U. S. NUCLEAR REGULATORY COMMISSION NRC FORM 366 (7.77) LICENSEE EVENT REPORT CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) 0 0 0 0 0 CON'T 0 1 SOURCE DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) During normal operation plant personnel discovered that Standing Order 0 2 80-45 "Scram Discharge Volume Residual Water or Vacuum Determination" 0 3 0 4 Thad not been performed on 8-19-80. The event was discovered one hour into the next day. Upon discovery the Standing Order was immediately performed 0 5 There were no effects upon public health and safety. COMP SYSTEM CAUSE CAUSE VALVE SUBCODE CODE CODE A A (13) REVISION OCCURRENCE SEQUENTIAL REPORT CODE EVENT YEAR REPORT NO. TYPE NO. LER/RO 21 10 11 8 | 0 | 13 0 REPORT NUMBER SHUTDOWN PRIME COMP. .COMPONENT MANUFACTURER ATTACHMENT SUBMITTED NPRD-4 FORM SUB. HOURS SUPPLIER CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The causes of this event are personnel error and inadequate procedures 1 0 The Standing Order was required once per day and was overlooked by all 3 shifts the day of 8-19-80. HNP-1-1050 and HNP-2-1050 Surveillance check procedures for both units have been revised to ensure that all Standing Orders are complied with. Procedures will be in effect by 10-9-80. 1 4 METHOD OF OTHER STATUS % POWER 0 | 0 | (29 Operator Observation 80 9 10 ACTIVITY CONTENT LOCATION OF RELEASE (36) AMOUNT OF ACTIVITY (35) RELEASED OF RELEASE NA 80 PERSONNEL EXPOSURES DESCRIPTION (39) 0 0 37 Z 38 NUMBER NA 80 PERSONNEL INJURIES DESCRIPTION (41) NUMBER 0 0 0 0 40 NA LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION Z (42) NA PUBLICITY 8009150283 NRC USE ONLY DESCRIPTION (45) NA

S. X. Baxley, Supt. Operations

NAME OF PREPARER ...

68

367-7781

PHONE (912)

NARRATIVE REPORT

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

License Event Report No. 50-321-1980-101

During normal plant operation plant personnel discovered that Standing Order 80-45, "Scram discharge volume residual water or vacuum determination" had not been performed on 8-19-80. The event was discovered at 0055 on 8-20-80 and the standing order was immediately performed.

The causes of this event are personnel error and inadequate procedures. The standing order was required once per day and was being routinely performed on the day shift. The day shift missed performing the standing order. The evening shift assumed the day shift performed the standing order. At the time of this event there was no adequate method of ensuring that a standing order was performed. HNP-1-1050 and HNP-2-1050 surveillance check procedures have been revised to include a data sheet to log all active standing orders at the beginning of each day. These procedures will be in effect by 10-9-80.