NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
01	LICENSEE CODE (2)	G A E I H 2
	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 6 6
	EVENT DATE (8)	0 1 2 7 8 3
	REPORT DATE (9)	

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On 1/27/83, while performing the "FIRE PROTECTION ISOLATION VALVES-POSITION AND LUBRICATION CHECKS" procedure (HNP-2-3358), the lube oil room deluge system's isolation valve (2U43-F101) was found locked closed for no known reason. On 4/14/83, the PRB determined that this event was reportable under Tech. Specs. section 6.9.1.9.c. Plant operation was not affected. The health and safety of the public were not affected by this non-repetitive event.

SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
AB	A	X	VALVEX	E	D

LER/RO REPORT NUMBER (17)

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
83	—	019	/	03	L	—	0

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)
X	Z	Z	Z	0000	Y	N	A	G256

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

An investigation conducted by plant personnel could determine no reason for the valve's being closed. The 2U43-F101 was opened and locked immediately upon discovery.

FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
E	070	NA	B	Routine Inspection

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

PERSONNEL EXPOSURES

NUMBER (37)	TYPE (38)	DESCRIPTION (39)
000	Z	NA

PERSONNEL INJURIES

NUMBER (40)	DESCRIPTION (41)
000	NA

8305130242 830428
PDR ADOCK 05000366
S PDR

LOSS OF OR DAMAGE TO FACILITY (43)

TYPE (42)	DESCRIPTION
Z	NA

PUBLICITY

ISSUED (44)	DESCRIPTION (45)
N	NA

NRC USE ONLY

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

GPO 917-926

NARRATIVE REPORT
FOR LER 50-366/1983-019

LICENSEE : GEORGIA POWER COMPANY
FACILITY NAME : EDWIN I. HATCH
DOCKET NUMBER : 50-366

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

This 30-day LER is required by Tech. Specs. section 6.9.1.9.c. due to the event's showing that the unit was not meeting the requirements of Tech. Specs. section 3.7.6.2.

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

On 1/27/83, the unit was in steady-state power operation at 1703 MWt (approximately 70 percent power).

Detailed description of the event(s):

On 1/27/83, while personnel were performing the "FIRE PROTECTION ISOLATION VALVES - POSITION AND LUBRICATION CHECKS" procedure (HNP-2-3358), the isolation valve (1U43-F101) for the lube oil room deluge system was found locked in the closed position. This valve must be in the open position for the deluge system to be operable, thus this event is contrary to the requirements of Tech. Specs. section 3.7.6.2.

On 2/1/83, the event of 1/27/83 was recognized by site personnel and a deviation report (2-83-13) was written. On 3/15/83, the PRB determined the event non-reportable due to the assumption that the valve was not inoperable for more than 14 days; however, additional investigation was requested to determine the reason for the valve's being closed.

On 4/14/83, the PRB re-evaluated the event and determined to report this event due to its showing a lack of administrative control.

Consequences of the event(s):

Plant operation was not affected. The valve was opened immediately upon discovery and the system returned to normal operable status. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

There was no redundant system.

Justification for continued operation:

The valve was returned to the normal open position and locked immediately upon discovery. Thus, the deluge system was returned to the normal mode of operation.

If repetitive, number of previous LER:

This event is non-repetitive. This is an isolated event.

Impact to other systems and/or Unit:

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

Cause(s) of the event(s):

An investigation conducted by plant personnel could determine no reason for the valve's being locked closed.

Immediate Corrective Action:

The valve was immediately opened and locked upon discovery.

Supplemental Corrective Action:

The immediate corrective action was sufficient and nothing more is required.

Scheduled (future) corrective action:

The immediate corrective action taken was sufficient and nothing more is required.

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

Nothing is required. This is an isolated event.