

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0	9	SYSTEM CODE		C	C	11	CAUSE CODE		E	12	CAUSE SUBCODE		B	13	COMPO INT CODE				V	A	.	V	E	X	14	COMP. SUBCODE		X	15	VALVE SUBCODE		B	16																																	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	SEQUENTIAL REPORT NO.		0	6	0	27	OCCURRENCE CODE		0	1	28	29	REPORT TYPE		T	30	31	REVISION NO.		0	32																																
17		LER/RO REPORT NUMBER		EVENT YEAR		8	2	21	22	ACTION TAKEN		A	18	FUTURE ACTION		G	19	EFFECT ON PLANT		C	20	SHUTDOWN METHOD		C	21	HOURS		0	1	6	8	22	ATTACHMENT SUBMITTED		Y	23	NPRD-4 FORM SUB.		N	24	PRIME COMP. SUPPLIER		N	25	COMPONENT MANUFACTURER		T	0	2	0	26															
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

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

8 9 10
PUBLICITY
ISSUED DESCRIPTION (45)
2 0 [N] (44) NA S PDR
8207270263 820715
PDR ADDCK 05000321
S PDR
NRC USE ONLY

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

LER #: 50-321/1982-60
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-321

Narrative Report
for LER 50-321/1982-60

On July 3, 1982, while operating at 100% steady state power, a spurious Reactor High Pressure signal resulted in a reactor scram at 07:49 CDT. At the beginning of the transient, level dropped to the Group I isolation setpoint closing the MSIV's and resulting in a steady reactor vessel repressurization. The safety relief valves (11) which were supposed to lift between 1080 and 1100 psig did not actuate to terminate the pressurization. At 1180 psig, 3 SRV's, F, G, and L, lifted for approximately 30 seconds, reducing pressure to normal, at which point the MSIV's were opened and the EHC pressure control system took over. The failure of the SRV's to actuate at the required setpoint is a violation of Technical Specification 2.2.A.1.b. The valves were declared inoperable and the unit was placed in cold shutdown. There were no safety consequences as a result of the event since no safety limits were exceeded. There was no degradation to plant equipment as a result of the event. The public health and safety were unaffected by the event. This is a non-repetitive occurrence.

The reason for the SRV actuation anomaly has not been determined, but is believed to be setpoint drift. All 11 pressure actuating cartridges have been sent to Wyle Laboratory for testing. The cartridges have been replaced with new or re-calibrated ones. Two valve bodies (E and L) have been disassembled and inspected by site, vendor and Wyle Laboratory personnel. No abnormal indications were found. A surveillance program that periodically exercises the relief valves will be used to prevent recurrence of this type problem.