NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0 1	G A E I H 1 (2)	0 0 - 0 0 0 0 0 - 0 0 (3)	4 1 1 1 1 (4)	(5)	
	LICENSEE CODE	LICENSE NUMBER	LICENSE TYPE	CAT	

CON'T

0 1	REPORT SOURCE L (6)	0 5 0 0 0 3 2 1 (7)	0 6 2 9 8 3 (8)	0 7 2 1 8 3 (9)
		DOCKET NUMBER	EVENT DATE	REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On 06-29-83 at approximately 1300 hours and again at approximately 2025
0 3 hours, it was discovered that only one "closed" indicating light was lit
0 4 for the "A" torus to drywell vacuum breaker (1T48-F323A). An LCO was
0 5 established and the "SUPPRESSION CHAMBER TO DRYWELL VACUUM BREAKER
0 6 SYSTEM OPERABILITY" procedure (HNP-1-3957) was performed per Tech.
0 7 Specs. section 3.7.A.4.b.(1). The health and safety of the public were
0 8 not affected by these non-repetitive events.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S D (11)	X (12)	Z (13)	V A L V E X (14)	C (15)	C (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 5 8	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	X (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	G 2 0 2 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of the 1330 event is unknown; however, the indicating light
1 1 returned to an operable status approximately 2 hours later. The cause
1 2 of these events has not been determined. These events will be
1 3 investigated and repairs made during the next plant cold shutdown.
1 4

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 9 9 (29)	NA	A (31)	Operator observation

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

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8308080249 830721
PDR ADOCK 05000321
S PDR

PUBLICITY

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

NAME OF PREPARER S. B. Tipps PHONE: (912)367-7851

GPO 917-926

NARRATIVE REPORT
FOR LER 50-321/1983-058

LICENSEE : GEORGIA POWER COMPANY
FACILITY NAME : EDWIN I. HATCH
DOCKET NUMBER : 50-321

Tech. Specs. section(s) which requires report:

1. This 30 day LER is required by Tech. Specs. section 6.9.1.9.b because this event showed that the unit was not meeting the requirements of Tech. Specs. section 3.7.A.4.b.

2. This 30 day LER is required by Tech. Specs. section 6.9.1.9.b because this event showed that the unit was not meeting the requirements of Tech. Specs. section 3.7.A.4.b.

Plant conditions at the time of the event(s):

1. The plant was in steady state operation at 2429 MWT (approximately 100% power).

2. The plant was in steady state operation at 2435 MWT (approximately 100% power).

Detailed description of the event(s):

1. During performance of a normal control room panel check on 06-29-83 at 1330 hours, operating personnel discovered that only one "closed" indicating light was illuminated for the "A" drywell to torus vacuum breaker (1T48-F323A). Tech. Specs. section 3.7.A.4.b requires that two indicating lights be operable (refer to deviation report number 1-83-151).

2. On 06-29-83 at 2025 hours, operating personnel discovered that only one "closed" indicating light was illuminated for the "A" drywell to torus vacuum breaker (1T48-F323A). Tech. Specs. section 3.7.A.4.b. requires that two indicating lights be operable (refer to deviation report number 1-83-154).

Consequences of the event(s):

1. There were no consequences of this event. Public health and safety were not affected by this event.

2. There were no consequences of this event. Public health and safety were not affected by this event.

Status of redundant or backup subsystems and/or systems:

1. The other "closed" indicating light remained operable for 1T48-F323A. The "closed" indicating lights remained operable on the eleven (11) remaining torus to drywell vacuum breakers.

2. The other "closed" indicating light remained operable for 1T48-F323A. The "closed" indicating lights remained operable on the eleven (11) remaining torus to drywell vacuum breakers.

Justification for continued operation:

1. An LCO was established, and the "SUPPRESSION CHAMBER TO DRYWELL VACUUM BREAKER OPERABILITY" procedure (HNP-3957) was satisfactorily performed which demonstrated operability per the requirements of Tech. Specs. sections 3.7.A.4.b.(1) and 4.7.A.4.b.

   The test required by Tech. Specs. section 3.7.a.4.b.(2) was not performed because the indicating light was noted to be operable approximately two hours later.

2. An LCO was established and HNP-1-3957 was satisfactorily performed which demonstrated operability as per Tech. Specs. section 3.7.A.4.b.(1) and 4.7.A.4.b. Additionally, the "DRYWELL TO SUPPRESSION CHAMBER LEAKAGE TEST" procedure (HNP-1-3951) was satisfactorily performed within 24 hours as required by Tech. Specs. section 3.7.A.4.b.(2).

If repetitive, number of previous LER:

1. This event is non-repetitive.

2. This event is non-repetitive.

Impact to other systems and/or Unit:

1. This event had no effect upon any other Unit 1 system nor did it affect any Unit 2 system.

2. This event had no effect upon any other Unit 1 system nor did it affect any Unit 2 system.

Cause(s) of the event(s):

1. The cause of this event has not been determined.

2. The cause of this event has not been determined.

Immediate Corrective Action:

1. None was required other than that indicated under "Justification for Continued Operation"; however, the indicating light was noted to be operable approximately two (2) hours later.

2. None was required other than that indicated under "Justification for Continued Operation".

Supplemental Corrective Action:

1. No supplemental corrective action was required.

2. No supplemental corrective action was required.

Scheduled (future) corrective action:

1. These events will be investigated and repairs made during the next plant cold shutdown.

2. These events will be investigated and repairs made during the next plant cold shutdown.

Action to prevent recurrence (if different from corrective actions):

1. The scheduled corrective action should prevent recurrence.

2. The scheduled corrective action should prevent recurrence.

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Telephone 912 367-7781
912 537-9444

Edwin I. Hatch Nuclear Plant

Georgia Power

GM-83-666
July 21, 1983

PLANT E. I. HATCH
Licensee Event Report
Docket No. 50-321

United States Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region II
Suite 3100
101 Marietta Street
Atlanta, Georgia 30303

ATTENTION: Mr. James P. O'Reilly

Attached is Licensee Event Report No. 50-321/1983-058. This report is required by Hatch Unit 1 Technical Specifications Section 6.9.1.9.b.

H. C. Nix
General Manager

1cc
HCN/SBT/djs

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