

CONTROL BLOCK:

							(1)
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(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'TEVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS				ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER				
G	18	Z	19	Z	20	Z	21	0	0	0	0	22	Y	23	N	24	Z	25	Z	9	9	9
32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54

FACILITY STATUS		% POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION
F	(28)	0 7 5 (29) NA	(30)	D (31)	NRC Audit on SSGT System (32)

PERSONNEL EXPOSURES										
NUMBER			TYPE	DESCRIPTION						
1	7	0	0	0	(37)	2	(38)	NA		

PERSONNEL INJURIES		DESCRIPTION	
NUMBER			
1	8	0	0
0	0	0	40
		NA	

8211040083 821021
RDR ADCK 052

1	9	Z	42	NA	LOSS OF OR DAMAGE TO FACILITY	43	PDR	ADUCK 05000366	S	PDR
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[illegible]

PHONE: 912-367-7851

LER #: 50-366/1982-112
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1982-112

During an NRC audit exit interview held on October 8, 1982, the site was notified of potential problems concerning the completeness of logic system testing. Starting on October 9, 1982, with Hatch Unit 2 at 75% power, and Hatch Unit 1 at 50% power, plant personnel discovered that plant procedures did not adequately test the automatic initiation logic of the following: Standby Gas Treatment System, Unit 2 (Deviation Report Number 2-82-253, Discovery date: 10-9-82, test required per Tech. Specs. 4.6.6.1.d.2), Reactor Core Isolation Cooling System (Deviation Report Number 2-82-255, Discovery date: 10-14-82, testing required per Tech. Specs. 4.3.4.1 and Table 3.3.4.1), High Pressure Coolant Injection System (Deviation Report Number 2-82-257, Discovery date: 10-14-82, testing required per Tech. Specs. 4.5.1.c.1), Automatic Depressurization System (Deviation Report Number 2-82-258, Discovery date: 10-14-82, testing required per Tech. Specs. 4.5.2.a), and Standby Gas Treatment System, Unit 1 (Deviation Report Number 1-82-185, Discovery date: 10-14-82, testing required per Unit 1 Tech. Specs. 4.7.B.1.d and Unit 2 Tech. Specs. 3/4.6.6.1). Health and safety of the public were not affected by this non-repetitive event.

The event resulted from the failure of procedures to adequately test several plant systems. The inadequacies included failure to test a relay and/or the continuity of one or more sets of contacts in each of the logic systems involved. New procedures were written and performed to test the logic excluded in the existing procedures. Further investigation is underway and a subsequent update report will be submitted.