

LICENSEE EVENT REPORT

CONTROL BLOCK: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)G A E I H 2 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
REPORT SOURCE L 0 5 0 0 0 3 6 6 1 1 1 3 8 3 1 2 0 5 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)

On 11/13/83, it was determined that safety relief valve tailpipe temperature recorder 2B21-R614 was stamping erratically. The recorder receives its inputs from temperature elements 2B21-K004 A-H, and K-M; therefore, the recorder was declared inoperable. This event is contrary to the requirements of Tech. Specs. Table 3.3.6.4-1, item 10.b. The health and safety of the public were not affected by this non-repetitive event (refer to attached narrative).

SYSTEM CODE C I 11 CAUSE CODE E 12 CAUSE SUBCODE X 13 COMPONENT CODE I N S T R U 14 COMP. SUBCODE R 15 VALVE SUBCODE Z 16
EVENT YEAR 8 3 SEQUENTIAL REPORT NO. 1 2 6 OCCURRENCE CODE 0 3 REPORT TYPE 4 REVISION NO. 0
ACTION TAKEN A 18 FUTURE ACTION Z 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0 0 0 0 ATTACHMENT SUBMITTED Y 23 NPD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER N 25 COMPONENT MANUFACTURER G 0 8 0 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

This event is the result of component failure. The recorder's advancing mechanism solenoid and its arm and hub assembly were replaced because they were worn. Proper recorder operation was confirmed per the "GENERAL ELECTRIC TYPE HG MULTIPOINT RECORDER" procedure (HNP-2-5264), and satisfactorily returned to service on 11/12/83 at 2130 hours.

FACILITY STATUS E 28 % POWER 9 8 4 29 OTHER STATUS NA 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Observation 32
ACTIVITY CONTENT RELEASED OF RELEASE Z 33 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36
PERSONNEL EXPOSURES NUMBER 0 0 0 37 TYPE Z 38 DESCRIPTION NA 39
PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION NA 41
LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43
PUBLICATION ISSUED N 44 DESCRIPTION NA 45

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NARRATIVE REPORT
FOR LER 50-366/1983-126

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, because it showed that the unit did not meet the requirements of Tech. Specs. 3.3.6.4.

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

The unit was in steady state operation at 2046 MWT (approximately 84% power) when this event occurred.

Detailed description of the event(s):

While performing a routine control room panel walk-down on 11/13/83 at approximately 1400 hours, operating personnel determined that safety relief valve (SRV) tailpipe temperature recorder 2B21-R614 was stamping erratically. SRV temperature recorder 2B21-R614 receives its inputs from temperature elements 2B21-NO04 A-H and K-M; therefore, recorder 2B21-R614 was declared inoperable, and a 30 day LCO was established because the plant was unable to meet the requirements of item 10.b of Tech. Specs. Table 3.3.6.4-1.

Consequences of the event(s):

This event did not affect plant operation. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

All associated redundant systems were operable at the time of this event.

Justification for continued operation:

Operation was continued as permitted by Tech. Specs. section 3.3.6.4, ACTION a.

If repetitive, number of previous LER:

This event is non-repetitive.

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Impact to other systems and/or Unit:

This event had no impact upon other systems in Unit 2, or Unit 1.

Cause(s) of the event(s):

After an investigation, technicians determined that this event was caused by component failure. The General Electric type HG multipoint recorder (2B21-R614) would not advance from one point to the next point properly (i.e., it would not indicate the temperature of one temperature element and then advance to indicate the temperature of the succeeding temperature element). However, the temperature for the point that was being recorded was correct.

Immediate Corrective Action:

The recorder's (2B21-R614) advancing mechanism's solenoid, and its arm and hub assembly were replaced because they were worn. The recorder's proper operation was satisfactorily confirmed per the "GENERAL ELECTRIC TYPE HG MULTIPOINT RECORDER" procedure (HNP-2-5264), and returned to service on 11/13/83 at 2130 hours

Supplemental Corrective Action:

No supplemental corrective action is required.

Scheduled (future) corrective action:

No future corrective action is required.

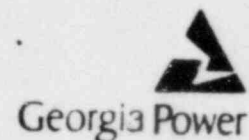
Action to prevent recurrence (if different from corrective actions):

N/A

Georgia Power Company
Post Office Box 439
Baxley, Georgia 31513
Telephone 912 367-7781
912 537-9444

USNRC REGION II
ATLANTA, GEORGIA

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Edwin I. Hatch Nuclear Plant

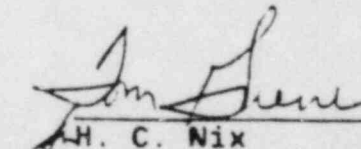
December 5, 1983
GM-83-1142

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. 50-366/1983-126. This report is required by Hatch Unit 2 Technical Specifications Section 6.9.1.9.b.


H. C. Nix
General Manager

HCN/STB/djs

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