NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
0 1	LICENSEE CODE (2)	GAEIH2
	LICENSE NUMBER (3)	00-00000-00
	LICENSE TYPE (4)	41111
	CAT (5)	
CON'T 0 1	REPORT SOURCE (6)	X
	DOCKET NUMBER (7)	05000366
	EVENT DATE	031282
	REPORT DATE (9)	040882

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 With Unit 2 in refueling mode, bench testing of the main steam safety
0 3 relief valves was in progress per HNP-2-6020. Wyle personnel noted that
0 4 the pilot sensing tube was missing from valve S/N 312. No significant
0 5 occurrence took place as a result of this event. Unit 1 has installed
0 6 valves of the same design. This is a non-repetitive event. This event
0 7 posed no threat to public health or safety. All of the other ten relief
0 8 valves were available and operable.

Line	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
0 9	CC	E	B	VALVEX	X	B

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
82	—	023	/	03	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)
Z	A	Z	Z	0000	Y	N	N	T020

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event was failure of the welds that hold the sensing
1 1 tube in place. The tube will be replaced by the vendor prior to rein-
1 2 stallation of the valve. The affected welds on all other Unit 2 valves
1 3 will be inspected prior to unit startup. The affected welds on all Unit
1 4 1 valves will be inspected during the next refueling outage.

Line	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
1 5	H	000	NA	D	Offsite Surveillance

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

PERSONNEL EXPOSURES

Line	NUMBER (37)	TYPE (38)	DESCRIPTION (39)
1 7	000	Z	NA

PERSONNEL INJURIES

Line	NUMBER (40)	DESCRIPTION (41)
1 8	000	NA

LOSS OF OR DAMAGE TO FACILITY (43)

Line	TYPE (42)	DESCRIPTION
1 9	Z	NA

PUBLICITY

Line	ISSUED (44)	DESCRIPTION (45)
2 0	N	NA

NRC USE ONLY

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NAME OF PREPARER H. L. Sumner - Supt. Plt. Eng. Serv. PHONE: 912-367-7851

GPO 917-926

LER #: 50-366/1982-023
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1982-023

With Unit 2 in the refueling mode, bench testing of the main steam safety/relief valves was in progress per plant procedure HNP-2-6020, "Main Steam Relief Valves Maintenance". During setup for testing at Wyle Laboratories, Wyle personnel noted that the pilot sensing tube was missing from valve body S/N 312 which had been installed during plant operation as 2B21-F013B. This valve is a Target Rock model 7567F safety/relief valve. Further investigation showed that the main disc and main seat of this valve were damaged in a way that could have been caused by passage of the pilot sensing tube during valve operation. The discharge route and present location of the tube has not yet been confirmed. Investigation is underway by site personnel to resolve this question. The purpose of the pilot sensing tube is to provide a true pressure to the pilot assembly during valve actuation. At this time the static pressure in the valve is reduced due to steam flowing through the open valve. The absence of the pilot sensing tube does not affect the valve actuation setpoint. The A/E is in the process of investigating this and any other potential effects that this type of failure could have on valve operability. At the time of the event, all of the remaining ten safety/relief valves were operable. Plant Technical Specifications requires nine of these valves to be operable for pressure relief function. No significant occurrence took place as a result of this event. The main steam safety/relief valves installed on Unit 1 are of the same make and model. This is a non-repetitive event. This event posed no threat to public health or safety.

This event was caused by a failure of the tube support welds. The support plates were found in place on the valve wall. The tube-to-plate welds had failed, thus releasing the tube.

The tube for this valve will be replaced by the vendor using a new support design. The new support is comprised of a single strap which fits over the tube and is welded to the wall on both sides. The other damaged components of this valve will also be replaced by the vendor.

The A/E is in the process of investigating the need for modification of the balance of plant valves. All of the remaining Unit 2 valves of this design, including spares, will be inspected to assure the integrity of the tube support welds prior to unit startup. All of the Unit 1 valves of this design will be inspected during the upcoming Unit 1 refueling outage. An update report will be submitted when the inspection is complete.