

LICENSEE EVENT REPORT

CONTROL BLOCK: [1] [2] [3] [4] [5] [6] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0] [1] [G] [A] [E] [I] [H] [2] [0] [0] [-] [0] [0] [0] [0] [0] [0] [-] [0] [0] [3] [4] [1] [1] [1] [1] [4] [5]

7 8 9 14 15 25 26 30 57 CAT 58

LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CONT
[0] [1] [L] [0] [5] [0] [0] [0] [3] [6] [6] [1] [0] [0] [9] [8] [2] [1] [0] [2] [1] [8] [2]

7 8 60 61 68 69 74 75 80

REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0] [2] Starting on October 9, 1982, with Hatch Unit 2 at 75% power, and Hatch
 [0] [3] Unit 1 at 50% power, plant personnel (as a result of an NRC audit on
 [0] [4] October 8, 1982) discovered that plant procedures did not adequately
 [0] [5] test the automatic initiation logic of several plant systems. The Tech
 [0] [6] Specs. testing requirements for the systems were not adequately met.
 [0] [7] Health and safety of the public were not affected by this non-repetitive
 [0] [8] event.

[0] [9] [S] [C] [D] [Z] [Z] [Z] [Z] [Z] [Z] [Z] [Z] [Z]

7 8 9 10 11 12 13 18 19 20

SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE

[1] [7] [8] [2] [1] [1] [2] [0] [1] [T] [0]

7 8 21 22 23 24 26 27 28 29 30 31 32

LER/RO REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.

[G] [Z] [Z] [Z] [0] [0] [0] [0] [Y] [N] [Z] [Z] [9] [9] [9]

33 34 35 36 37 40 41 42 43 44 47

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1] [0] Plant procedures did not adequately test their respective systems. New
 [1] [1] procedures were written and performed to test the logic excluded in the
 [1] [2] existing procedures. The systems involved are now in compliance with
 [1] [3] the requirements. Further investigation is underway and a subsequent
 [1] [4] report will be written.

[1] [5] [F] [0] [7] [5] [NA] [D] [NRC Audit on SBTG System]

7 8 9 10 12 13 44 45 46 80

FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION

[1] [6] [Z] [Z] [NA] [NA]

7 8 9 10 11 44 45 80

ACTIVITY CONTENT AMOUNT OF ACTIVITY LOCATION OF RELEASE

[1] [7] [0] [0] [0] [Z] [NA]

7 8 9 11 12 13 80

PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION

[1] [8] [0] [0] [0] [NA]

7 8 9 11 12 80

PERSONNEL INJURIES NUMBER DESCRIPTION

[1] [9] [Z] [NA]

7 8 9 10 80

LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION

[2] [0] [N] [NA]

7 8 9 10 80

PUBLICITY ISSUED DESCRIPTION

**8211040083 821021
PDR ADDCK 05000366
S PDR**

NRC USE ONLY

LER #: 50-366/1982-112
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1982-112

During an NRC audit exit interview held on October 8, 1982, the site was notified of potential problems concerning the completeness of logic system testing. Starting on October 9, 1982, with Hatch Unit 2 at 75% power, and Hatch Unit 1 at 50% power, plant personnel discovered that plant procedures did not adequately test the automatic initiation logic of the following: Standby Gas Treatment System, Unit 2 (Deviation Report Number 2-82-253, Discovery date: 10-9-82, test required per Tech. Specs. 4.6.6.1.d.2), Reactor Core Isolation Cooling System (Deviation Report Number 2-82-255, Discovery date: 10-14-82, testing required per Tech. Specs. 4.3.4.1 and Table 3.3.4.1), High Pressure Coolant Injection System (Deviation Report Number 2-82-257, Discovery date: 10-14-82, testing required per Tech. Specs. 4.5.1.c.1), Automatic Depressurization System (Deviation Report Number 2-82-258, Discovery date: 10-14-82, testing required per Tech. Specs. 4.5.2.a), and Standby Gas Treatment System, Unit 1 (Deviation Report Number 1-82-185, Discovery date: 10-14-82, testing required per Unit 1 Tech. Specs. 4.7.B.1.d and Unit 2 Tech. Specs. 3/4.6.6.1). Health and safety of the public were not affected by this non-repetitive event.

The event resulted from the failure of procedures to adequately test several plant systems. The inadequacies included failure to test a relay and/or the continuity of one or more sets of contacts in each of the logic systems involved. New procedures were written and performed to test the logic excluded in the existing procedures. Further investigation is underway and a subsequent update report will be submitted.