NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

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

CON'T 01 | REPORT SOURCE L (6) | 0 5 0 0 0 3 6 6 (7) DOCKET NUMBER | 0 1 2 8 8 2 (8) EVENT DATE | 0 2 2 3 8 2 (9) REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On 1-28-82, with Unit 2 at 50 percent power (1228 MWt) a LLRT was done on the D/W personnel airlock innerspace (as per HNP-2-3952, Primary Containment Periodic Type B and Type C Leakage Tests) as required by Tech Spec 4.6.1.3.b. A review of the test results determined that the leakage rate was in excess of the .05 La limit dictated by Tecn Spec 3.6.1.3.b (As found leakage:would not pressurize - .05 La:3020 ACCM). This is a non-repetitive event. There was no effect on the public.

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
S A (11)	E (12)	B (13)	P E N E T R (14)	A (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 2	—	0 1 4	/	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)	(19)	Z (20)	Z (21)	0 0 0 0	Y (23)	Y (24)	A (25)	C 3 1 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

An investigation determined that the cause of the innerspace leaking was due to a damaged shaft and seal assembly on the outer airlock door (the shaft is used to operate inner door). Corrective action consisted of removing the damaged assembly and temporarily replacing it with a blind flange. The innerspace was then successfully retested (As left:695 ACCM).

FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
E (28)	0 5 0 (29)	NA	B (31)	Local Leak Rate Test

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

TYPE	DESCRIPTION
Z (42)	NA

PUBLICITY

ISSUED	DESCRIPTION (45)
N (44)	NA

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NRC USE ONLY

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GPO 917-926

LER #: 50-366/1982-14
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1982-14

On January 28, 1982, with Unit 2 at 50 percent thermal power (1228 MWt) a Local Leak Rate Test (LLRT) was performed on the drywell personnel airlock innerspace (as per HNP-2-3952, PRIMARY CONTAINMENT PERIODIC TYPE B AND TYPE C LEAKAGE TESTS). This LLRT was being done as the "at least once per 6 months" test required by Tech Spec section 4.6.1.3.b.

A review of the test results showed that the leakage rate was in excess of the .05 La limit dictated by Tech Spec section 3.6.1.3.b (As found leakage: innerspace would not pressurize - .05La:3020 ACCM). This is a non-repetitive event. The public health and safety was not affected by this event.

The LLRT failed at 1500 on January 28, 1982, and as a result an LCO (#2-82-34) was declared per Tech Spec 3.6.1.3, Action B: "With the primary containment airlock inoperable, except as a result of an inoperable airlock door, maintain at least one air lock door closed; restore the inoperable airlock to OPERABLE status within 24 hours". The LCO continues in 3.6.1.3, Action C as follows: "Otherwise, be in at least HOT SHUTDOWN within the next 12 hours and in COLD SHUTDOWN within the following 24 hours." The corrective action and successful retest (see details below) were completed and the LCO closed out at 1915 on January 29, 1982 - the unit was allowed to continue operating.

An investigation determined that the cause of the innerspace leakage was due to the leaking of the lower shaft and wheel assembly on the outer airlock door (used to operate the inner door from outside the airlock on the outer door side). Immediate corrective action was to remove the damaged shaft and wheel assembly and temporarily cover the resultant hole with a blind flange (Reference DCR # 82-012 and implementing MR 2-82-459). The innerspace was then successfully retested (As left leakage:695 ACCM). Final corrective action is incomplete at this time - an investigation is underway to determine what final corrective action will be needed. A review of this event for generic concerns revealed no such problems.