

LICENSEE EVENT REPORT

CONTROL BLOCK:

(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	59

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7 8

REPORT SOURCE L 6 0 5 0 0 0 3 2 1 7 0 9 1 0 7 9 8 1 2 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 | With Unit 1 in run and Unit 2 in shutdown, a potential failure mode for
0 3 | several primary containment purge and inerting valves was discovered by
0 4 | the architect-engineer and valve vendor. It was postulated that, if a
0 5 | LOCA occurred while the valves were open, the steam pressure could cause
0 6 | these valves to overtravel and lose seating capability. This would allow
0 7 | leakage of contamination to the reactor bldg. This failure mode applies
0 8 | to both units and is non-repetitive. This event is 10CFR21 reportable.

09		SYSTEM CODE		SE		CAUSE CODE		B		CAUSE SUBCODE		A		COMPONENT CODE				VALVE SUBCODE		A																													
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27																													
LER/RO REPORT NUMBER		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.		ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED		NPRD-4 FORM SUB.		PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER																					
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																				
7		9		0		8		1		0		1		X		1		H		F		Z		Z		0		0		0		0		Y		N		A		F		1		2		5		2	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event has been attributed to design deficiencies. A
1 1 design change to prevent the valves from opening more than 50 degrees
1 2 has been implemented for both Unit 1 and Unit 2. This event has been
1 3 found to be reportable under the requirements of 10CFR21.
1 4

FACILITY STATUS (28) B
% POWER (29) 0 1 4
OTHER STATUS (30) NA
METHOD OF DISCOVERY (31) B Notification from A/E
DISCOVERY DESCRIPTION (32)
ACTIVITY CONTENT
RELEASED OF RELEASE (33) Z
AMOUNT OF ACTIVITY (35) NA
LOCATION OF RELEASE (36)
PERSONNEL EXPOSURES
NUMBER (37) 0 0 0
TYPE (38) Z
DESCRIPTION (39) NA
PERSONNEL INJURIES
NUMBER (40) 0 0 0
DESCRIPTION (41) NA
LOSS OF OR DAMAGE TO FACILITY
TYPE (42) Z
DESCRIPTION (43) NA
PUBLICITY
ISSUED (44) N
DESCRIPTION (45) NA
NRC USE ONLY

8312200067 831209
PDR ADOCK 05000321
S PDR
IE22

NAME OF PREPARER S. B. Tipps

PHONE: (912) 367-7851

NARRATIVE REPORT
FOR LER 50-321/1979-081, Rev. 1
UPDATE REPORT-PREVIOUS REPORT DATE 09/20/79

LICENSEE : GEORGIA POWER COMPANY
FACILITY NAME : EDWIN I. HATCH
DOCKET NUMBER : 50-321

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

This 14-day LER is required by Tech. Specs. section 6.9.1.8.e due to the event's showing that the unit was not meeting the requirements of Tech. Specs. section 3.7.d.1 for Unit 1, and 3.6.3.a for Unit 2.

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

The Unit 1 mode selector switch was in "RUN" and reactor power was at 341 MWt (approximately 14% power). The Unit 2 mode selector switch was in "Shutdown".

Detailed description of the event(s):

On 09/10/79, a potential failure mode for several primary containment purge and inerting valves was discovered by the architect-engineer (Bechtel Corporation) and the valve vendor (Fisher Valves). These valves are T48-F307, F308, F309, F318, F319, F320, F324 and F326 for each unit. It could be postulated that if a LOCA occurred while the valves were open, the steam pressure could cause the valves to overtravel and lose their seating capability. This could have allowed the escape of radioactivity into the secondary containment. Depending upon the magnitude of the event, the secondary containment filtration system, the Standby Gas Treatment System, could potentially be overloaded and therefore cause the offsite dose limit to be exceeded.

The evaluation for 10CFR21 reportability was completed on December 6, 1983. The evaluation determined this event to be reportable under 10CFR21 requirements.

Consequences of the event(s):

This was a postulated event. Therefore, the safe operation of the plant was not affected, nor were the health and safety of the public affected by this event. This event has been found to be reportable under part 10CFR21.

Status of redundant or backup subsystems and/or systems:

No redundant or backup subsystems and/or systems were affected by this event.

Justification for continued operation:

A standing order was issued for both units, which required maintained closure of valves T48-F307, F308, F309, F310, F311, F324, F312, and F313 except while performing drywell vacuum breaker surveillance testing or during drywell inerting or deinerting. Closure of valves F312 and F313 provides isolation, which was previously provided by closure of valves F318, F319, F320 and F326. Valves F312 and F313 were tagged closed. This standing order has since been rescinded based upon the completion of DCR's 79-394 and 79-395 which corrected this problem (as defined under supplemental corrective action).

If repetitive, number of previous LER:

This event is non-repetitive.

Impact to other systems and/or Unit:

Both units have similar systems. The number and location of these components in use at Plant Hatch are found in the "Detailed description of this event" section of this narrative report. It was found that depending upon the magnitude of a LOCA, the Standby Gas Treatment System could be overloaded, which could result in offsite exposure comparable to those referred to in 10CFR100.11. The design, which was in error, was provided by Bechtel Corporation and Fisher Valves.

Cause(s) of the event(s):

The cause has been attributed to design error.

Immediate Corrective Action:

The standing order described in the "Justification for continued operation" section of this narrative report was issued.

Supplemental Corrective Action:

Design change requests 79-394 (Unit 1) and 79-395 (Unit 2) were implemented to limit the opening of these valves by no more than 50 degrees. Design Change Request 79-394 was completed on February 21, 1980, and DCR 79-395 was completed on March 10, 1981.

Scheduled (future) corrective action:

No further action is required.

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

The corrective actions taken should be sufficient to preclude recurrence.

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



Georgia Power

Edwin I. Hatch Nuclear Plant **DEC 16 410:56**

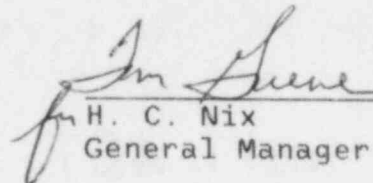
December 9, 1983
GM-83-1175

PLANT E. I. HATCH
Licensee Event Report
Docket No. 50-321

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. 50-321/1979-081, Rev. 1. This report is required by Hatch Unit 1 Technical Specifications Section 6.9.1.8.e. This revision is made due to the determination that this event is reportable under 10CFR21 requirements.


H. C. Nix
General Manager

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HCN/SBT/djs

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