NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

UPDATE REPORT
PREVIOUS REPORT DATE 11/23/82

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	LICENSEE CODE: G A E I H 2 (2)	LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3)	LICENSE TYPE: 4 1 1 1 1 (4)	CAT: (5)

CON'T 0 1	REPORT SOURCE: L (6)	DOCKET NUMBER: 0 5 0 0 0 3 6 6 (7)	EVENT DATE: 1 0 3 0 8 2 (8)	REPORT DATE: 0 3 1 9 8 4 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 While inserting control rods for reactor shutdown, reed switch position
0 3 indicators for control rods 14-07 and 34-43 were found inoperable. This
0 4 event is contrary to Tech. Specs. 3.1.3.7. Both control rods were fully
0 5 inserted. Their positions were determined within one hour by use of the
0 6 "Full-in" position indicators, therefore, Tech. Specs. 3.1.3.7, ACTION a
0 7 was satisfied. The health and safety of the public were not affected.
0 8 This event is repetitive as last reported on LER 50-366/1982-088.

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	I E (11)	E (12)	E (13)	I N S T R U (14)	S (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 2	—	1 2 3	/	0 3	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
C (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	N (23)	N (24)	N (25)	G 0 8 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 These events were caused by component failure. On 05/09/83 the RPIS
1 1 probe was replaced in CRD 2C11-14-07. On 10/30/83 CRD 2C11-34-43 was
1 2 repaired by replacing its display memory card in panel 2H11-P615. Subse-
1 3 quent to repair, both control rod drives were satisfactorily function-
1 4 ally tested and returned to service (refer to attached narrative).

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	F (28)	0 2 2 (29)	NA	A (31)	Operator Observation

1 6	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	NA

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	NA

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)	NA	

NAME OF PREPARER S. B. Tipps PHONE: (912)367-7851

NARRATIVE REPORT
FOR LER 50-366/1982-123, Rev. 1
UPDATE REPORT - PREVIOUS REPORT DATE 11/23/82

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. section 3.1.3.7.

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

The unit was in power descent at 535 MWT (approximately 21% power) when these events occurred.

Detailed description of the event(s):

1. On 10/30/82 at approximately 0230 CST, control rod 2C11-34-43 was inserted, but operating personnel received no indication at positions 30, 20, 10, or 00 (refer to deviation 2-82-282).

2. At approximately the same time, control rod 2C11-14-07 was also inserted, but operating personnel did not receive an indication at the position which should have been number 36 (refer to deviation 2-82-283). These events are contrary to Tech. Specs. section 3.1.3.7.

Consequences of the event(s):

These events did not affect plant operation. The health and safety of the public were not affected by these events.

Status of redundant or backup subsystems and/or systems:

There is no redundant or backup systems for these control rods.

Justification for continued operation:

Both control rods were fully inserted, and their positions were determined within one hour by use of the "full in" position indicators. Thus continued operation was permitted per Tech. Specs. section 3.1.3.7, ACTION a.

If repetitive, number of previous LER:

This event is repetitive as last reported on LER 50-366/1982-088.

Impact to other systems and/or Unit:

These events had no impact upon any other system in Unit 2, or Unit 1.

Cause(s) of the event(s):

These events were caused by component failure.

Immediate Corrective Action:

Both control rods were fully inserted, and their positions were determined within one hour by use of the "full in" position indicators; hence, the requirement of Tech. Specs. section 3.1.3.7, ACTION a was satisfied. The reed switch position indicators will be repaired during the 1983 refueling outage.

Supplemental Corrective Action:

1. After an investigation it was determined that CRD 2C11-14-07 position indicator probe reed switches had failed. The position indicator probe was replaced, and CRD 2C11-14-07 was satisfactorily functionally tested per the "RPIS PROBE PREINSTALLATION FUNCTIONAL TEST AND INSTRUCTIONS FOR REMOVAL AND INSTALLATION" procedure (HNP-6985), and returned to service on 05/09/83.

2. After an investigation, it was determined that the cause of this event was not a failed position indicator probe in control rod 2C11-34-43; but a failed display memory card in control room panel 2H11-P615. The memory card was replaced. The CRD was then satisfactorily moved and correct position indication was displayed on 10/30/83.

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

Georgia Power

Edwin I. Hatch Nuclear Plant

March 19, 1984
GM-84-181

PLANT E. I. HATCH
Licensee Event Report
Docket No. 50-366

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

ATTENTION: Mr. James P. O'Reilly

Attached is Licensee Event Report No. 50-366/1982-123, 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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