NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On 07/09/83 and 07/14/83 , the CRD LOW PRESSURE OR HIGH LEVEL alarm was
0 3 received for HCU's 2C11-26-31 and 02-19 respectively. The HCU's were
0 4 declared inoperable per Tech. Specs. section 3.1.3.5, ACTION a. Then,
0 5 on 07/20/83 and 07/22/83, it was discovered that the HCU's had been
0 6 incorrectly returned to service following corrective actions. The
0 7 health and safety of the public were not affected by these events. These
0 8 events are repetitive as last reported on LER 50-366/1982-093.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	R B (11)	X (12)	Z (13)	V A L V E X (14)	H (15)	D (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 4 0	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
A (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	C 4 8 7 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of both of the first two events has been attributed to leaking
1 1 EP-111 nitrogen charging valves. The EP-111 nitrogen charging valves
1 2 were replaced and the HCU's were returned to service. The root cause of
1 3 the incorrect return is unknown. Refer to the narrative report for
1 4 details.

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

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

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	NA

8308180319 830728
PDR ADOCK 05000366
S PDR

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)	NA	

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

GPO 917-926

NARRATIVE REPORT
FOR LER 50-366/1983-040

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

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

1. 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. section 3.1.3.5.

2. 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. section 3.1.3.5.

3. 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 3.1.3.5.

4. 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 3.1.3.5.

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

1. This event occurred on 07/09/83, with the reactor mode switch in the startup and hot standby position and reactor power at 8 MWT (approximately 0% power).

2. This event occurred on 07/14/83, with the reactor mode switch in the run position and reactor power at 635 MWT (approximately 26% power).

3. This event occurred on 07/20/83, with the reactor mode switch in the run position and reactor power at 901 MWT (approximately 37 % power).

4. This event occurred on 07/22/83 with the reactor mode switch in the run position and reactor power at 1259 MWT (approximately 52 % power).

Detailed description of the event(s):

1. On 07/09/83 at approximately 1400 hours, the CRD LOW PRESSURE OR HIGH LEVEL alarm was received in the control room for HCU 2C11-26-31. Shift personnel discovered that this CRD accumulator had low nitrogen pressure. This made this HCU inoperable which is a failure to satisfy the requirements of Tech. Specs. section 3.1.3.5. (refer to Deviation Report number 2-83-146).

2. On 07/14/83, the CRD LOW PRESSURE OR HIGH LEVEL alarm was received in the control room for HCU 2C11-02-19. Shift personnel investigated and found that the EP-111 valve (nitrogen charging valve) was leaking. This made this HCU inoperable which is a failure to satisfy the requirements of Tech. Specs. section 3.1.3.5. (refer to Deviation Report number 2-83-156).

3. On 07/20/83, plant personnel (during investigation for the purpose of writing event number 2), discovered that the functional test required after the corrective action had not been performed prior to returning HCU 2C11-02-19 to an operable status. (refer to Deviation Report number 2-83-166). Following is the sequence of events:

   a. The EP-111 valve (nitrogen charging valve) for the HCU was replaced on 07/14/83.

   b. The HCU was returned to operable status on 07/14/83.

   c. The unit started up on 07/18/83, following a scram (refer to LER number 50-366/1983 042).

   d. The discovery that the functional test had not been performed was made on 07/20/83.

   Thus, this HCU was considered operable while it was still "administratively" inoperable; the associated control rod was withdrawn on 07/14/83. This is a failure to satisfy the requirements of Tech. Specs. section 3.1.3.5.

4. On 07/22/83, plant personnel (during investigation for the purpose of writing event number 1), discovered that the functional test required after replacement of the EP-111 valve had not been performed until two days after HCU 2C11-26-31 was returned to an operable status. (refer to Deviation Report number 2-83-170).

   Thus, this HCU was considered operable while it was still "administratively" inoperable; the associated control rod was withdrawn on 07/11/83. This is a failure to satisfy the requirements of Tech. Specs. section 3.1.3.5.

Consequences of the event(s):

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

2. Plant operation was not affected by this event. The health and safety of the public were not affected by this event.

3. Plant operation was not affected by this event. The health and safety of the public were not affected by this event.

4. Plant operation was not affected by this event. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

1. There is no redundant or backup subsystem for this nitrogen accumulator.

2. There is no redundant or backup subsystem for this nitrogen accumulator.

3. There is no redundant or backup subsystem for this nitrogen accumulator.

4. There is no redundant or backup subsystem for this nitrogen accumulator.

Justification for continued operation:

1. Unit 2 was placed in an 8 hour LCO as required by Tech. Specs. section 3.1.3.5, ACTION a.

2. Unit 2 was placed in an 8 hour LCO as required by Tech. Specs. section 3.1.3.5, ACTION a.

3. Unit 2 was placed in an 8 hour LCO as required by Tech. Specs. section 3.1.3.5, ACTION a.

4. No justification was required. At the time of discovery the functional test had already been successfully performed.

If repetitive, number of previous LER:

1. LER 50-366/1982-093

2. LER 50-366/1982-093

3. This is a non-repetitive event.

4. This is a non-repetitive event.

Impact to other systems and/or Unit:

1. This event did not impact any other systems on Unit 2 ; this event did not impact Unit 1.

2. This event did not impact any other systems on Unit 2 ; this event did not impact Unit 1.

Impact to other systems and/or Unit (continued):

3. This event did not impact any other systems on Unit 2 ; this event did not impact Unit 1.

4. This event did not impact any other systems on Unit 2 ; this event did not impact Unit 1.

Cause(s) of the event(s):

1. The cause of this event was initially unknown; however, as detailed in "Supplemental Corrective Action:" it was later determined to be a leaking EP-111 valve (nitrogen charging valve).

2. The cause of this event was a leaking EP-111 valve (nitrogen charging valve).

3. The root cause of this event is presently unknown. However, it is speculated that it was due to a combination of the following:

   a. Personnel error

   b. Procedural inadequacy

   c. The practice of not issuing Limiting Conditions of Operation (LCO's) when the involved system is not required to be operable.

4. The root cause of this event is presently unknown. However, it is speculated that it was due to a combination of the following:

   a. Personnel error

   b. Procedural inadequacy

   c. The practice of not issuing Limiting Conditions of Operation (LCO's) when the involved system is not required to be operable.

Imediate Corrective Action:

1. On 07/09/83 at approximately 1850 hours, the accumulator was recharged with nitrogen and returned to service.

2. On 07/14/83, the EP-111 nitrogen charging valve was replaced. Then, the accumulator was recharged with nitrogen and returned to service.

Imediate Corrective Action (continued):

3. The required functional test was immediately performed. This test showed that the new valve was performing satisfactorily, and that the HCU had actually been operable since the valve replacement.

4. None was required.

Supplemental Corrective Action:

1. On 07/12/83, the EP-111 valve for HCU 2C11-26-31 was discovered to be leaking. The EP-111 valve was replaced on 07/13/83.

2. No supplemental corrective action was required.

3. The following actions were begun on 07/21/83:

   a. Site personnel started reviewing all outstanding Maintenance Requests to ensure all required functional testing has been performed.

   b. A Standing Order was issued that requires an LCO to be issued for Tech. Specs. required components or systems whenever preventive or corrective maintenance is to be performed. These LCO's are to be issued regardless of plant conditions.

   c. A committee was established to investigate what happened and to propose corrective actions.

4. The following actions were begun on 07/21/83:

   a. Site personnel started reviewing all outstanding Maintenance Requests to ensure all required functional testing has been performed.

   b. A Standing Order was issued that requires an LCO to be issued for Tech. Specs. required components or systems whenever preventive or corrective maintenance is to be performed. These LCO's are to be issued regardless of plant conditions.

   c. A committee was established to investigate what happened and to propose corrective actions.

Scheduled (future) corrective action:

1. No scheduled (future) corrective action is required.

2. No scheduled (future) corrective action is required.

3. This will depend upon the results of the investigation being performed under "Supplemental Corrective Action". The results of this investigation will be included in an update report to this LER.

4. This will depend upon the results of the investigation being performed under "Supplemental Corrective Action". The results of this investigation will be included in an update report to this LER.

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

1. N/A

2. N/A

3. N/A

4. N/A

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Georgia Power

Edwin I. Hatch Nuclear Plant

July 28, 1983
GM-83-702

PLANT E. I. HATCH
Licensee Event Report
Docket No. 50-366

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

Attached is Licensee Event Report No. 50-366/1983-040. This report is required by Hatch Unit 2 Technical Specifications Section 6.9.1.9.b.

H. C. Nix
General Manager

HCN/SBT/djs

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