

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) EDWIN I. HATCH, UNIT II										DOCKET NUMBER (2) 0 5 0 0 0 3 6 1 6										PAGE (3) 1 OF 0 3																					
TITLE (4) MISPOSITIONED INSTRUMENT VALVES																																									
EVENT DATE (5)						LER NUMBER (6)						REPORT DATE (7)						OTHER FACILITIES INVOLVED (8)																							
MONTH			DAY			YEAR			YEAR			SEQUENTIAL NUMBER			REVISION NUMBER			MONTH			DAY			YEAR			FACILITY NAMES						DOCKET NUMBER(S)								
0 8			3 0			8 4			8 4			0 2			7 0			0 0			0 9			2 8			8 4									0 5 0 0 0 0 0 0 0 0					
OPERATING MODE (9) 4						THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																																			
POWER LEVEL (10) 0 0 0 0						20.402(b)						20.405(c)						50.73(a)(2)(iv)						73.71(b)																	
						20.405(a)(1)(i)						50.36(c)(1)						50.73(a)(2)(v)						73.71(c)																	
						20.405(a)(1)(ii)						50.36(c)(2)						50.73(a)(2)(vii)						OTHER (Specify in Abstract below and in Text, NRC Form 365A)																	
						20.405(a)(1)(iii)						50.73(a)(2)(i)						50.73(a)(2)(viii)(A)																							
						20.405(a)(1)(iv)						50.73(a)(2)(ii)						50.73(a)(2)(viii)(B)																							
20.405(a)(1)(v)						50.73(a)(2)(iii)						50.73(a)(2)(ix)																													
LICENSEE CONTACT FOR THIS LER (12)																																									
NAME T. L. Elton, Acting Superintendent of Regulatory Compliance														TELEPHONE NUMBER 9 1 2 3 6 7 + 1 7 8 1 5 1																											
AREA CODE																																									
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																									
CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NPDs		CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NPDs																							
SUPPLEMENTAL REPORT EXPECTED (14)														EXPECTED SUBMISSION DATE (15)		MONTH		DAY		YEAR																					
YES (If yes, complete EXPECTED SUBMISSION DATE)														X NO																											
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																																									
<p>On 08/30/84, plant personnel determined that isolation valves and test valves for four pressure transmitters were mispositioned. An investigation was immediately initiated to determine if other valves were mispositioned on any other RPS or ECCS instrumentation. The investigation did not show any other valves to be mispositioned. The investigation was concluded with the determination that the mispositioning of the valves on the four pressure transmitters was the result of personnel error. The mispositioned valves were then correctly positioned as per the "RPS & ECSS INSTRUMENT VALVE LINEUP" procedure (HNP-2-1004). This LER is required by 10CFR50.73(a)(2)(i)(B) because these events show that the plant was operated in a condition prohibited by Tech. Specs. table 3.3.2-1(5c) and section 3.4.2.2.</p>																																									
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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
EDWIN I. HATCH, UNJT 2	0 5 0 0 0 3 6 6 8 4	- 0 2 7	- 0 0 0 2	0 3	OF	3

TEXT (If more space is required, use additional NRC Form 365A's) (17)

This 30 day LER is required by 10CFR 50.73(a)(2)(i)(B) because these events show that the plant was operated in a condition prohibited by Tech. Specs. table 3.3.2-1(5c) and section 3.4.2.2.

On 08/30/84, with the plant in operation at 30 MWt (approximately 1% power), plant personnel determined:

- That the isolation valve (IV2) for RCIC turbine exhaust diaphragm high pressure differential pressure transmitter 2E51-N085B was mispositioned.
- That the isolation and test valves (IV1 and TV1) on pressure transmitter 2B21-N122B were both mispositioned.
- That the test valves (IV1) and isolation valves (IV1) for both pressure transmitters 2B21-N120C and 2B21-N120D were mispositioned.

After a security investigation was completed (began on 08/30/84 and ended 09/01/84), plant personnel determined that the instrument valves had been placed in the incorrect position due to personnel error.

The as found valve positions had the following effects:

- The RCIC turbine exhaust diaphragm high pressure differential pressure transmitter 2E51-N085B was isolated; therefore, this event is contrary to Tech. Specs. section table 3.3.2-1(5c).
- The low low set pressure transmitter 2B21-N122B which is the trip device for safety relief valve 2B21-F013G was isolated. Consequently the valve's low low set relief function was inoperable. This event is contrary to Tech. Specs. section 3.4.2.2., ACTION b. Although this event caused the loss of the low low pressure set relief function of safety relief valve 2B21-F013G, the safety relief valve's relief set pressure and its manual opening capabilities remained intact.
- Low low set pressure transmitters 2B21-N120C and 2B21-N120D, which are the arming devices for safety relief valves 2B21-F013F and 2B21-F013D respectively were isolated in such a manner that their low low set function was rendered inoperable. This event is contrary to Tech. Specs. 3.4.2.2, ACTION b. However, the affected safety relief valves' relief set pressure and their manual opening capabilities remained intact.

In the "b" and "c" events, the valves were closed at each pressure transmitter thus making each transmitter inoperable. Therefore, 3 out of the 4 low low set valves were inoperable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

FACILITY NAME (1) EDWIN I. HATCH, UNIT 2	DOCKET NUMBER (2) 0 5 0 0 0 3 6 6 8 4	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		— 0 2 7	— 0 0	0 3	OF	0 3	

TEXT (If more space is required, use additional NRC Form 365A's) (17)

In each event, the instrument valves were immediately placed in their proper positions per the "RPS & ECCS INSTRUMENT VALVE LINEUP" procedure (HNP-2-1004). Additionally, all other RPS and ECCS instrumentation was inspected for proper valve position and verified to be satisfactory per HNP-2-1004 on 08/30/84.

The supervisors responsible for the technicians who misaligned the valves defined in the first event have reviewed the incident in detail and have been instructed to take additional precautions to further lessen the possibility of this event in the future. Those technicians responsible for the misalignment of the instrument valves in the second and third events were contract personnel, who were disciplined and terminated.

This is a non-repetitive event with these particular instrument valves; however, instrument valves have been mispositioned as last reported in LER number 50-366/1983-144. These events had no impact upon any other system in Unit 2, or Unit 1; nor did they affect the health and safety of the public.

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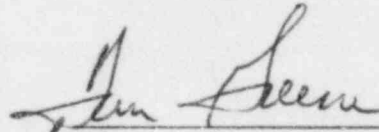
Edwin I. Hatch Nuclear Plant

September 28, 1984
GM-84-835

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

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

Attached is Licensee Event Report No. 50-366/1984-027. This report is required by 10CFR 50.73(a)(2)(i).



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