to be operable whenever the respective mode switch is in the Shutdown position.

Because SR 3.3.2.1.6 was a new requirement and equivalent tests had not been performed in the previous 18 months, the tests were required by SR 3.0.1 to be performed when the rod block function was first required to be operable after 7/13/95. That is, the functional tests were required to be performed the first time the respective mode switch was placed in the Shutdown position after the new surveillance requirements became effective. Therefore, the Unit 1 functional test should have been performed on 1/4/96 when the mode switch was placed in the Shutdown position following a reactor scram on high steam dome pressure (Licensee Event Report 50-321/1996-001). The Unit 2 functional test should have been performed on 9/2/95 when the mode switch was placed in the Shutdown position following a manual reactor scram in response to decreasing main condenser vacuum (Licensee Event Report 50-366/1995-003).

During a review of conditional surveillance requirements, Operations personnel determined that no procedures existed to perform the channel functional test required by SR 3.3.2.1.6 and that the Unit 1 and Unit 2 functional tests had not been performed as required on 1/4/96 and 9/2/95, respectively. At the time this deficiency was discovered, neither unit was in a mode in which this control rod block function was required to be operable; therefore, no actions were required to be taken. However, Operations personnel initiated Required Action Sheets 1-96-322 and 2-96-242 on 10/22/96 as tracking mechanisms to ensure the surveillance is completed or the required actions taken when each unit enters the mode in which this function is required to be operable.

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TEXT (If more space is required, use additional copies of NRC Form 366A)(17)

CAUSE OF EVENT

This event was caused by personnel error. Responsible personnel failed to ensure procedures to perform the new tests were in place at the time the new surveillance requirements became effective. Consequently, there were no procedures in place to ensure the functional tests were performed the first time the mode switches were placed in the Shutdown position after the new requirements became effective as required by SRs 3.0.1 and 3.3.2.1.6.

REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This report is required by 10 CFR 50.73 (a)(2)(i) because a condition existed which was prohibited by the plant's Technical Specifications. Specifically, the channel function test of the Unit 1 and Unit 2 Reactor-Mode-Switch-in-Shutdown control rod block function was not performed on 1/4/96 and 9/2/96, respectively, as required by SRs 3.0.1 and 3.3.2.1.6.

Control rods provide the primary means for control of reactivity changes. Control rod block instrumentation includes channel sensors, logic circuitry, switches, and relays that are intended to ensure that inadvertent rod movement does not occur in various situations. During high power operation, the rod block monitor provides protection for control rod withdrawal error events. During low power operations, control rod blocks from the rod worth minimizer enforce specific control rod sequences designed to mitigate the consequences of the control rod drop accident. During shutdown conditions, control rod blocks from the Reactor-Mode-Switch-in-Shutdown function ensure that all control rods remain inserted to prevent inadvertent criticality events.

During situations when the mode switch is required to be in the Shutdown position, the core is assumed to be subcritical; therefore, no positive reactivity insertion events are analyzed. The Reactor-Mode-Switch-in-Shutdown control rod withdrawal block ensures that the reactor remains subcritical by blocking control rod withdrawal thereby preserving the assumptions of the safety analysis.

In this event, the Reactor-Mode-Switch-in-Shutdown control rod block function had not been tested as required by Unit 1 and Unit 2 Technical Specifications SRs 3.0.1 and 3.3.2.1.6. Because the functional test was not performed, the control rod block function could not be assumed to work; however, numerous procedural controls would have prevented personnel from attempting to withdraw a control rod while the mode switch was in the Shutdown position. For example, procedure 34GO-OPS-066-0S, "Single Control Rod Withdrawal in Shutdown or Refuel," requires the mode switch to be locked in the refuel position prior to the withdrawal of any control rod.

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(While the mode switch is in the refuel position, the refuel position one-rod-out interlock prevents more than one control rod from being withdrawn at a time. The core is designed to remain subcritical with one control rod withdrawn. The one-rod-out interlock was operable as required by Unit 1 and Unit 2 Technical Specifications Limiting Conditions for Operation 3.9.2, that is, the channel functional test required by SR 3.9.2.2 was completed successfully at the requisite frequency.) The procedure also requires that the mode switch be confirmed to be locked in the refuel position once every 12 hours thereafter.

Procedures 34GO-OPS-001-1S and 2S, "Plant Startup," require the mode switch to be placed in the start & hot standby position prior to the withdrawal of control rods. Procedures 34GO-OPS-013-1S and 2S, "Normal Plant Shutdown," contain a note that states the requirements of Technical Specifications Special Operations Limiting Condition for Operation 3.10.3, which includes moving the mode switch to the refuel position, must be met if a control rod is to be withdrawn while the unit is in Mode 3 (hot shutdown). The requirements of Limiting Condition for Operation 3.10.3 are implemented by procedure 34GO-OPS-066-0S. Procedures 34SV-C11-004-1S and 2S, "CRD Timing," require the mode switch to be placed in the start & hot standby position prior to the withdrawal of a control rod.

These numerous procedural controls ensured the reactor remained subcritical during shutdown by administratively blocking control rod withdrawal. The procedural controls therefore served the same function as the Reactor-Mode-Switch-in-Shutdown control rod block and preserved the previously described assumptions of the safety analysis. Therefore, it is concluded that this event had no adverse impact on nuclear safety. This analysis is applicable to the shutdown condition.

CORRECTIVE ACTIONS

Responsible personnel still employed with the company have been made aware of the error and its consequences.

Tracking mechanisms in the form of Required Action Sheets 1-96-322 and 2-96-242 have been initiated to ensure the functional tests of the Reactor-Mode-Switch-in-Shutdown control rod block function are performed or the required actions taken when the mode switch is next placed in the Shutdown position.

The new Unit 1 and Unit 2 Technical Specifications SRs, first made effective on 7/13/95, were reviewed to determine if procedures had been identified in the commitment tracking computer matrix as performing the specified tests. It was found two additional SRs were not included in plant procedures: Unit 1 SR 3.10.6.3 and Unit 2 SR 3.10.6.3. These SRs, which require a periodic

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verification that fuel is being loaded in compliance with an approved spiral sequence, must be performed only when Special Operations Limiting Condition for Operation 3.10.6 is used. Neither unit has invoked Limiting Condition for Operation 3.10.6, which allows more than one control rod to be withdrawn with fuel in the reactor vessel, since it was made effective 7/13/95 because no procedures exist to allow this activity to be performed. Therefore, SR 3.10.6.3 has not been required to be performed. Before Special Operations Limiting Condition for Operation 3.10.6 is used, procedures will be written to cover this activity; these procedures will include the requirement to perform SR 3.10.6.3.

ADDITIONAL INFORMATION

No systems other than those already mentioned in this report were affected by this event.

No failed components caused or resulted from this event.

Previous similar events in the last two years in which Technical Specifications required surveillances were not performed were reported in the following Licensee Event Reports:

50-321/1994-015, dated 12/19/94
50-321/1995-001, dated 2/6/95
50-321/1996-002, dated 3/22/96
50-321/1996-011, dated 8/19/96
50-366/1995-002, dated 5/4/95.

In most of these previous events, the applicable surveillance procedures were adequate to perform the required test; however, personnel, for various reasons, failed to perform the procedure at the specified time. Corrective actions for the previous events addressed the personnel and scheduling issues which resulted in the surveillance procedures not being performed on time. In one previous event, the surveillance procedures were performed at the specified frequency; however, the procedures were not adequate to satisfy completely the surveillance requirement. Corrective actions for this previous event involved revising the inadequate procedures and verifying procedures used to perform similar surveillances were adequate.

Because this event was of a different type than the previous similar events in that no procedures existed to perform the required tests, corrective actions for the previous events could not have prevented this event.