

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	G	A	E	I	H	2	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5
7	8	LICENSEE CODE						14	LICENSE NUMBER										25	LICENSE TYPE					30	57 CAT		58	

CON'T

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

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

On 07/09/83 and 07/14/83 , the CRD LOW PRESSURE OR HIGH LEVEL alarm was received for HCU's 2C11-25-31 and 02-19 respectively. The HCU's were declared inoperable per Tech. Specs. section 3.1.3.5, ACTION a. Then, on 07/20/83 and 07/22/83, it was discovered that the HCU's had been incorrectly returned to service following corrective actions. The health and safety of the public were not affected by these events. These events are repetitive as last reported on LER 50-366/1982-093.

SYSTEM CODE R B		CAUSE CODE X		CAUSE SUBCODE Z		COMPONENT CODE V A L V E X				COMP. SUBCODE H		VALVE SUBCODE D					
EVENT YEAR 8 3		SEQUENTIAL REPORT NO. 0 4 0		OCCURRENCE CODE 0 3		REPORT TYPE X		REVISION NO. 1									
ACTION TAKEN A		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 N		COMPONENT MANUFACTURER C 8 7	

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 has been determined to be procedural inadequacy.

1 4 Refer to the narrative report for details.

FACILITY STATUS (C) (26) % POWER (0) (0) (0) (29) OTHER STATUS (30) METHOD OF DISCOVERY (A) (31) DISCOVERY DESCRIPTION (32) Operator Observation
 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)
 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION (39)
 PERSONNEL INJURIES NUMBER DESCRIPTION (41)
 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION (43)
 PUBLICITY ISSUED DESCRIPTION (45)
 NRC USE ONLY

NAME OF PREPARER S. B. Tipps

PHONE: (912) 367-7851

NARRATIVE REPORT
FOR LER 50-366/1983-040, Rev. 1
UPDATE REPORT - PREVIOUS REPORT DATE 07/28/83

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 has been determined to be procedural inadequacy.
4. The root cause of this event has been determined to be procedural inadequacy.

Immediate 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.
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 performed:
 - a. Site personnel reviewed all outstanding Maintenance Requests to ensure all required functional testing had been performed.
 - b. A Standing Order was issued that required 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. This standing order was later deleted on 10/10/83 when HNP-901 was revised as detailed below.
 - c. The findings of the committee, that was established to investigate what happened and to propose corrective actions, determined that the cause of the event appears to have been the lack of any mechanism to "flag" the Maintenance Requests as having the capacity to violate Technical Specifications requirements. As a result of the investigation, the "LIMITING CONDITIONS FOR OPERATIONS AND CUMULATIVE DOWNTIME" procedure (HNP-901) was revised. It now includes initiating an LCO when maintenance is being performed on equipment whose downtime is limited by Technical Specifications even when the equipment is not required to be operable when the maintenance is begun. Review of the revised section in HNP-901 by the committee resulted in a consensus that no further corrective action is required.
4. The following actions were performed:
 - a. Site personnel reviewed all outstanding Maintenance Requests to ensure all required functional testing had been performed.
 - b. A Standing Order was issued that required 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. This standing order was later deleted on 10/10/83 when HNP-901 was revised as detailed below.

Supplemental Corrective Action (Continued):

- c. The findings of the committee, that was established to investigate what happened and to propose corrective actions, determined that the cause of the event appears to have been the lack of any mechanism to "flag" the Maintenance Requests as having the capacity to violate Technical Specifications requirements. As a result of the investigation, the "LIMITING CONDITIONS FOR OPERATIONS AND CUMULATIVE DOWNTIME" procedure (HNP-901) was revised. It now includes initiating an LCO when maintenance is being performed on equipment whose downtime is limited by Technical Specifications even when the equipment is not required to be operable when the maintenance is begun. Review of the revised section in HNP-901 by the committee resulted in a consensus that no further corrective action is required.

Scheduled (future) corrective action:

1. No scheduled (future) corrective action is required.
2. No scheduled (future) corrective action is required.
3. No scheduled (future) corrective action is required.
4. No scheduled (future) corrective action is required.

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

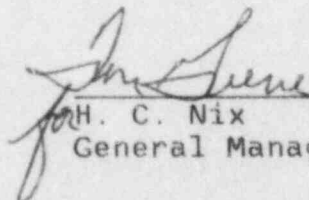
March 12, 1984
GM-84-56


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, Rev. 1.
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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