

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) EDWIN I. HATCH, UNIT II DOCKET NUMBER (2) 050003616 PAGE (3) 1 OF 03

TITLE (4) MISPOSITIONED INSTRUMENT VALVES

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
08	30	84	84	027	00	09	28	84			05000

OPERATING MODE (9) 4

POWER LEVEL (10) 0.0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 366A)
<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
T. L. Elton, Acting Superintendent of Regulatory Compliance	912 367 1781

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On 08/30/84, plant personnel determined that isolation valves and test valves for four pressure transmitters were mispositioned. An investigation was immediately initiated to determine if other valves were mispositioned on any other RPS or ECCS instrumentation. The investigation did not show any other valves to be mispositioned. The investigation was concluded with the determination that the mispositioning of the valves on the four pressure transmitters was the result of personnel error. The mispositioned valves were then correctly positioned as per the "RPS & ECSS INSTRUMENT VALVE LINEUP" procedure (HNP-2-1004). This LER is required by 10CFR50.73(a)(2)(i)(B) because these events show that the plant was operated in a condition prohibited by Tech. Specs. table 3.3.2-1(5c) and section 3.4.2.2.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
			- 0 2 7	- 0 0 0	2	0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

This 30 day LER is required by 10CFR 50.73(a)(2)(i)(B) because these events show that the plant was operated in a condition prohibited by Tech. Specs. table 3.3.2-1(5c) and section 3.4.2.2.

On 08/30/84, with the plant in operation at 30 MWt (approximately 1% power), plant personnel determined:

- a. That the isolation valve (IV2) for RCIC turbine exhaust diaphragm high pressure differential pressure transmitter 2E51-N085B was mispositioned.
- b. That the isolation and test valves (IV1 and TV1) on pressure transmitter 2B21-N122B were both mispositioned.
- c. That the test valves (IV1) and isolation valves (IV1) for both pressure transmitters 2B21-N120C and 2B21-N120D were mispositioned.

After a security investigation was completed (began on 08/30/84 and ended 09/01/84), plant personnel determined that the instrument valves had been placed in the incorrect position due to personnel error.

The as found valve positions had the following effects:

- a. The RCIC turbine exhaust diaphragm high pressure differential pressure transmitter 2E51-N085B was isolated; therefore, this event is contrary to Tech. Specs. section table 3.3.2-1(5c).
- b. The low low set pressure transmitter 2B21-N122B which is the trip device for safety relief valve 2B21-F013G was isolated. Consequently the valve's low low set relief function was inoperable. This event is contrary to Tech. Specs. section 3.4.2.2., ACTION b. Although this event caused the loss of the low low pressure set relief function of safety relief valve 2B21-F013G, the safety relief valve's relief set pressure and its manual opening capabilities remained intact.
- c. Low low set pressure transmitters 2B21-N120C and 2B21-N120D, which are the arming devices for safety relief valves 2B21-F013F and 2B21-F013D respectively were isolated in such a manner that their low low set function was rendered inoperable. This event is contrary to Tech. Specs. 3.4.2.2, ACTION b. However, the affected safety relief valves' relief set pressure and their manual opening capabilities remained intact.

In the "b" and "c" events, the valves were closed at each pressure transmitter thus making each transmitter inoperable. Therefore, 3 out of the 4 low low set valves were inoperable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) EDWIN I. HATCH, UNIT 2	DOCKET NUMBER (2) 0 5 0 0 0 3 6 6 8 4	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		84	027	00	03	OF	03

TEXT (If more space is required, use additional NRC Form 365A's) (17)

In each event, the instrument valves were immediately placed in their proper positions per the "RPS & ECCS INSTRUMENT VALVE LINEUP" procedure (HNP-2-1004). Additionally, all other RPS and ECCS instrumentation was inspected for proper valve position and verified to be satisfactory per HNP-2-1004 on 08/30/84.

The supervisors responsible for the technicians who misaligned the valves defined in the first event have reviewed the incident in detail and have been instructed to take additional precautions to further lessen the possibility of this event in the future. Those technicians responsible for the misalignment of the instrument valves in the second and third events were contract personnel, who were disciplined and terminated.

This is a non-repetitive event with these particular instrument valves; however, instrument valves have been mispositioned as last reported in LER number 50-366/1983-144. These events had no impact upon any other system in Unit 2, or Unit 1; nor did they affect the health and safety of the public.

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Edwin I. Hatch Nuclear Plant

September 28, 1984
GM-84-835

PLANT E. I. HATCH
Licensee Event Report
Docket No. 50-366

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D. C. 20555

Attached is Licensee Event Report No. 50-366/1984-027. This report is required by 10CFR 50.73(a)(2)(i).



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