

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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 G A E I H 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 1000 1 L 0 5 0 0 0 3 6 6 1 0 2 8 8 1 1 1 2 4 8 1 9
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On 10-18-81, & on 11-12-81, with Unit 2 at steady state 99% power a walk
0 3 down of the HPCI system was performed & it was observed on 10-28-81 that
0 4 a rigid restraint on the HPCI pump disch. line was broken & on 11-12-81
0 5 that a HPCI pump disch. line hanger was bent. The A/E's evaluation in
0 6 each case, found only a reduction of the stress safety factor; HPCI was
0 7 not declared inop. There were no effects upon public health & safety due
0 8 to this event. This is a non-repetitive occurrence for this system.

0 9 SYSTEM CAUSE CAUSE COMPONENT COMP. VALVE
CODE CODE SUBCODE CODE SUBCODE SUBCODE
S F 11 E 12 B 13 S U P O R T 14 B 15 Z 16
9 10 11 12 13 14 15 16 17 18 19 20
17 LER/RO EVENT YEAR SEQUENTIAL OCCURRENCE REPORT REVISION
NUMBER REPORT NO. REPORT NO. CODE TYPE NO.
8 1 1 0 4 0 3 L 0
21 22 23 24 25 26 27 28 29 30 31 32
ACTION FUTURE EFFECT SHUTDOWN HOURS ATTACHMENT NPRD-4 PRIME COMP. COMPONENT
TAKEN ACTION ON PLANT METHOD 22 SUBMITTED FORM SUB. SUPPLIER MANUFACTURER
B X Z Z 0 0 0 0 Y N A B 2 0 9
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Investigation by the A/E is in progress to identify the cause of the
1 1 failed restraint; the bent hanger was apparently a result of the failed
1 2 restraint. The restraint & the hanger were repaired. A visual inspection
1 3 of all HPCI hangers revealed no other failures. Investigation is still
1 4 underway by the A/E into the cause, an update report will be submitted.

1 5 FACILITY % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION
STATUS 28 0 9 9 29 NA C 31 Maint. Walkdown of System
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 6 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE
33 Z 34 NA NA
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 7 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
0 0 0 37 Z 38 NA
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 8 PERSONNEL INJURIES NUMBER DESCRIPTION
0 0 0 40 NA
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
Z 42 NA
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

2 0 PUBLICITY ISSUED DESCRIPTION
N 44 NA
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 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

8112070514 811124
PDR ADOCK 0500 366
S PDR

NRC USE ONLY

NAME OF PREPARER C. L. Coggin - Supt. Plt. Eng. Serv.

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LER #: 50-366/1980-104
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1980-104

On 10-28-81, with Unit 2 at steady state 99% thermal power, a walkdown of the HPCI piping was being performed by site personnel. During this walkdown, maintenance personnel observed that the threaded rod for the turnbuckle on a rigid restraint (2E41-HPCI-R51; Bergen Patterson model # 2200-R/3-3-1'-11 1/2") on the HPCI pump discharge line was broken. Deviation report 2-81-184 was written, and is reportable under Tech Spec Section 6.9.1.9.b. Upon preliminary evaluation, performed by the A/E, it was determined that the system operability was not in jeopardy, the failed restraint only reduced the pipe stress safety factor. The HPCI system was not declared inoperable. The threaded rod of the restraint was replaced and was returned to its original design status.

On 11-12-81, with Unit 2 at steady state 93% thermal power, and with HPCI inoperable due to maintenance being performed for a design change, a walkdown of the HPCI system piping was being performed by site personnel. It was observed that a pipe hanger (2E41-HPCI-H30; Bergen Patterson model # 2200-R/3-10-5'-3 1/4") on the HPCI pump discharge line (the hanger immediately downstream of 2E41-HPCI-R51) was bent approximately 30-50° at the pipe clamp perpendicular to the pipe axis. Deviation report 2-81-201 was written and is reportable per Tech Spec 6.9.1.9.b. Analysis by the A/E indicated that since the rigid restraint failure (2E41-HPCI-R51) was apparently the cause of this pipe hanger's bending, and since the restraint is back to the original design status, the system operability is not in question. The bent hanger was straightened, and will be replaced during the next unit refueling outage as a matter of good practice. In either event, there were no effects upon public health and safety due to these events. This is a non-repetitive event for this system.

The cause of the rigid restraint's failing is still under investigation by the A/E, but preliminary results indicate a dynamic load on the restraint associated with a water hammer could have contributed to the failure. A visual walkdown of all HPCI pipe supports has been performed and no other failures were observed. An update report will be submitted.