

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

GPO 917-926

NARRATIVE REPORT
FOR LER 50-366/1983-053

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.b. due to the event's showing that the unit was not meeting the requirements of Tech. Specs. section 3.6.3.

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

On July 13, 1983, when the first event was discovered the unit was in start-up at 50 MWT (approximately 2% reactor power). On July 14, 1983, when the second event was discovered the unit was in hot shutdown.

Detailed description of the event(s):

On July 13, 1983, during performance of "DRYWELL AND TORUS PURGE" procedure (HNP-2-1502) personnel did not get the closed position indication on torus purge valve 2T48-F309 when operating valve from open to closed.

On July 14, 1983, during performance of "DRYWELL AND TORUS PURGE" procedure (HNP-2-1502) personnel received both open and closed position indication on torus purge valve 2T48-F309 when operating valve from open to closed.

Consequences of the event(s):

In both events the 2T48-F309 valve was verified in its closed position locally and the requirements of Tech. Specs. section 3.6.3, ACTION a.2. were performed. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

The redundant primary containment isolation valve 2T48-F324 was operable.

Justification for continued operation:

The performance of the required Tech. Specs. section 3.6.3, ACTION a.2. is justification for continued operation.

If repetitive, number of previous LER:

This is a non-repetitive event.

Impact to other systems and/or Unit:

There was no impact to any other system nor to the other unit.

Cause(s) of the event(s):

The cause of the first event was attributed to setpoint drift. An investigation revealed the valve closed limit switch set point (accuation point) had drifted while the valve was operating properly.

The cause of the second event was attributed to set point drift. An investigation revealed that both valve position limit switches and limit switch accuator arm had drifted from their intended position while the valve operated properly.

Immediate Corrective Action:

For the first event the limit switches were adjusted to correct the valve indication problem.

For the second event the woodruff keys holding the limit switch accuator arm to the stem of valve were replaced and the set screws on the limit switches were replaced. The limit switches were then readjusted.

Supplemental Corrective Action:

There is no supplemental corrective action to these events.

Scheduled (future) corrective action:

There is no scheduled future corrective action to these events.

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

The replacement of the woodruff keys holding accuator arm to the valve stem and the replacement of the set screws was the action to prevent recurrence.

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Bdwin I. Hatch Nuclear Plant



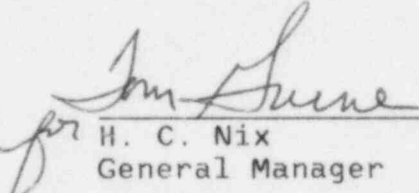
August 12, 1983
GM-83-800

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. 50-366/1983-053. This report is required by Hatch Unit 2 Technical Specifications Section 6.9.1.9.b.


for H. C. Nix
General Manager

HCN/SBT/djs

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