**U.S. NUCLEAR REGULATORY COMMISSION** NRC FORM 366 (7.77) LICENSEE EVENT REPORT  $(\mathbf{1})$ CONTROL BLOCK: (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) 0 0 0 0 - 0 0 34 LICENSE TYPE 30 20 0 0 58 (5) G A E I H I 1 0 LICENSEE CODE CON'T 18 00 8 0 9 1 4 75 BEPO REPORT L 6015 10 10 10 13 2 11 11 0 1 SOURCE DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) On 08/19/83, it was determined that the "D" main steam line radiation 0 2 monitor (1D11-K603D) was fluctuating. On 08/21/83, it was determined 0 3 that monitor 1D11-K603 had drifted downscale. In both instances, the 0 4 associated trip system was placed in the tripped system as required by 0 5 footnote c for item 4 of Tech. Specs. Table 3.2-1. The health and 0 6 safety of the public were not affected by this non-repetitive event. 0 7 8 SYSTEM CAUSS CAUSE COMP VALVE COMPONENT CODE CODE SUBCODE SUBCODE | S | T | R | U |(14 II X (15 IZ B A (11 X X (13) N (16 (12 0 9 OCCURRENCE REVISION SEQUENTIAL REPORT REPORT NO. CODE TYPE EVENT YEAR NO. LER/RO 0 3 0 8 0 0 REPORT 8 | L 3 NUMBER COMPONENT NPRD-4 PRIME COMP SUBMITTED ACTION EFFECT ON PLANT SHUTDOW FUTURE HOURS (22) FORM SUE SUPPLIER MANUFACTURER N 24 B N (25) G | 0 | 8 10 Y (23) (18) Z Z (19) (20) CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) An investigation determined that these events were caused by a shorted 1 0 connector on the monitor's power input cable. The cable connector was 1 1 The monitor was then calibrated per the "LOGARITHMIC replaced. 1 2 RADIATION MONITOR" procedure (HNP-1-5100) and returned to satisfactory 1 3 service on 08/21/83 at approximately 0515 hours. 4 80 METHOD OF DISCOVERY FACILITY (30)DISCOVERY DESCRIPTION (32 OTHER STATUS % POWER Operator Observation E (28) 1 0 0 (29) NA A (31) 5 80 ACTIVITY CONTENT 13 LOCATION OF RELEASE (36) AMOUNT OF ACTIVITY (35) RELEASED OF RELEASE NA Z (33) Z (34) MA 6 80 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER TYPE 0 0 (37) Z (38) NA G 7 80 PERSONNEL INJURIES DESCRIPTION (41) NUMBER 0 0 0 (40) NA 80 LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION 8309210347 830915 PDR ADDCK 05000321 Z (42) 9 NA PDR 20 PUBLICITY NRC USE ONLY DESCRIPTION (45) 7822 SUED N (42) NA 69 S. B. Tipps (912)367-7851 NAME OF PREPARER. PHONE:-

# NARRATIVE REPORT FOR LER 50-321/1983-080

LICENSEE : GEORGIA POWER COMPANY FACILITY NAME : EDWIN I. HATCH DOCKET NUMBER : 50-321

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

This 30-day LER is required by Tech. Specs. section 6.9.1.9.b because it showed that the unit did not meet the "required operable channels per trip system" requirement of Tech. Specs. table 3.2-1, item 4.

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

The plant was in steady state operation at 2421 MWt (approximately 100% power) when this event occurred.

# Detailed description of the event(s):

On 08/19/83, plant personnel noted that the "D" main steam line (MSL) radiation monitor (1D11-K603D) was fluctuating. On the night shift of 08/19/83, the monitor was indicating approximately 550 mR/HR, and on the day shift of 08/19/83 the monitor was indicating approximately 1150 mR/HR. Consequently the monitor was declared inoperable at approximately 1150 hours. On 08/21/83, 1D11-K603D was observed drifting downscale. It was declared inoperable at approximately 0205 hours.

## Consequences of the event(s):

These events did not affect plant operations. The health and safety of the public were not affected by these events.

# Status of redundant or backup subsystems and/or systems:

Main steam line radiation monitors 1D11-K6O3A, B, and C were operable during these events.

# Justification for continued operation:

In both cases, the associated trip system was placed in the tripped condition as required by footnote c for item 4 of Tech. Specs. table 3.2-1.

#### If repetitive, number of previous LER:

This is a non-repetitive LER.

Narrative Report for LER 50-321/1983-084, Rev. 1 Fage Two

# Impact to other systems and/or Unit:

These events had no impact upon other systems in Unit 1, or Unit 2.

# Cause(s) of the event(s):

After an investigation, it was determined that a shorted power input cable connector caused these events.

# Immediate Corrective Action:

On 08/19/83, main steam line radiation monitor 1011-K603D was replaced with a calibrated spare monitor for observation for proper operation at approximately 1325 hours. On 08/21/83, after investigating the downscale indication, plant personnel determined that the monitor's power input cable connector was shorted. The cable connector was replaced and the original monitor was re-installed. The monitor was then calibrated per the "LOGARITHMIC RADIATION MONITOR" procedure (HNP-1-5100) and satisfactorily returned to service on 08/21/83 at approximately 0515 hours.

Supplemental Corrective Action:

No supplemental corrective action was required.

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 Telephone 912 367-7781 912 537-9444

# Edwin I. Hatch Nuclear Plant 83 SEP 19 A 9:55

Georgia Power

September 15, 1983 GM-83-894

PLANT E. I. HATCH Licensee Event Report Docket No. 50-321

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. 50-321/1983-080. This report is required by Hatch Unit 1 Technical Specifications Section 6.9.1.9.b.

Nix General Manager

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160 HCN/SBT/djs

XC:

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