

## LICENSEE EVENT REPORT

CONTROL BLOCK: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 G A E I H 1 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 100CON'T  
0 1 REPORT SOURCE L 6 0 5 0 0 0 3 2 1 7 0 4 1 1 8 3 8 0 5 0 3 8 3 9  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

## EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During normal shift operations on April 11, 1983, the "A" channel torus

0 3 water level narrow range recorder (T48-R607A, red pen) was found

0 4 operating erratically. The T48-R607A, red pen was declared inoperable.

0 5 The plant not meeting Tech. Specs. table 3.2-11, Item 8 requirements

0 6 was placed into a 30-day LCO as required by Tech. Specs. table 3.2-11,

0 7 note c. The health and safety of the public were not affected by

0 8 this non-repetitive event.

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

0 9 SYSTEM CODE S A 11 CAUSE CODE X 12 CAUSE SUBCODE Z 13 COMPONENT CODE Z Z Z Z Z Z Z 14 COMP. SUBCODE Z 15 VALVE SUBCODE Z 16

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

17 LE R/FD REPORT NUMBER 8 3 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

ACTION TAKEN X 18 FUTURE ACTION Z 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0 0 0 0 22 ATTACHMENT SUBMITTED Y 23 NPR-4 FORM SUB. N 24 PRIME COMP. SUPPLIER Z 25 COMPONENT MANUFACTURER Z 9 9 9 9 26

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

## CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event was attributed to a dirty control amplifier

1 1 plug connection in T48-R607A red pen drive circ it. The dirty control

1 2 amplifier plug connection was cleaned. The "LEEDS AND NORTHRUP

1 3 SPEEDOMAX 100 RECORDER" procedure (HNP-1-5372) was run successfully on

1 4 T48-R607A returning it to service on April 11, 1983.

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

1 5 FACILITY STATUS E 28 % POWER 1 0 0 29 OTHER STATUS NA 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Observation 32

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

1 6 ACTIVITY CONTENT Z 33 RELEASED OF RELEASE Z 34 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 37 TYPE Z 38 DESCRIPTION NA 39

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

1 8 PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION NA 41

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

2 0 PUBLICITY N 44 DESCRIPTION NA 45

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

ISSUED N 44 DESCRIPTION NA 45

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

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S PDR

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

NRC USE ONLY

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

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7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 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 99 100

NARRATIVE REPORT  
FOR LER 50-321/1983-046

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.b due to the event's showing that the unit was not meeting the requirements of Tech. Specs. table 3.2-11, Item 8.

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

On April 11, 1983, the plant was in steady-state power operation at 2433 MWt (approximately 100% power).

Detailed description of the event(s):

During normal shift operations on April 11, 1983, plant personnel declared the "A" channel torus water level narrow range recorder (T48-R607A, red pen) inoperable due to erratic operation.

Consequences of the event(s):

The plant was placed into a 30-day LCO as required by Tech. Specs. table 3.2-11, note c. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

The "B" channel torus water level narrow range recorder (T48-R607B) remained operable during this event.

Justification for continued operation:

The plant was placed into a 30-day LCO as required by Tech. Specs. 3.2-11, note c.

If repetitive, number of previous LER:

This is a non-repetitive event.

Impact to other systems and/or Unit:

This problem did not affect other plant systems, nor did it affect the other unit.

Cause(s) of the event(s):

The cause of this event was attributed to a dirty control amplifier plug connection in recorder T48-R607A red pen drive circuit.

Narrative Report for LER 50-366/1983-046  
Page Two

Immediate Corrective Action:

The dirty control amplifier plug connection was cleaned on T48-R607A red pen. Then "LEEDS AND NORTHRUP SPEEDOMAX 100 RECORDER" procedure (HNP-1-5372) was run successfully to ensure operability of "A" channel narrow range of torus water level on April 11, 1983.

Supplemental Corrective Action:

No supplemental corrective action is required.

Scheduled (future) corrective action:

No scheduled future corrective action is required.

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

No further action is required to prevent recurrence.