NRC FORM 366 (7-77)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

8005090439 5

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

Line	Field	Value
01	LICENSEE CODE (2)	G A E I H 2
01	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
01	LICENSE TYPE (4)	4 1 1 1 1
01	CAT (5)	
01	REPORT SOURCE (6)	L
01	DOCKET NUMBER (7)	0 5 0 0 0 3 6 6
01	EVENT DATE (8)	0 4 0 5 8 0
01	REPORT DATE (9)	0 4 2 9 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 While performing surveillance procedure HNP-2-3184, Remote Shutdown Panel
03 Instrument Checks, the torus water level instrument, 2T48-R070, was found
04 downscale. Investigations revealed that transmitter, 2T48-N070, was in-
05 advertently installed backwards following calibration on March 11, 1980.
06 The reactor was in cold shutdown the entire time the transmitter was re-
07 versed. The instrument is not required in cold shutdown. There was no
08 effect on public health and safety. This is a non-repetitive event.

SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
I D	A	Z	Z Z Z Z Z Z	Z	Z

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 0	—	0 4 7	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
H	Z	Z	Z	0 0 0 0	Y	Y	Z	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of the event was attributed to personnel error. The technician
11 failed to verify the markings of the transmitter with the proper tubing.
12 The technician was made aware of this mistake and instructed as to the
13 importance of verifying the proper installation. No generic problems
14 were revealed during the investigations.

Line	Field	Value
15	FACILITY STATUS (28)	G
15	% POWER (29)	0 0 0
15	OTHER STATUS (30)	NA
15	METHOD OF DISCOVERY (31)	B
15	DISCOVERY DESCRIPTION (32)	Operator observation
16	ACTIVITY RELEASED (33)	Z
16	CONTENT OF RELEASE (34)	Z
16	AMOUNT OF ACTIVITY (35)	NA
16	LOCATION OF RELEASE (36)	NA
17	PERSONNEL EXPOSURES NUMBER (37)	0 0 0
17	TYPE (38)	Z
17	DESCRIPTION (39)	NA
18	PERSONNEL INJURIES NUMBER (40)	0 0 0
18	DESCRIPTION (41)	NA
19	LOSS OF OR DAMAGE TO FACILITY TYPE (42)	Z
19	DESCRIPTION (43)	NA
20	PUBLICITY ISSUED (44)	N
20	DESCRIPTION (45)	NA

NRC USE ONLY

NAME OF PREPARER R. T. Nix PHONE: 912-367-7781

NARRATIVE REPORT

Georgia Power Company
Plant E. I. Hatch
Baxley, Georgia 31513

Reportable Occurrence Report No. 50-366/1980-047.

On April 5, 1980, while performing routine surveillance procedure HNP-2-3184, Remote Shutdown Panel Instrument Checks, the torus water level indicator, 2T48-R070, was found to be downscale. Investigations revealed the associated transmitter, 2T48-N070, had been installed backwards following calibration on March 11, 1980. The instrument is a Rosemount Model 1151DP transmitter and is constructed to allow the body to be installed either of two ways. The body is plainly marked high side and low side to avoid the type error made here. The instrument installation was corrected and the instrument returned to service. The technician was made aware of his mistake and reminded of the importance of verifying the correct installation.

During the time the transmitter was installed backwards, the reactor remained in cold shutdown, Condition 4. This instrument loop is not required to be operable during Conditions 4 and 5, but it is being reported because it is required operable, therefore reportable, in conditions 1, 2 and 3. The generic review revealed no inherent problems associated with the event. There was no effect on public health and safety. This is a non-repetitive event.