NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

UPDATE REPORT
PREVIOUS REPORT DATE 3-24-83

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

0 1 | LICENSEE CODE: G A E I H 1 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT (5)

CON'T 0 1 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 3 2 1 (7) | EVENT DATE: 0 8 2 4 8 3 (8) | REPORT DATE: 0 9 2 2 8 3 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On 02/24/83, RWCU inboard isolation valve (G31-F001) failed to close
0 3 and on 02/25/83, when attempting to return RWCU to operable status, the
0 4 RWCU outboard isolation valve (G31-F004) failed to open. Prior to the
0 5 implementation of the scheduled corrective action for the first event,
0 6 the G31-F001 failed to close in T.S. Table 3.7-1 time limit. These
0 7 events are contrary to the requirements of Tech. Specs. section 3.7.D.1.
0 8 The health and safety of the public were not affected by these events.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S D (11)	E (12)	A (13)	V A L V O P (14)	A (15)	D (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 2 3	/	0 3	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
F (18)	B (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	C 6 6 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 An investigation revealed that G31-F001 failed to close due to limit
1 1 switch LS-1 being out of adjustment, and that G31-F004 failed due to a
1 2 burned up motor. The open indication limit switch was paralleled with
1 3 a torque switch to permit G31-F001 to operate and the G31-F004's valve
1 4 motor was replaced. (see narrative for complete details.)

1 5 | FACILITY STATUS: E (28) | % POWER: 0 3 5 (29) | OTHER STATUS (30): NA | METHOD OF DISCOVERY: A (31) | DISCOVERY DESCRIPTION (32): Operator Observation

1 6 | ACTIVITY RELEASED: Z (33) | CONTENT OF RELEASE: Z (34) | AMOUNT OF ACTIVITY (35): NA | LOCATION OF RELEASE (36): NA

PERSONNEL EXPOSURES
1 7 | NUMBER: 0 0 0 (37) | TYPE: Z (38) | DESCRIPTION (39): NA

PERSONNEL INJURIES
1 8 | NUMBER: 0 0 0 (40) | DESCRIPTION (41): NA

LOSS OF OR DAMAGE TO FACILITY (43)
1 9 | TYPE: Z (42) | DESCRIPTION: NA

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PUBLICITY
2 0 | ISSUED: N (44) | DESCRIPTION (45): NA | NRC USE ONLY

NAME OF PREPARER S. B. Tipps PHONE: (912)367-7851

GPO 917-926

NARRATIVE REPORT
FOR LER 50-321/1983-023, Rev. 1
UPDATE REPORT-PREVIOUS REPORT DATE 3/24/83

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. 6.9.1.9.b due to the event's showing that the plant was not meeting the requirements of Tech. Specs. section 3.7.D.1.

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

On 02/24/83, when the first event occurred, the plant was operating at 840 MWt (approximately 34% power).

On 02/25/83, when the second event occurred, the plant was operating at 1192.25 MWt (approximately 49% power).

On 08/24/83, the plant was in steady state operation at 2435 MWt (approximately 100% power).

Detailed description of the event(s):

On 02/24/83, while attempting to place the Reactor Water Clean Up (RWCU) system in service, operating personnel noted that the RWCU inboard primary containment isolation valve (G31-F001) would not close (Refer to Deviation Report number 1-83-050).

On 02/25/83, while attempting to restore the RWCU system (after completion of repairs on the G31-F001 valve), operating personnel noted that the RWCU outboard primary containment isolation valve (G31-F004) could not be opened with the control switch (Refer to Deviation Report number 1-83-053). The valve was then partially opened manually, and personnel discovered that the valve could not be opened or closed with the control switch.

On 08/24/83, during performance of the "PRIMARY CONTAINMENT ISOLATION VALVE OPERABILITY" procedure (HNP-1-3962), the reactor water cleanup inboard isolation valve (1G31-F001) failed to close within 30 seconds as required by Tech. Specs. table 3.7-1 (as found closure time of 32.3 seconds) (Refer to Deviation Report number 1-83-215).

Consequences of the event(s):

Plant conditions were not affected by these events. The health and safety of the public were not affected by these events.

Status of redundant or backup subsystems and/or systems:

When the G31-F001 valve failed, the G31-F004 valve was operable and vice versa. On 08/24/83 when G31-F001 failed to close in required time the G31-F004 was operable.

Justification for continued operation:

When the G31-F001 valve would not close, it was declared inoperable. The G31-F004 valve was then closed and plant operation continued as allowed by Tech. Specs. 3.7.D.2.

When the G31-F004 valve would not close, it was declared inoperable. The G31-F001 valve was then closed and plant operation continued as allowed by Tech. Specs. 3.7.D.2.

When the G31-F001 valve would not close in the required time, it was declared inoperable. The G31-F004 valve was then closed and plant operation continued as allowed by Tech. Specs. 3.7.D.2.

If repetitive, number of previous LER:

These are non-repetitive events and as such there are no previous LER's.

Impact to other systems and/or Unit:

These events had no impact on either any other Unit 1 systems or any Unit 2 systems.

Cause(s) of the event(s):

The G31-F001 valve operator's limit switch number one (LS1) normally functions to allow the valve to begin closing (from a fully opened position) when the closing torque switch (TS-C: this switch opens on mechanical overload in the closing direction) is open. In this case, the LS1 was out of adjustment such that it would allow the valve to start closing, but LS1 would open before TS-C could close. Thus, the valve started to close, and then it stopped moving.

The cause of failure of the G31-F004 valve was burned windings in the valve operator's motor and burred and binding declutch fingers in the valve operator.

An investigation revealed that G31-F001 failed to close in the required time limit due to the valve's disc being withdrawn further than necessary into the valve's bonnet on its open stroke; additionally, the valve's stem needed lubricating.

Immediate Corrective Action:

Corrective action for the G31-F001 valve was implemented per a temporary design change (DCR No. 83-33). This change added a jumper in an appropriate control room panel such that LS7 (normally used for open light indication only) would be paralleled with LS1 and TS-C (refer to Figure 1 for switch development for LS7). The work was done due to the inaccessibility of the valve's limit switch (in the drywell). The valve was then satisfactorily functionally tested as per the "PRIMARY CONTAINMENT ISOLATION VALVE OPERABILITY" procedure (HNP-1-3962), and returned to service on 02/24/83. This procedure also demonstrated that the valve operating time was within the 30 seconds maximum operating time of Tech. Specs. Table 3.7-1.

The operator's motor was replaced on the G31-F004 valve, and the burrs were removed from the declutch fingers (this also got rid of the binding). The valve was then satisfactorily functionally tested as per HNP-1-3962 and returned to service on 02/26/83 (valve operating time was within the 30 second limit of Tech. Specs. Table 3.7-1).

On 08/27/83, to resolve the last event personnel polished the stem, lubricated the stem, and set the valve stroke to manufacturer specifications on G31-F001. Also, G31-F001 was repacked and limit switch LS1 was adjusted, and all other limit switches were checked with the spring tension (applied switch contact force) being adjusted to ensure that the limit switches make proper contact when in their closed position. Then the jumper installed per temporary design change (DCR 83-33) was removed. G31-F001 was functionally tested per HNP-1-3962 and placed in operable status on 08/27/83.

Supplemental Corrective Action:

No supplemental corrective action is required.

Scheduled (future) corrective action:

No scheduled corrective action is required.

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

N/A

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Telephone 912 367-7781
912 537-9444

Edwin I. Hatch Nuclear Plant

Georgia Power

September 22, 1983
GM-83-932

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. 50-321/1983-023, Rev. 1. This report is required by Hatch Unit 1 Technical Specifications Section 6.9.1.9.b.

H. C. Nix
General Manager

HCN/SBT/djs

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