LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Line	Field	Value
0 1	LICENSEE CODE (2)	G A E I H 1
	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
	LICENSE TYPE (4)	4 1 1 1 1
	CAT (5)	
CON'T 0 1	REPORT SOURCE (6)	L
	DOCKET NUMBER (7)	0 5 0 0 0 3 2 1
	EVENT DATE (8)	0 6 3 0 8 1
	REPORT DATE (9)	0 7 1 5 8 1

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During steady state power operation it was discovered that the isolation
0 3 valve for the drywell-to-torus system differential pressure instruments
0 4 (T48-N081, N082, N083) was closed, thereby isolating the instruments.
0 5 Redundancy was available although the instruments were isolated. There
0 6 were no effects upon public health and safety due to this event. This
0 7 is a nonrepetitive event for the subject valve and instruments.
0 8

0 9	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
	I E	A	C	I N S T R U	S	Z

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 1	—	0 6 2	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
X	Z	Z	Z	0 0 0 0	Y	Y	A	X X X X

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of the valve closure was apparently due to the failure to fol-
1 1 low procedure during the performance of a test or experiment request
1 2 #80-5 that was previously initiated on 6-4-81. The valve was returned
1 3 to the correct position, and the associated personnel were informed of
1 4 the importance of complete adherence to procedures.

1 5	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
	E	0 9 7	NA	B	QC Inspector Observation

1 6	ACTIVITY RELEASED (33)	CONTENT OF RELEASE (34)	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z	Z	NA	NA

PERSONNEL EXPOSURES

1 7	NUMBER (37)	TYPE (38)	DESCRIPTION (39)
	0 0 0	Z	NA

PERSONNEL INJURIES

1 8	NUMBER (40)	DESCRIPTION (41)
	0 0 0	NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE (42)	DESCRIPTION
	Z	NA

PUBLICITY

2 0	ISSUED (44)	DESCRIPTION (45)	NRC USE ONLY
	N		

8107280611 810715
PDR ADOCK 05000321
S PDR

NAME OF PREPARER C. L. Coggin, Supt. Plt. Eng. Serv. PHONE: 912-367-7851

LER #: 50-321/1981-062
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-321

Narrative Report
for LER 50-321/1981-062

During steady state power operation it was discovered on 6-30-81, that the low side isolation valve for the drywell-to-torus system differential pressure instruments (T48-N081, N082, and N083) was closed, thereby isolating the instruments. The functions of these instruments were, respectively, as follows: 1. initiation of the differential pressure pump in the event of a low D/W-to-torus differential pressure; 2. low differential pressure alarm, and 3. opening of a valve (T48-F204) to allow the system to go into a recirc mode, thereby stopping pressurization, in the event of a high differential pressure.

Upon discovery of the event recorder charts (T48-R631A&B) that monitor the D/W-to-torus differential pressure were reviewed, and it was determined that the D/W-to-torus differential pressure did not decrease below the 1.5 psi setpoint. The fact that these charts are reviewed each shift would have prohibited a potential undetected high or low D/W-to-torus differential pressure. Also a redundant valve (T48-F205) was available for the recirc mode in the event of a high differential pressure.

The cause of the event was apparently due to the failure to follow procedure during the attempts to perform test or experiment request #80-5 on 6-4-81. Investigation revealed that the valve was closed per the TER and not restored to normal. This was caused by the fact that the test performance was aborted due to procedural problems and the fact that the test steps were not signed off per plant procedures in a chronological fashion.

The event was discovered during the performance of an unrelated surveillance as a result of the observation by a site quality control inspector. The valve was returned to normal, and the associated reporting of the event was initiated. The associated personnel have been reminded of the importance of complete adherence to procedures.