

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

safety of the public were not affected by this non-repetitive event.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

service as per HNP-1-3304 on 3/3/83.

NAME OF PREPARER

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NARRATIVE REPORT
FOR LER 50-321/1983-026

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 required by Tech. Specs. section 6.9.1.9.a due to the event's showing that the unit was not meeting the requirements of Tech. Specs. Table 3.2-2, item 10.

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

This event occurred on 3/3/83, with the mode switch in the run position and reactor power at 487 MWt (approximately 20% of full power).

Detailed description of the event(s):

On 3/3/83, while performing the "HPCI STEAM LINE PRESSURE INSTRUMENT FT&C" procedure (HNP-1-3304), plant personnel discovered HPCI's B&D steam line pressure switches (E41-N001B&D) to be out of calibration. These switches actuated at 93.7 and 97.7 psig respectively (i.e., an observed value of 101 and 105 psig, respectively, minus the 7.3 psig head correction factor). Tech. Specs. section 3.2-2, item 10 requires that the switches actuate greater than or equal to 100 psig decreasing pressure.

Consequences of the event(s):

Plant operations were not affected. The switches were recalibrated immediately upon discovery. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

Redundant HPCI steamline pressure switches (E41-N001A&C) remained operable during this event. Also RCIC, ADS, Core Spray and RHR LPCI mode remained operable.

Justification for continued operation:

The switches were calibrated and returned to service upon discovery. The calibration drift of these switches did not make the HPCI system inoperable. Additionally, if HPCI had been inoperable, ADS, RHR LPCI mode, RCIC and Core Spray remained operable during this event.

If repetitive, number of previous LER:

This event is non-repetitive.

Impact to other systems and/or Unit:

This event had no effect on any other Unit 1 systems; this event had no effect on Unit 2.

Cause(s) of the event(s):

An investigation by plant personnel revealed that the switches failed due to setpoint drift.

Immediate Corrective Action:

The switches were recalibrated and functionally tested satisfactorily as per the "BARKSDALE PRESSURE SWITCH" procedure (HNP-1-5279). The switches were then returned to service on 3/3/83 as per HNP-1-3304.

Supplemental Corrective Action:

The immediate corrective action was sufficient. A review of other systems revealed that this is a generic problem, but as of this date, Barksdale pressure switches are the best available components for their particular application. Consideration of replacing these switches will occur when a more suitable pressure switch becomes available to the industry.

Scheduled (future) corrective action:

All corrective actions were made immediately and no future corrective actions are needed.

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

The immediate corrective action taken should be sufficient to preclude recurrence.