NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Value
01	LICENSEE CODE (2)	GAEIH2
01	LICENSE NUMBER (3)	00-00000-00
01	LICENSE TYPE (4)	41111
01	CAT (5)	
01 CON'T	REPORT SOURCE (6)	L
01	DOCKET NUMBER (7)	05000366
01	EVENT DATE (8)	012882
01	REPORT DATE (9)	022382

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On 1-28-82, with Unit 2 at 50 percent power (1228 MWt) a LLRT was done
03 on the D/W personnel airlock innerspace (as per HNP-2-3952, Primary
04 Containment Periodic Type B and Type C Leakage Tests) as required by
05 Tech Spec 4.6.1.3.b. A review of the test results determined that the
06 leakage rate was in excess of the .05 La limit dictated by Tech Spec
07 3.6.1.3.b (As found leakage:would not pressurize - .05 La:3020 ACCM).
08 This is a non-repetitive event. There was no effect on the public.

09	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
	SA	E	B	PENETR	A	Z

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	82	—	014	/	03	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)
X	`	Z	Z	0000	Y	Y	A	C310

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 An investigation determined that the cause of the innerspace leaking was
11 due to a damaged shaft and seal assembly on the outer airlock door (the
12 shaft is used to operate inner door). Corrective action consisted of
13 removing the damaged assembly and temporarily replacing it with a blind
14 flange. The innerspace was then successfully retested (As left:695 ACCM).

15	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
	E	050	NA	B	Local Leak Rate Test

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

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

18	PERSONNEL INJURIES NUMBER (40)	DESCRIPTION (41)
	000	NA

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

20	PUBLICITY ISSUED (44)	DESCRIPTION (45)	NRC USE ONLY
	N	NA	

8204280485

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LER #: 50-366/1982-14
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1982-14

On January 28, 1982, with Unit 2 at 50 percent thermal power (1228 MWt) a Local Leak Rate Test (LLRT) was performed on the drywell personnel airlock innerspace (as per HNP-2-3952, PRIMARY CONTAINMENT PERIODIC TYPE B AND TYPE C LEAKAGE TESTS). This LLRT was being done as the "at least once per 6 months" test required by Tech Spec section 4.6.1.3.b.

A review of the test results showed that the leakage rate was in excess of the .05 La limit dictated by Tech Spec section 3.6.1.3.b (As found leakage: innerspace would not pressurize - .05La:3020 ACCM). This is a non-repetitive event. The public health and safety was not affected by this event.

The LLRT failed at 1500 on January 28, 1982, and as a result an LCO (#2-82-34) was declared per Tech Spec 3.6.1.3, Action B: "With the primary containment airlock inoperable, except as a result of an inoperable airlock door, maintain at least one air lock door closed; restore the inoperable airlock to OPERABLE status within 24 hours". The LCO continues in 3.6.1.3, Action C as follows: "Otherwise, be in at least HOT SHUTDOWN within the next 12 hours and in COLD SHUTDOWN within the following 24 hours." The corrective action and successful retest (see details below) were completed and the LCO closed out at 1915 on January 29, 1982 - the unit was allowed to continue operating.

An investigation determined that the cause of the innerspace leakage was due to the leaking of the lower shaft and wheel assembly on the outer airlock door (used to operate the inner door from outside the airlock on the outer door side). Immediate corrective action was to remove the damaged shaft and wheel assembly and temporarily cover the resultant hole with a blind flange (Reference DCR # 82-012 and implementing MR 2-82-459). The innerspace was then successfully retested (As left leakage:695 ACCM). Final corrective action is incomplete at this time - an investigation is underway to determine what final corrective action will be needed. A review of this event for generic concerns revealed no such problems.