NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT

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

01 | GAEIH2 (2) | 00-00000-00 (3) | 4111 (4) | (5)

LICENSEE CODE (7-14) | LICENSE NUMBER (15-25) | LICENSE TYPE (26-30) | CAT (57-58)

CON'T

01 | REPORT SOURCE: L (6) | 05000366 (7) | 081183 (8) | 091083 (9)

DOCKET NUMBER (60-68) | EVENT DATE (69-74) | REPORT DATE (75-80)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | On 8/11/83, during the post-maintenance review of DCR 83-76, it was de-

03 | termined that the torus vent valve's (2T48-F318) instrument air piping

04 | had been returned to service on 6/10/83 without the necessary perform-

05 | ance of HNP-6907. This is contrary to the requirements of Tech. Specs.

06 | section 6.9.1.9.c. The valve's instrument air piping remained operable,

07 | thus plant operation was not affected. The health and safety of the

08 | public were not affected by this non-repetitive event.

09 | SYSTEM CODE: SB (11) | CAUSE CODE: A (12) | CAUSE SUBCODE: F (13) | COMPONENT CODE: PIPEXX (14) | COMP. SUBCODE: A (15) | VALVE SUBCODE: Z (16)

(17) LER/RO REPORT NUMBER: EVENT YEAR 83 | SEQUENTIAL REPORT NO. 064 | OCCURRENCE CODE 03 | REPORT TYPE L | REVISION NO. 0

ACTION TAKEN: H (18) | FUTURE ACTION: Z (19) | EFFECT ON PLANT: Z (20) | SHUTDOWN METHOD: Z (21) | HOURS (22): 0000 | ATTACHMENT SUBMITTED: Y (23) | NPRD-4 FORM SUB.: N (24) | PRIME COMP. SUPPLIER: N (25) | COMPONENT MANUFACTURER: X999 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | This event is the result of a personnel oversight. Upon discovery, the

11 | valve's instrument air piping was functionally tested satisfactorily per

12 | HNP-6907 and returned to service on 8/11/83. The responsible person

13 | was counseled as to the importance of performing the required procedure

14 | prior to returning the system to service.

15 | FACILITY STATUS: E (28) | % POWER: 093 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Post-Maint. Review

16 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

17 | PERSONNEL EXPOSURES — NUMBER: 000 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

18 | PERSONNEL INJURIES — NUMBER: 000 (40) | DESCRIPTION (41): NA

19 | LOSS OF OR DAMAGE TO FACILITY — TYPE: Z (42) | DESCRIPTION (43): NA

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PDR ADOCK 05000366
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20 | PUBLICITY — ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

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

GPO 917-926

NARRATIVE REPORT
FOR LER 50-366/1983-064

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.c.

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

This event was discovered on 8/11/83 with the unit in steady state operation at 2254 MWt (approximately 93% power).

Detailed description of the event(s):

On 6/10/83, after completion of a Design Change Request (DCR), the torus vent valve (2T48-F318) and its associated instrument air piping were returned to service. On 8/11/83 during a post-maintenance review, it was determined that the torus vent valve's instrument air piping had been returned to service without the necessary performance of the "PRESSURE TESTING OF PIPING AND COMPONENTS" procedure (HNP-6907).

Consequences of the event(s):

The 2T48-F318 valve and its associated piping remained operable, thus plant operation was not affected. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

N/A

Justification for continued operation:

The 2T48-F318 valve's instrument air piping was functionally tested per HNP-6907. The results of this test were satisfactory, thus indicating that safe operation and reliability of the valve was not jeopardized after completion of the DCR on 6/10/83.

If repetitive, number of previous LER:

This is a non-repetitive event.

Impact to other systems and/or Unit:

This event had no effect on any other Unit 2 system. This event did not affect Unit 1.

Cause(s) of the event(s):

This event was the result of a personnel oversight. The responsible person over looked the requirement to perform HNP-6907 prior to returning the valve to service.

Immediate Corrective Action:

The valve's instrument air piping was functionally tested satisfactorily per the required HNP-6907 procedure and then returned to service on 8/11/83.

Supplemental Corrective Action:

The responsible person was counseled as to the importance of performing the required procedure prior to returning a system to service.

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
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912 537-9444



Georgia Power

Edwin I. Hatch Nuclear Plant

September 1, 1983
GM-83-866

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. 50-366/1983-064. This report is required by Hatch Unit 2 Technical Specifications Section 6.9.1.9.c.

Jon Greene for H. C. Nix
General Manager

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