

LICENSEE EVENT REPORT

CONTROL BLOCK: _____ (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 0 0 | 4 1 1 1 1 | _____ | _____ |
7 8 9 14 15 25 26 30 57 CAT 58

CON'T
0 1 | L | 0 5 0 0 0 0 3 6 6 | 0 2 2 8 8 0 | 0 2 1 0 8 3 |
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
0 2 | During an instrument check, the "B" Drywell H2 O2 Analyzer recorder was
0 3 | found giving an erroneous reading. While investigating the problem, it
0 4 | was found that the "B" analyzer system had a leak in it. The "B"
0 5 | analyzer was inoperative at this time. There were no effects upon the
0 6 | public health and safety due to this event. This is a repetitive event
0 7 | as last reported on LER 50-366/1980-019.

0 9 | S A | X | Z | I N S T R U | E | Z |
7 8 9 10 11 12 13 18 19 20
17 | LER/RO REPORT NUMBER | 8 0 | - | 0 2 8 | / | 0 3 | X | - | 1 |
21 22 23 24 26 27 28 29 30 31 32
18 | E | Z | 7 | Z | 0 0 0 0 | Y | N | N | X 9 9 9 |
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
1 0 | The cause for "B" analyzer failure has been attributed to system in
1 1 | leakage. The leak was repaired and the analyzer was calibrated and
1 2 | returned to service. This instrument, Model K-4, is manufactured by
1 3 | Comsip Delphi.

1 5 | E | 0 9 9 | NA | B | Operator Observation
7 8 9 10 12 13 44 45 46 80

1 6 | Z | Z | NA | NA |
7 8 9 10 11 44 45 80

1 7 | O G O | Z | NA
7 8 9 11 12 13 80

1 8 | 0 0 0 | NA
7 8 9 11 12 80

1 9 | Z | NA | S |
7 8 9 10 43 80

2 0 | N | NA |
7 8 9 10 45 80

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LER No.: 50-366/1980-028, Rev. 1
Licensee: Georgia Power Company
Facility: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1980-028, Revision 1
Update Report - Previous Report Date 2/28/80

While doing an instrument check, the "B" Drywell H2 O2 Analyzer Recorder was found indicating erroneously. It was determined that the "B" analyzer system had some in leakage. The "A" analyzer was also inoperative at this time due to diaphragm failure (ref: LER 2-80-19). There were no effects upon public health and safety or plant operation due to this event. The failure of the instruments on this event is a repetitive event as last reported on Reportable Occurrence No. 50-366/1980-019.

The cause of the event was attributed to system in leakage. The leak was repaired and the analyzer was calibrated and returned to service. The instruments are manufactured by Comsip Delphi, Model K-4.

The generic review revealed the instruments to be common only to Unit II. No generic problems were found but the instrument performance has not been as well as expected.

A vendor's representative visited the job site on 3/24/80, and repaired leaking air lines, replaced vacuum pump diaphragms, replaced catalyst cells, installed trim pots in the place of resistors, and recommended a design change to install an improved model of the system's hot boxes.

On 4/16/80, the vendor's representative returned to the job site and performed a design change where he installed an improved model of the system's hot boxes. On 4/18/80, the H2 O2 analyzer system was satisfactorily functionally tested per "COMSIP DELPHI MODEL K-IV HYDROGEN AND OXYGEN ANALYZER FUNCTIONAL TEST AND CALIBRATION" procedure and returned to service.