

(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	3	4	1	1	1	1	4			5		
7	8	LICENSEE CODE						14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	57	CAT 58		

CON'T

0	1
7	8

REPORT SOURCE

L	6	0	5	0	0	0	3	2	1	7	0	4	1	2	8	3	8	0	5	0	9	8	3	9
60	61	DOCKET NUMBER						68	69	EVENT DATE						74	75	REPORT DATE						80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On 4/12/83, an operator observed that the O₂ recorder pen on the primary
0 3 | containment atmosphere H₂O₂ recorder 1P33-R601A was reading approxi-
0 4 | mately 17%, while the O₂ recorder pen on 1P33-R601B was reading about
0 5 | 3.35%. This is contrary to the requirements of Tech. Specs. table 3.2-11,
0 6 | Action c for Item 11. The "B" H₂O₂ analyzer was operable. Unit 1 was
0 7 | placed in a 30-day LCO as a result of this event. The health and safety
0 8 | of the public were not affected by this non-repetitive event.

SYSTEM CODE S E		CAUSE CODE X		CAUSE SUBCODE Z		COMPONENT CODE I N S T R U				COMP. SUBCODE R		VALVE SUBCODE Z	
9 10		11 12		12 13		13 18				19 20		20 21	
LER/RO REPORT NUMBER 8 3		EVENT YEAR 8 3		SEQUENTIAL REPORT NO. —		OCCURRENCE CODE 0 4 7		REPORT TYPE L		REVISION NO. 0			
21 22		23 24		24 26		26 27		27 29		29 30		30 31	
ACTION TAKEN E	FUTURE ACTION Z	EFFECT ON PLANT Z	SHUTDOWN METHOD Z	HOURS 0 0 0 0	ATTACHMENT SUBMITTED Y	NPRD-4 FORM SUB. N	PRIME COMP. SUPPLIER A	COMPONENT MANUFACTURER H 1 2 5					
33 34	34 35	35 36	36 37	37 40	40 41	41 42	42 43	43 44	44 47	47 48	48 49	49 50	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event was due to a tubing cap being off and the sample
1 1 valve being open in the "A" analyzer sample line. The tubing cap was
1 2 replaced and the sample valve closed. The "A" O₂ analyzer was recalibrated
1 3 per procedure. The O₂ reading on recorder 1P33-R601A was satisfactorily
1 4 functionally tested on 4/13/83 and returned to operable status.

1		5		E		(28)		1		0		0		(29)		NA		(30)		METHOD OF DISCOVERY		(31)		A		(32)		Discovery Description		(32)		Operator Observation	
---	--	---	--	---	--	------	--	---	--	---	--	---	--	------	--	----	--	------	--	---------------------	--	------	--	---	--	------	--	-----------------------	--	------	--	----------------------	--

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)
1 6 Z (33) Z (34) NA
2 8 9 10 11 44
LOCATION OF RELEASE (36)
NA
45 80

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	000	(37) Z	(38) NA					

PERSONNEL INJURIES		DESCRIPTION	
NUMBER			
1	2	0	0
0	0	0	40
		NA	

1	9	Z	(42)	NA	LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION	(43)	8305250577 830509 PDR ADOCK 05000321 S PDR
---	---	---	------	----	---	------	--

	PUBLICITY	(45)	NRC USE ONLY
ISSUED DESCRIPTION	(44)	NA	
7 8 9 10 68 69 80			

NAME OF PREPARER S. B. Tipps

PHONE: (912) 367-7851

Immediate Corrective Action:

The tubing cap was replaced and the sample valve was closed. The "A" O₂ analyzer was recalibrated per the "HAYS LOW RANGE O₂ ANALYZER MODEL 632II CALIBRATION" procedure (HNP-1-5254). The O₂ reading on the primary containment atmosphere H₂O₂ recorder 1P33-R601A was satisfactorily functionally tested and returned to operable status on 4/13/83.

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 action to prevent recurrence is required.

NARRATIVE REPORT
FOR LER 50-321/1983-047

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 requiring the plant be placed into an LCO as required by Tech. Specs. table 3.2-11, Action c for item 11.

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

This event occurred on 4/12/83 with reactor power at 2430 MWt (approximately 100%).

Detailed description of the event(s):

On 4/12/83, an operator observed that the O₂ recorder pen on the primary containment atmosphere H₂O₂ recorder 1P33-R601A was reading approximately 17%, while the O₂ recorder pen on 1P33-R601B was reading approximately 3.35%. The O₂ parameter on the 1P33-R601A recorder was declared inoperable.

Consequences of the event(s):

Unit 1 was placed in a 30-day LCO as a result of this event. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

The "B" primary containment atmosphere H₂O₂ analyzer was operable.

Justification for continued operation:

Unit 1 was placed in a 30-day LCO as required by Tech. Specs. Table 3.2-11, Action c for Item 11.

If repetitive, number of previous LER:

This event is non-repetitive.

Impact to other systems and/or Unit:

This event had no impact on any other Unit 1 system or on Unit 2.

Cause(s) of the event(s):

The cause of this event was due to a tubing cap being off and the sample valve being open in "A" analyzer sample line; an investigation could reveal no reason for the cap's being off and the valve's being open. This caused air from the reactor building atmosphere to be drawn in and gave a high O₂ reading.