

## LICENSEE EVENT REPORT

CONTROL BLOCK: 

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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0	1	L	6	0	5	0	0	0	3	6	6	7	0	8	1	1	8	3	8	0	9	0	1	8	3	9
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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On 8/11/83, during the post-maintenance review of DCR 83-76, it was de-

0 3 | terminated that the torus vent valve's (2T48-F318) instrument air piping

0 4 | had been returned to service on 6/10/83 without the necessary perform-

0 5 | ance of HNP-6907. This is contrary to the requirements of Tech. Specs.

0 6 | section 6.9.1.9.c. The valve's instrument air piping remained operable,

0 7 | thus plant operation was not affected. The health and safety of the

0 8 | public were not affected by this non-repetitive event.

0	9	S	B	11	A	12	F	13	P	I	P	E	X	X	14	A	15	Z	16
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17 LER/RO REPORT NUMBER 8 3

18 ACTION TAKEN H 19 FUTURE ACTION Z 20 EFFECT ON PLANT Z 21 SHUTDOWN METHOD Z 22 HOURS 0 0 0 0

23 SEQUENTIAL REPORT NO. 0 6 4

24 OCCURRENCE CODE 0 3

25 REPORT TYPE L

26 REVISION NO. 0

27 ATTACHMENT SUBMITTED Y 28 NPRD-4 FORM SUB. N 29 PRIME COMP. SUPPLIER N 30 COMPONENT MANUFACTURER X 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | This event is the result of a personnel oversight. Upon discovery, the

1 1 | valve's instrument air piping was functionally tested satisfactorily per

1 2 | HNP-6907 and returned to service on 8/11/83. The responsible person

1 3 | was counseled as to the importance of performing the required procedure

1 4 | prior to returning the system to service.

1	5	E	28	0	9	3	29	NA	30	A	31	Post-Maint. Review	32
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1 6 | Z 33 Z 34 NA 35 NA 36

1 7 | 0 0 0 37 Z 38 NA 39

1 8 | 0 0 0 40 NA 41

1 9 | Z 42 NA 43

2 0 | N 44 NA 45

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PDR ADOCK 05000366  
S PDR

NRC USE ONLY

NAME OF PREPARER S. B. Tipps

PHONE: (912)367-7851

NARRATIVE REPORT  
FOR LER 50-366/1983-064

LICENSEE : GEORGIA POWER COMPANY  
FACILITY NAME : EDWIN I. HATCH  
DOCKET NUMBER : 50-366

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

This 30-day LER is required by Tech. Specs. section 6.9.1.9.c.

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

This event was discovered on 8/11/83 with the unit in steady state operation at 2254 MWt (approximately 93% power).

Detailed description of the event(s):

On 6/10/83, after completion of a Design Change Request (DCR), the torus vent valve (2T48-F318) and its associated instrument air piping were returned to service. On 8/11/83 during a post-maintenance review, it was determined that the torus vent valve's instrument air piping had been returned to service without the necessary performance of the "PRESSURE TESTING OF PIPING AND COMPONENTS" procedure (HNP-6907).

Consequences of the event(s):

The 2T48-F318 valve and its associated piping remained operable, thus plant operation was not affected. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

N/A

Justification for continued operation:

The 2T48-F318 valve's instrument air piping was functionally tested per HNP-6907. The results of this test were satisfactory, thus indicating that safe operation and reliability of the valve was not jeopardized after completion of the DCR on 6/10/83.

If repetitive, number of previous LER:

This is a non-repetitive event.

Narrative Report for LER 50-366/1983-064  
Page Two

Impact to other systems and/or Unit:

This event had no effect on any other Unit 2 system. This event did not affect Unit 1.

Cause(s) of the event(s):

This event was the result of a personnel oversight. The responsible person over looked the requirement to perform HNP-6907 prior to returning the valve to service.

Immediate Corrective Action:

The valve's instrument air piping was functionally tested satisfactorily per the required HNP-6907 procedure and then returned to service on 8/11/83.

Supplemental Corrective Action:

The responsible person was counseled as to the importance of performing the required procedure prior to returning a system to service.

Scheduled (future) corrective action:

No future corrective action is required.

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

N/A

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Baxley, Georgia 31513  
Telephone 912 367-7781  
912 537-9444

USNRC REGIONAL  
ATLANTA, GEORGIA



Georgia Power  
83 SEP 6 48:56

Edwin I. Hatch Nuclear Plant

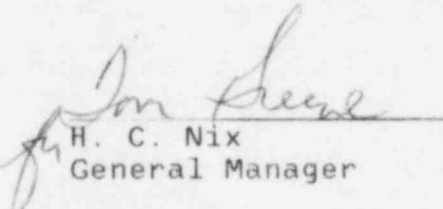
September 1, 1983  
GM-83-866

PLANT E. I. HATCH  
Licensee Event Report  
Docket No. 50-366

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. 50-366/1983-064. This report is required by Hatch Unit 2 Technical Specifications Section 6.9.1.9.c.

  
H. C. Nix  
General Manager

*see*  
HCN/SBT/amh

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