NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

UPDATE REPORT - PREVIOUS
REPORT DATE 5/5/83

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

Field	Value
01 LICENSEE CODE (2)	G A E I H 1
LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
LICENSE TYPE (4)	4 1 1 1 1
CAT (5)	
CON'T 01 REPORT SOURCE (6)	L
DOCKET NUMBER (7)	0 5 0 0 0 3 2 1
EVENT DATE (8)	0 3 2 3 8 3
REPORT DATE (9)	0 5 1 6 8 3

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 3/20/83, the PRB determined that a lack of administrative control
03 existed in complying with the "CABLE AND CABLE WAYS INSTALLATION"
04 procedure (HNP-6921) because of the material condition of the cable
05 trays. Engineering evaluation revealed that plant operating safety was
06 not affected. Cable tray discrepancies were restored to acceptable
07 limits. The health and safety of the public were not affected by this
08 non-repetitive event.

09	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
	X X	D	Z	Z Z Z Z Z Z	Z	Z

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 3 6	/	0 1	X	—	3

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)
G	X	Z	Z	0 0 0 0	Y	N	Z	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of this event is the lack of specific procedure instructions
11 in delineating responsibilities. The procedure has been revised to
12 clearly specify supervisory and quality control inspection responsi-
13 bilities. Also, design acceptance criteria is available for installa-
14 tion, and maintenance and inspection.

15	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
	E	0 9 9	NA	D	NRC Inspection

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

PERSONNEL EXPOSURES

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

PERSONNEL INJURIES

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

LOSS OF OR DAMAGE TO FACILITY (43)

19	TYPE (42)	DESCRIPTION
	Z	NA

8305270234 830516
PDR ADOCK 05000321
S PDR

PUBLICITY

20	ISSUED (44)	DESCRIPTION (45)
	N	NA

NRC USE ONLY

IE22

NAME OF PREPARER S. B. Tipps PHONE: (912)367-7851

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Georgia Power

Edwin I. Hatch Nuclear Plant

May 16, 1983
GM-83-477

PLANT E. I. HATCH
Licensee Event Report
Docket No. 50-321

United States Nuclear Regulatory Commission
Office of Inspection and Enforcement
Region II
Suite 3100
101 Marietta Street
Atlanta, Georgia 30303

ATTENTION: Mr. James P. O'Reilly

Pursuant to Sections 6.9.1.9.c and 6.9.1.8.i. of Hatch Unit One Technical Specifications and Section 6.9.1.9.c. of Unit Two Technical Specifications, please find attached Reportable Occurrence Report No. 50-321/1983-036, Revision 3.

H. C. Nix
General Manager

HCN/SBT/abb

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IE22

NARRATIVE REPORT
FOR LER 50-321/1983-036, Revision 3
Update Report - Previous Report Date 5/5/83

LICENSEE : GEORGIA POWER COMPANY
FACILITY NAME : EDWIN I. HATCH
DOCKET NUMBER : 50-321

Tech. Specs. section(s) which requires report:

1. This LER is required by Tech. Specs. section 6.9.1.9.c. (reference deviation report number 1-83-68).

2. This LER is required by Tech. Specs. section 6.9.1.8.i due to the event's showing that the unit was not meeting the requirements of Unit 1 Tech. 3.5.B.3 (reference deviation report number 1-83-74).

3. This LER is required by Tech. Specs. section 6.9.1.9.c (reference deviation report number 1-83-27A).

4. This LER is required by Tech. Specs. section 6.9.1.9.c. (reference deviation report number 1-83-82).

5. This LER is required by Unit 2 Tech. Specs. section 6.9.1.9.c. (Reference deviation report number 2-83-49). (Items 1 thru 4 and item 6 apply to Unit 1.)

6. This LER is required by Unit 1 Tech. Specs. section 6.9.1.9.b. (Reference deviation report number 1-83-96).

Plant conditions at the time of the event(s):

1. This event occurred on 3/20/83, with the mode switch in the run position and reactor power at 2424 MWt (approximately 99% of full power).

2. This event occurred on 3/23/83, with the unit in steady state operation at 2433 MWt (approximately 100% power).

3. This event occurred on 3/22/83 with the unit in steady state operation at 2430 MWt (approximately 100% power).

4. This event occurred on 4/5/83 with the unit in steady state operation at 2429 MWt (approximately 100% power).

5. This event occurred on 4/5/83 with the unit shutdown for refueling.

6. This event occurred on 4/26/83, with the unit in steady state operation at 2402 MWt (approximately 98% power).

Detailed description of the event(s):

1. On 3/20/83, the Plant Review Board determined that there was a lack of administrative control concerning cable tray restoration. This determination was made due to the discovery of an inadequacy in procedural control and inspection of work performed on cable trays.

2. The "CABLE TRAY AND EQUIPMENT CONDITION INSPECTION" procedure was being performed. A four inch aluminum channel containing the power feed cables for RHR valve motor 1E11-F015B was found cracked. Also, a conduit support supporting the control cables for a RHR valve motor 1E11-F017A was found disconnected. The operability of both loops of the Residual Heat Removal (RHR) LPCI system would be suspect during a seismic event which could be contrary to the requirements of Tech. Specs. 3.5.B.3.

3. Safety related cables H11-P621-E57-C060 and H11-P621-E57-C061 were found routed in the non-seismic west cableway. These cables are associated with the automatic transfer of the RCIC suction from the condensate storage tank (CST) to the suppression chamber.

4. Safety related cables R24-S025-E57-C51C and R24-S025-E57-C55C were found routed in the non-seismic westcableway. These cables provide for the automatic closure of Plant Service Water (PSW) valves 1P41-F310A and 1P41-F310D on a condenser room flooding signal.

5. Safety related cables PVE703C04 and PVE704C04 were found routed in the non-seismic west cableway. These cables provide for the automatic closure of Plant Service Water (PSW) valves 2P41-F316A and 2P41-F316D on a condenser room flooding signal.

6. During performance of a cable tray walkdown per the "CABLE TRAY AND EQUIPMENT CONDITION INSPECTION" procedure, inspecting personnel discovered that Division I and Division II cable separation had not been maintained as required by FSAR Section 8.8.3.5.L.1: A section of Kaowool is missing from cable tray number TEN7-01 near NSSS cabinet 1H11-P630, and near cable trays TMG0-02 and TMG0-03.

Consequences of the event(s):

1. Plant operations were not affected by this event. The health and safety of the public were not affected by this event.

2. An orderly reactor shutdown was initiated per Tech. Specs. section 3.5.B.3. The health and safety of the public were not affected by this event.

3. This event had no effect on plant operation. The health and safety of the public were not affected by this event.

Consequences of the event(s):

4. This event had no effect on plant operation. The health and safety of the public were not affected by this event.

5. This event had no effect on plant operation. The health and safety of the public were not affected by this event.

6. This event had no effect on plant operations. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

1. N/A.

2. The HPCI, RCIC, ADS, and CS systems were operable.

3. The HPCI, ADS, CS, and RHR systems were operable.

4. Each of the subject valves is backed-up by redundant valves whose circuitry is routed independently of the west cableway. These redundant valves were operable.

5. Each of the subject valves is backed-up by redundant valves whose circuitry is routed independently of the west cableway. These redundant valves were operable.

6. The status of the redundant cable trays is not a factor in this event because there was not an operability concern (see "Justification for continued operation").

Justification for continued operation:

1. After the initial inspection, engineering determined that no operational problem existed; however, the cable tray discrepancies that were found during the initial inspection were restored to acceptable limits using a generic model as a guideline for determining the acceptance criteria.

2. The damaged four inch aluminum channel was replaced and the conduit supports reconnected. The system was returned to operable status within 24 hours. Also, the HPCI, RCIC, ADS, and CS systems were operable.

3. Bechtel Power Corp. performed a study which showed that a failure of the subject cables will not jeopardize primary containment integrity, will not have adverse safety implications on RCIC operability, and will not prevent a desired suction transfer. Also, the HPCI, ADS, CS, and RHR systems were operable.

Justification for continued operation:

4. Bechtel Power Corporation provided an analysis which covered the effects of failures of the subject cables regardless of redundant equipment. The analysis concluded that no adverse safety implications result from the routing of the subject cables in the west cableway. Also, each of the subject valves is backed-up by redundant valves whose circuitry is routed independently of the west cableway.

5. Bechtel Power Corporation provided an analysis which covered the effects of failures of the subject cables regardless of redundant equipment. The analysis concluded that no adverse safety implications result from the routing of the subject cables in the west cableway. Also, each of the subject valves is backed-up by redundant valves whose circuitry is routed independently of the west cableway.

6. A fire watch was established immediately after the event was discovered.

If repetitive, number of previous LER:

1. This is a non-repetitive event.

2. This is a non-repetitive event.

3. This is a non-repetitive event.

4. This is a repetitive event. LER 50-321/1983-036, Rev. 1, Item 3, discusses other safety related cables found in the non-seismic west cableway.

5. This is a repetitive event. LER 50-321/1983-036, Rev. 1, Item 3, discusses other safety related cables found in the non-seismic west cableway.

6. This is a non-repetitive event.

Impact to other systems and/or Unit:

1. Unit 2 was affected by this event due to the "CABLE AND CABLEWAYS INSTALLATION" procedure (HNP-6921) being common to both units. An extensive inspection of the safety-related cable trays for Unit 2 is scheduled for the up-coming refueling outage (approximate start date 4/5/83).

2. This event had no impact on Unit 2 and no impact to other systems on Unit 1.

Impact to other systems and/or Unit:

3. This event had no impact on Unit 2 and no impact to other systems on Unit 1.

4. This event had no impact on Unit 2 and no impact to other systems on Unit 1.

5. This event had no impact on Unit 1 and no impact to other systems on Unit 2.

6. This event did not affect any other Unit 1 nor Unit 2 systems.

Cause(s) of the event(s):

1. The cause of this event was due to the "CABLE AND CABLE WAYS INSTALLATION" procedure (HNP-6921) not clearly defining the responsibilities of the responsible personnel. Additionally the necessary design detail information for determining acceptance criteria was not on hand at the time of this event.

2. The cause of this event was due to a construction and/or installation error.

3. The cause of this event was a design error.

4. The cause of this event was a design error.

5. The cause of this event was a design error.

6. The cause of this event is due to construction and/or installation error.

Immediate Corrective Action:

1. When it was recognized that lack of administrative control existed, electrical modifications and cable pulling were stopped and the "CABLE AND CABLE WAYS INSTALLATION" procedure (HNP-6921) was revised to require adequate supervision and quality control inspection when construction or maintenance work is performed on cables and cable ways. Inspection personnel (i.e., Quality Control, Engineers) were trained to enable them to recognize deficiencies related to proper installation and re-installation of cables and cable ways.

2. Upon discovery, the damaged four inch aluminum channel was replaced and the conduit support reconnected.

3. No immediate corrective action is required.

4. No immediate corrective action is required.

Immediate Corrective Action:

5. No immediate corrective action is required.

6. A fire watch was established as a precautionary measure and will continue until the cable tray fire barrier is installed.

Supplemental Corrective Action:

1. No supplemental corrective action was required.

2. No supplemental corrective action was required.

3. No supplemental corrective action was required.

4. No supplemental corrective action was required.

5. No supplemental corrective action was required.

6. No supplemental corrective action is required.

Scheduled (future) corrective action:

1. Future corrective action will include a revised quality assurance program checklist and an upgraded applicable quality assurance audit plan. Additionally, contractors will be provided with detailed directions with management acceptance criteria.

2. No further action is required.

3. Bechtel Power Corporation will provide a recommendation regarding the disposition of the subject cables.

4. Bechtel Power Corporation will provide a recommendation regarding the disposition of the subject cables.

5. Bechtel Power Corporation will provide a recommendation regarding the disposition of the subject cables.

6. A maintenance request has been generated which reflects this deficiency. The Kaowool fire barrier will be installed after the walkdown and engineering evaluation is complete, and during cable tray restoration.

Action to prevent recurrence (if different from corrective actions):

1. The "CABLE AND CABLE WAYS INSTALLATION" procedure (HNP-6921) has been revised to more clearly define the responsibilities of supervision, engineering and Quality Control inspection of all raceway installations, cable installations and raceway restoration. Maintenance, construction and Quality Control inspections require the completion of an appropriate procedure data package. Additionally, Quality Control personnel and supervision (foreman and above) of Engineering, Maintenance and Retrofit are being trained to recognize deficiencies related to proper installation and re-installation of cables and cableways.

2. No further action will be required.

3. No further action will be required, other than the scheduled (future) action.

4. No further action will be required, other than the scheduled (future) action.

5. No further action will be required, other than the scheduled (future) action.

6. The "CABLE AND CABLE WAYS INSTALLATION" procedure (HNP-6921) has been revised to more clearly define the responsibilities of Supervision, Engineering, and Quality Control inspection of all raceway installation, cable installations and raceway restoration. Maintenance, construction, and Quality Control inspections require the completion of an appropriate procedure data package. Additionally, Quality Control personnel and supervision (foreman and above) of Engineering, Maintenance and Retrofit are being trained to recognize deficiencies related to proper re-installation of cables and cable ways.