LICENSEE EVENT REPORT

CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)
0 1 G A E I H 2 2 0 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 1 4 5 5 TOTAL SE TYPE 30 57 CAT 58
CON'T O 1 SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) During a normal review of E BAR determinations, it was discovered that
select isotopes (i.e., CU 64) had been identified, but were omitted from
the process computer E BAR library when the program was originally
o initiated. This event is contrary to the requirements of Tech. Specs.
section 3.4.5.b. Plant operation was not affected by this event as Unit
2 was shutdown for refueling when the event was discovered. The health
and safety of the public were not affected by this non-repetitive event. 7 8 9 SYSTEM CAUSE CAUSE COMP. VALVE
TODE SUBCODE S
17) REPORT NUMBER 8 3 - REPORT NO. CODE TYPE NO. O 3 4 - O 3 4 O 1 T O 3
ACTION FUTURE ON PLANT SHUTDOWN METHOD HOURS 22 ATTACHMENT FORM SUB. SUPPLIER MANUFACTURER X 18 Z 19 Z 20 Z 21 0 0 0 0 1 1 23 24 24 25 25 26 27 26 27 27 27 28 27 28 28 29 29 29 29 29 29
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause of this event has been determined to be an incorrect computer
program supplied by the vendor. The program library will be corrected
prior to unit startup. A review was completed on 6/2/83 and no Tech.
Spec. limits have been violated due to this event.
14
7 8 9 FACILITY STATUS SPOWER OTHER STATUS 30 METHOD OF DISCOVERY DESCRIPTION 32 [1 15 H 169 0 0 0 0 0 NA 1 B 31 Personnel Observation 1
7 8 9 10 12 13 44 45 46 80 ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) NA NA NA NA
7 8 9 10 12 13 44 45 46 80 RELEASED OF RELEASE AMOUNT OF ACTIVITY 35 NA
7 8 9 10 12 13 44 45 46 RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) NA N
7 8 9 10 12 13 44 45 46 RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) NA 1 6 Z (33) Z (34) NA
7 8 9 10 11 12 13 44 45 46 10 11 16 17 18 9 11 12 13 80 PERSONNEL INJURIES NUMBER DESCRIPTION (41) NA PERSONNEL INJURIES NA PERSONNEL

'Georgia Power Company Post Office Box 439 Baxley, Georgia 31513 Telephone 912 367-7781 912 537-9444



Edwin I. Hatch Nuclear Plant

June 6, 1983 GM-83-524 USNRO REGION TO THE AND REGION

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

Pursuant to Section 6.9.1.8.i. of Hatch Unit Two Technical Specifications, please find attached Reportable Occurrence Report No. 50-366/1983-034.

H. C. Nix General Manager

HCN/SBT/abb

XC:

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J. T. Beckham, Jr.

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NARRATIVE REPORT FOR LER 50-366/1983-034

LICENSEE : GEORGIA POWER COMPANY

FACILITY NAME : EDWIN I. HATCH

DOCKET NUMBER : 50-366

Tech. Specs. section(s) which requires report:

This 14-day report is required by Tech. Specs. section 6.9.1.8.i. due to the event's showing that the unit was not meeting the requirements of Tech. Specs. section 3.4.5.b.

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

This event occurred on 5/25/83 with the Unit 2 reactor in the refuel mode.

Detailed description of the event(s):

During a normal review of E BAR determinations, it was discovered that select isotopes (i.e., CU 64) had been identified but were omitted from the process computer E BAR library when the program was originally initiated.

Consequences of the event(s):

Plant operation as not affected by this event as Unit 2 was shutdown for refueling when the event was discovered. The health and safety of the public were not affected by this event.

Status of redundant or backup subsystems and/or systems:

There are no redundant or backup systems.

Justification for continued operation:

This program is not required to be operable when the unit is in refuel. The program library will be corrected prior to unit startup. No Tech. Specs. violations have occurred because of this omission.

If repetitive, number of previous LER:

This event is non-repetitive.

Narrative Report for LER 50-366/1983-034 Page Two

Impact to other systems and/or Unit:

This event had no impact to other systems on Unit 2 or to Unit 1.

Cause(s) of the event(s):

The cause of this event has been determined to be an incorrect computer program supplied by the vendor, Applied Physical Technology/Nuclear Data Services.

Immediate Corrective Action:

No Immediate Corrective Action was required due to the unit's being in refuel.

Supplemental Corrective Action:

A worst case review of E BAR determinations for Unit 2 reactor water was performed to determine if any Tech. Specs. limits have been violated since the startup of Unit 2. The review was completed on 6/2/83 and no Tech. Specs. limits have been violated due to this event.

Scheduled (future) corrective action:

The program library will be corrected prior to unit startup.

Action to prevent recurrence (if different from corrective actions):

N/A