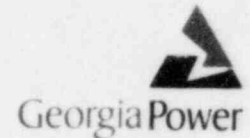


(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Georgia Power Company
Post Office Box 439
Baxley, Georgia 31513
Telephone 912 367-7781
912 537-9444



Edwin I. Hatch Nuclear Plant

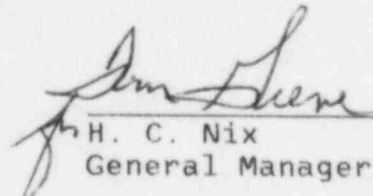
May 23, 1983
GM-83-429

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 Section 6.9.1.9.c. of Hatch Unit One Technical
Specifications, please find attached Reportable Occurrence
Report No. 50-321/1983-049.


H. C. Nix
General Manager

SB1
HCN/SBT/abb

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USNRC REGION II
ATLANTA, GEORGIA
83 JUN 1 11:00

NARRATIVE REPORT
FOR LER 50-321/1983-049

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

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

This 30-day LER is due to the event's showing that the unit was not meeting the requirements of Tech. Specs. section 6.9.1.9.c.

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

On May 5, 1983, the plant was in steady state power operation at 2422 MWt (approximately 100% power).

Detailed description of the event(s):

During an NRC inspection on May 5, 1983, the sanitary water supply valve (X42-F073D) was found open, but not locked open as required by the "RHR SERVICE WATER" procedure (HNP-1-1117). The X42-F073D valve is located on ~~a~~ one inch sanitary water line which supplies clean seal water to the "D" RHR service water pump's (E11-C001D) seals.

Consequences of the event(s):

There were no consequences to this event. However, if the X42-F073D valve had been found in the wrong position (i.e., closed), either locked or unlocked, then the RHR service water (dirty river water) being pumped by the E11-C001D RHR service water pump would have been permitted to leak past the seals. This would have sprayed water around the bottom of the pump motor, and this would have shortened the life of the pump seals. The E11-C001D RHR service water pump would still have been capable of maintaining and supplying rated pressure for an indefinite time with the leaking seals. This is due to the fact that the pincher bearing would reduce the pressure of the service water being applied to the bottom of the seals (thus limiting the flow of the leak). The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

The redundant RHR service water pumps were operable.

Justification for continued operation:

See "Immediate Corrective Action".

If repetitive, number of previous LER:

This is a non-repetitive event.

Impact to other systems and/or Unit:

This event did not impact other systems or the other unit.

Cause(s) of the event(s):

The cause of this event has been attributed to personnel error. Personnel failed to secure X42-F073D with a chain and lock such that the position of the valve could not be altered per "RHR SERVICE WATER" procedure (HNP-1-1117).

Immediate Corrective Action:

The X42-F073D valve was chain locked in the open position as required by HNP-1-1117 on May 5, 1983.

Supplemental Corrective Action:

No supplemental corrective action is required.

Scheduled (future) corrective action:

No scheduled (future) correction is required.

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

Responsible personnel were counseled as to the importance of properly performing valve line-ups. Also, training directive O-83-10 was issued on May 5, 1983. This training directive pointed out a revision to HNP-1-1117 and HNP-2-1117. This revision makes RHR service water valve line-ups clearer, and it informs personnel that all valves with painted handwheels at the intake structure are required to be locked.