NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
PLANT HATCH, UNIT 2	0 5 0 0 0 3 6 6	1 OF 1 7

TITLE (4)
FAILED VALVES DISCLOSE DESIGN DEFICIENCIES AND TECHNICAL SPECIFICATION VIOLATION

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)
0 2	1 2	8 8	8 8	0 0 7	0 1	0 7	1 1	8 8	PLANT HATCH, UNIT 1	0 5 0 0 0 3 2 1
										0 5 0 0 0

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

OPERATING MODE (9): 5			
20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10): 0 0 0			
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	X 50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
J. D. Heidt, Nuclear Licensing Manager - Hatch	4 0 4 5 2 6 - 4 3 5 0

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
B	J M	T B G	T 0 2 0	Y					

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On 2/12/88 at approximately 0900 CST, plant maintenance personnel were performing Local Leak Rate Testing (LLRT) of some valves on the air supply lines serving the pneumatic actuators for testing the Torus to Drywell vacuum breakers (EIIS Code BF) in Unit 2. The valves did not pass the LLRT. An investigation determined the valves and the lines did not meet all of the system design requirements in the Final Safety Analysis Report (FSAR). Additional investigations determined the same valves on Units 1 and 2 were not correctly tested. This is a condition prohibited by the plants' Technical Specifications. The Unit 1 valves and piping were correctly designed.

The root cause of these events is design deficiency.

Corrective actions for the events included: 1) initiating appropriate Technical Specification actions, 2) correcting Unit 2 valve deficiencies, 3) initiating a complete investigation of the events and strengthening design controls, and 4) developing a design change for the Unit 1 valves.

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

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(ii), because some of the small (half inch to inch) diameter air lines (that are used for testing of the Unit 2 torus to drywell vacuum breakers [EIIS Code BF]) did not meet all of the design requirements of the Final Safety Analysis Report (FSAR). This is a condition that is cutside of the design basis for these lines.

In the course of the investigation for the preceding Unit 2 event, it was determined that this report is also required per 10 CFR 50.73 (a)(2)(i), because conditions existed on Units 1 and 2 that were prohibited by the plants' Technical Specifications. Specifically, Table 3.7-4 of the Unit 1 Technical Specifications allows Local Leak Rate Tests (LLRTs) not to be performed in the direction required for isolation, provided that this testing is equivalent to, or more conservative than, testing in the accident direction. For Unit 2, Section 4.6.1.2 of the Technical Specifications requires that containment leakage shall be determined in accordance with the criteria specified in Appendix J of 10 CFR 50. Appendix J section III C again requires that the results, from the tests for pressure applied in a different direction, will provide equivalent or more conservative results. It was determined that the test direction for the Units 1 and 2 solenoid isolation valves would not result in a conservative test.

B. UNIT(s) STATUS AT TIME OF EVENT

1. Power Level/Operating Mode

Unit 2 was a in cold shutdown condition at an approximate power level of 0 MWt (approximately 0% rated power). The reactor mode switch was in the refuel position. The reactor vessel head was removed for the seventh refueling outage and there was no fuel in the vessel.

Unit 1 was in steady state operation at an approximate power level of 2436 MWt (approximately 100% thermal rated power). The reactor mode switch was in the run position.

2. Inoperable Equipment

There was no inoperable equipment that contributed to this event.

C. DESCRIPTION OF EVENT

1. Event

On 2/12/88 at approximately 0900 CST, non-licensed maintenance personnel began the Local Leak Rate Test (LLFT) of Unit 2 solenoid isolation valves (2T48-F342A through L) (EIIS Code JM) on the air lines serving the pneumatic vacuum breaker actuators (2T48-F323A through L) (EIIS Code JM) for testing the Torus to Drywell vacuum breakers (EIIS Code BF). The configuration of one of the lines is presented as figure 1. This system is considered a closed system (GDC-57). Therefore, the pneumatic actuator is the inboard isolation barrier and the two way solenoid valve is the outboard isolation barrier.

The testing was per plant procedure 42SV-TET-001-2S (Primary Containment Periodic Type B and Type C Leakage Tests). Prior to 2/12/88, the valves had been tested in a direction that was opposite to the accident direction. Plant personnel believed this method satisfied Technical Specification requirements since it was expected to yield conservative results based on the understood design configuration. However, with Revision 3 to the procedure (dated 1/13/88) the valves were now tested in the accident direction. This revision had resulted from the implementation of some Architect/Engineer (A/E - Southern Company Services) recommendations to enhance the LLRT program.

Between 0900 and 1400 CST, two solenoid valves in two separate lines failed to hold the required test pressure. At 1400 CST, plant engineering personnel were requested to aid in determining the reason for the failures. At that point, it was suspected that the valves might be open because of a logic problem.

Between 1400 and 1545 CST, plant engineering personnel reviewed the logic channel design drawings, Piping and Instrument Drawings (P&IDs), and valve vendor manuals. The review indicated that the valves were installed according to logical construction practices (i.e. valve flow direction identical to plant air test flow direction). However, upon closer examination, plant engineering personnel started to question if this installation was adequate.

Engineering personnel determined that when the valves were previously tested in the reverse direction, the test pressure would tend to drive the valves onto the valve seats. This would tend to decrease any leakage that would be present. When the valves were now tested in the accident direction, the test pressure appeared to lift the valve off of its seat. See figure 2 for valve details.

At 2/12/88 at 1545 CST, plant engineering personnel contacted representatives of the A/E (Bechtel Eastern Power Corporation - BEPC) to determine whether the valves, as currently installed, could accomplish their design function. The scope of the request covered both Units 1 and 2, since the valve installation on Unit 1 is similar to Unit 2, although the valves are different models (Target Rock models 73K-001 for Unit 1 and 75F-009 for Unit 2). It was determined the Unit 1 valves were installed according to logical construction practices.

After discussion with the valve vendor, the BEPC personnel contacted plant engineering personnel at 1900 CST and stated that both Unit 1 and Unit 2 valves would remain closed only when the pressure was less than approximately 2 to 5 psig. Since the accident pressure in the torus, as presented in the FSAR, is approximately 28 psig for Unit 1 and 26 psig for Unit 2, plant engineering and A/E personnel determined the valves potentially would not perform their design function of containment isolation.

Based on this information it was concluded that the original design was deficient. To accomplish their design function of retaining accident pressure and thereby preserving containment integrity, the valves should have either been installed in a direction reverse to which they were actually installed, or the valves should have been installed with a stronger spring that would have withstood accident pressures.

Plant engineering, Nuclear Safety and Compliance, and management personnel discussed this situation with respect to both plants. By approximately 1915 CST, management and supervisory personnel had determined that Unit 2 was still in compliance with the plant's Technical Specifications at that point since the unit was in cold shutdown (primary containment integrity was not required).

However, since Unit 1 was operating at rated thermal power, primary containment integrity was required. Plant engineering personnel notified plant operations personnel of these findings at approximately 1915 CST. Plant operations personnel declared the valves on Unit 1 inoperable at 1920 CST. They entered the appropriate Technical Specifications action statement and initiated a Limiting Condition for Operation (LCO). The LCO required that if primary containment integrity could not be met, an orderly shutdown of the reactor shall be initiated and the reactor shall be brought to hot shutdown within 12 hours and cold shutdown within 24 hours.

NRC personnel were notified of the initiation of plant shutdown under the LCO in accordance with 10 CFR 50.72 reporting requirements at 2019 CST.

At 0030 CST on 2/13/88, while plant operations personnel were initiating the shutdown requirements, plant maintenance and engineering personnel wrote a Maintenance Work Order (MWO) to reestablish primary containment integrity. The outboard air supply valves (three way valve on figure 1) were removed, the lead wires to the valves were tagged and bagged, and the lines were capped. Work started at 0200 CST.

By installing the caps on the lines, this was equivalent to installing a blind flange in the lines and the penetrations were effectively sealed. This was a conservative action since the inboard isolation barriers, the vacuum breaker pneumatic actuators, had remained operable as demonstrated by previous LLRT testing. On 2/13/88 at 0245 CST, the work was completed and verified on all the Unit 1 valves. At 0330 CST, the LCO was terminated.

Plant engineering, with the assistance of Corporate Office personnel (Nuclear Safety and Licensing - NSLD and Engineering), and the A/E then performed a closer review of the actual Unit 1 design. On 2/19/88 it was confirmed by the valve vendor that the Unit 1 solenoid valves had a stronger spring which would assure pressure retention up to an accident pressure of 35 psig. Since the design basis accident pressure which these valves would actually see is the torus pressure (with a peak of 28 psig) it was then concluded that the Unit 1 design was acceptable in its current configuration.

On 2/22/88, plant Engineering personnel wrote Design Change Request (DCR) 88-31 to correct the design for the Unit 2 solenoid valves (2T48-F342 A through L) and for the A/E to provide necessary support documentation.

On 2/24/88, in the course of reviewing the applicable drawings to prepare the design change to reverse the valves on Unit 2, BEPC personnel detected another design discrepancy. They determined that the piping, per the isometric drawings, should have been pipe class HAE. However, per the P&ID, the pipe class should have been HAB.

Pipe class HAE is ANSI B31.1 piping. Pipe class HAB is ASME Section III Class 2 piping. The FSAR design bases for primary containment piping systems state that the piping attached to the primary containment should be ASME Section III Class 1, 2, or 3 and seismically qualified.

BEPC personnel notified Corporate engineering personnel of this item and Corporate engineering personnel notified site engineering personnel. Upon notification of the deficiency, plant engineering personnel documented the condition on a Deficiency Card (as required by the plant's administrative control procedures) at 0925 CST.

On 2/25/88, corporate personnel and site personnel determined that the piping was outside of the design basis of the system. An action plan was initiated to bring these lines into conformance with their design basis. Additionally plant Nuclear Safety and Compliance (NSC) personnel notified plant operations personnel of the design defect. Plant operations personnel reviewed the 10 CFR 50.72 reporting requirements and determined that the event was reportable. NRC personnel were notified of the condition at 1704 CST.

As a result of the design deficiency on Unit 2, plant engineering and NSC personnel investigated to determine if Unit 1 had a similar problem. They determined that the corresponding Unit 1 system was ANSI B31.1 upgraded material. Since the construction code for Unit 1 allowed the use of B31.1 upgraded material, it was determined that the design deficiency did not affect Unit 1.

However, plant and corporate personnel continued to review the event to assure that there were no other deficiencies on Units 1 and 2. The Technical Specifications were reviewed again relative to LLRT testing. Table 3.7-4 of the Unit 1 Technical Specifications allows LLRTs not to be performed in the direction required for isolation, provided that this testing is equivalent to, or more conservative than, testing in the accident direction. For Unit 2, Section 4.6.1.2 of the Technical Specifications requires that containment leakage shall be determined in accordance with the criteria specified in Appendix J of 10 CFR 50. Appendix J section III C again requires that the results from the tests for a pressure applied in a different direction will provide equivalent or more conservative results.

The investigation (performed on 2/12/88) had demonstrated that testing of the valves in a reverse direction (to the accident direction) was not a more conservative testing method. The test pressure would force the valves onto their seats which could result in a leakage rate that would be less than they may actually experience. Based on this, it was concluded that the intent of the Technical Specifications was not met for the valves on both Units 1 and 2 and a reportable condition, per the requirements of 10 CFR 50.73 existed.

2. Dates/Times

Date	Time (CST)	Description
2/12/88	0900	Non-licensed maintenance personnel began the LLRT of Unit 2 isolation solenoid valves (2T48-F342A through L) per plant procedure 42SV-TET-001-2S. This procedure had been revised as of 1/13/88 to change the application of test pressure to these valves (to test in the accident direction).

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Date	Time (CST)	Description
2/12/88	0900-1400	The first two tested valves (2T48-F342E & F) would not retain applied test pressure.
	1400	Engineering was asked to assist in investigating the valve failures. It was believed that a possibility existed for the valves to be open because of a logic problem.
	1400 - 1545	Engineering reviewed logic channel design drawings, valve vendor manuals, and P&IDs. It appeared the valves were installed per the drawings, but it was suspected that the installation was not appropriate for the valves' isolation function.
	1545	The A/E (BEPC) was called to determine whether the valves, as currently installed, could accomplish their design function. The request scope included both Units 1 & 2.
	1900	The A/E called plant Engineering to advise them of the discussion with the vendor. The solenoid valve vendor had stated that the valves in Unit 1 (model 73K-001) and Unit 2 (model 75F-009), as installed, had springs which would only hold pressure in the range of 2 to 5 psig.
	1915	Unit 2 was still in compliance with the Technical Specifications since containment integrity was not required when the unit was in cold shutdown. However containment integrity was still required on Unit 1, so plant operations personnel were notified of the findings.

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

Date	Time (CST)	Description
2/12/88	1920	Unit 1 licensed personnel declared the valves inoperable since, with a potential accident pressure of 28 psig in the torus, the valves could not perform their isolation function. Operations personnel initiated LCO 1-88-50.
	2019	Notification was made to the NRC.
2/13/88	0030	MWO 1-88-0606 was written to remove the three-way ASCO valve outboard of the Unit 1 1T48-F342 A through L valves, cap the air lines, and bag and tag the electrical lead wires.
	0200	Maintenance personnel began work on MWO 1-88-0606.
	0245	Maintenance personnel completed work on MWO 1-88-0606.
	0330	Licensed personnel terminated LCO 1-88-50.
2/19/88		After closer review of the Unit 1 design it was confirmed by the valve vendor that the Unit 1 valves had springs good for 35 psig therefore the design was acceptable as is.
2/22/88		DCR 88-31 was written by plant Engineering to provide a design resolution for the Unit 2 solenoid valve discrepancy.

Date	Time (CST)	Description
2/24/88	0925	Deficiency Card 2-88-909 was written to document a discrepancy between the isometric drawings and the P&ID drawing on the Unit 2 vacuum breaker air lines found while preparing the design change to address the valve discrepancy.
2/25/88	1704	The Unit 2 air lines were determined to be outside their design basis. An action plan was initiated to bring these lines into conformance prior to restart. NRC personnel were notified of the design deficiency under 10 CFR 50.72 reporting requirements. Unit 1 was reviewed for applicability of the same design deficiency; Unit 1 was not deficient. Finally, it was determined that by previously testing the solenoid valves in the reverse direction, the intent of the Units 1 and 2 Technical Specifications had not been met. This was determined to be a reportable condition under 10 CFR 50.73.

3. Other Systems Affected

No systems other than the twelve, one half inch diameter air supply lines to the torus to drywell vacuum breakers were affected by this event. These lines provide air for the testing of the vacuum breaker valves. They also provide containment integrity, out to the first isolation valve.

4. Method of Discovery

The fact that the Unit 2 valves were not installed correctly to perform the isolation function was discovered by plant engineering personnel while they were investigating the valves' failure during the LLRT performed per plant procedure 42SV-TET-001-2S.

The design deficiency relative to the seismic and code class of piping on Unit 2 was discovered by BEPC personnel as a result of reviewing design documents. The design documents were reviewed as part of immediate corrective action plans to correct the valve installation deficiency.

The fact that the Units 1 and 2 Technical Specifications testing requirements for the valves were not fully satisfied was discovered by plant and Corporate personnel during the review of the event.

5. Operator Actions

Operations personnel performed the following actions:

1. Declared the Unit 1 valves inoperable and initiated the appropriate Technical Specifications action statements, including generating LCOs.

2. Notifying the NRC, per the requirements of 10 CFR 50.72, of the design defect on Unit 2.

Plant engineering personnel performed the following actions:

1. Investigated the reason for the Unit 2 valves not meeting LLRT requirements.

2. Investigated the design deficiency relative to the air supply piping meeting design requirements.

NSC personnel performed the following actions:

1. Evaluated the events relative to the reporting requirements of 10 CFR 50.72 and 10 CFR 50.73 and advised other plant groups of the need to make reports.

6. Auto/Manual Safety System Response

No safety systems actuated in this event, nor were any required to actuate.

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

D. CAUSE OF EVENT

1. Immediate Cause:

The immediate cause of this event was component (valve) failure. The outboard isolation solenoid valve on the air line serving the pneumatic vacuum breaker actuator failed the LLRT.

2. Root/Intermediate Cause:

The root cause for the events is design deficiency. These deficiencies occurred in the following areas:

a. BEPC A/E personnel failed to clearly indicate the installation direction for the isolation valves. As such, construction personnel installed the valves in the normal direction of process flow, rather than in the isolation direction. This design error was not detected during testing, since design personnel did not identify that the testing direction was not conservative.

b. BEPC A/E personnel did not recognize that the instrument air lines penetrating primary containment were required to meet the requirements of the ASME Section III Code for Class 2 components. Typically, instrument air lines were not considered as process lines and generally were not believed to have a safety function. The condition of the air supply lines was unique and this uniqueness contributed to the design deficiency.

E. ANALYSIS OF EVENT

The primary containment and associated isolation systems provide timely protection against the onset and consequences of accidents that involve the gross release of radioactive materials from the fuel and nuclear system process barriers. This protection occurs by the isolation of appropriate process lines that penetrate the primary containment.

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

For a release of radioactive materials to occur, the following barriers would have to be breached: fuel cladding, reactor coolant pressure boundary, and primary containment. For a gross failure of the fuel cladding, the primary containment and reactor vessel isolation control system initiates isolation of the reactor vessel to contain released fission products. For a breach in the nuclear system process barrier outside the primary containment, the isolation control system acts to interpose additional barriers between the reactor and the breach. This limits the potential release products and conserves reactor inventory. For a breach of the nuclear system process barrier inside the primary containment, the isolation control system acts to close off release routes through the primary containment and to trap radioactive materials inside primary containment.

The instrument air lines used for testing of the Unit 1 and Unit 2 drywell to torus vacuum breakers are part of the primary containment system. The solenoid valves are the secondary barrier used to secure primary containment integrity. The pneumatic actuators (air cylinder and piston on figure 1) are the primary barrier.

Were a severe accident (such as a Loss of Coolant Accident - LOCA) to occur, the radioactive materials released during the accident would pass through the water in the suppression pool (torus). Many of the radioactive materials would be removed during their passage through the suppression pool water. Some radioactive materials could accumulate in the air space above the suppression pool water. Were one of the pneumatic actuators (the primary barrier to the release of radioactive materials in the torus to drywell vacuum breaker air test lines) to fail, some of these radioactive materials could be introduced into the air supply piping at accident pressures.

The air supply piping meets all of the requirements for an ASME Class 2 component except complete material records are not available.

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The NRC has reviewed the qualifications of this piping and has concluded that ". . . the lines as installed provide an acceptable level of quality and safety, and that replacement of the lines just to satisfy the documentation requirements for Class 2 piping would not add significantly to the safety of the plant."

Based on the above information, it is concluded that this event had no adverse impact on nuclear plant safety. Additionally, this analysis is applicable for all other plant operating conditions.

F. CORRECTIVE ACTIONS

The corrective actions for these events included:

1. Initiating the conservative LCO action on Unit 1 based on the information known at the time. This included capping all the Unit 1 vacuum breaker air lines.

2. Initiating appropriate design activities to correct the installation of the Unit 2 solenoid valves and to bring the air lines into compliance with FSAR commitments. The direction of the Unit 2 solenoid valves (2T48-F342 A through L) has been reversed.

3. Initiating a complete investigation of the event. During the week of 4/18/88, Georgia Power Company (GPC) Quality Assurance (QA) personnel performed an audit of BEPC. This audit was conducted to determine: 1) the adequacy of the BEPC design review process, 2) how the instrument air lines were originally designed and installed to an American National Standards Institute (ANSI) B31.1 piping code, and 3) why the 2T48-F342A-L valves were not installed to meet the FSAR primary containment design requirements.

The audit determined that at the time of the original design of the instrument air lines, there was no formal design verification performed by multiple disciplines. Each discipline performed its own review. The design of the instrument air lines was performed by members of the control design group rather than by members of the mechanical design group. The mechanical group normally is assigned responsibility to ensure that the design meets ASME code requirements. Also, the designers did not indicate the correct orientation of the valves. This was a design oversight.

BEPC has implemented corrective actions to strengthen its design control process. These corrective actions include: 1) strengthening administrative controls to include a formal design verification within each discipline, 2) proceduralizing the required coordination between each discipline, 3) requiring the performance of an integrated discipline design review, as required, for those designs requiring multi-discipline action, 4) training design personnel on the design verification methodology, and 5) increasing management focus on design verification.

4. Initiating a Design Change Request (DCR 88-30) to replace the existing Unit 1 solenoid valves' (1T48-F342A-L) springs with stronger springs. These springs will allow the valves to be tested at containment accident pressure (which is above the torus accident pressure). It is currently anticipated that the springs will be replaced in the next scheduled Unit 1 refueling outage which is tentatively scheduled for the Fall of 1988.

G. ADDITIONAL INFORMATION

1. FAILED COMPONENT(s) IDENTIFICATION

MPL (Plant Index Identifier): 2T48-F342 A-L
Manufacturer: Target Rock
Model Number: 75F-009
Type: Solenoid globe valve
EIIS: JM

2. PREVIOUS SIMILAR EVENTS

No previous similar events were noted.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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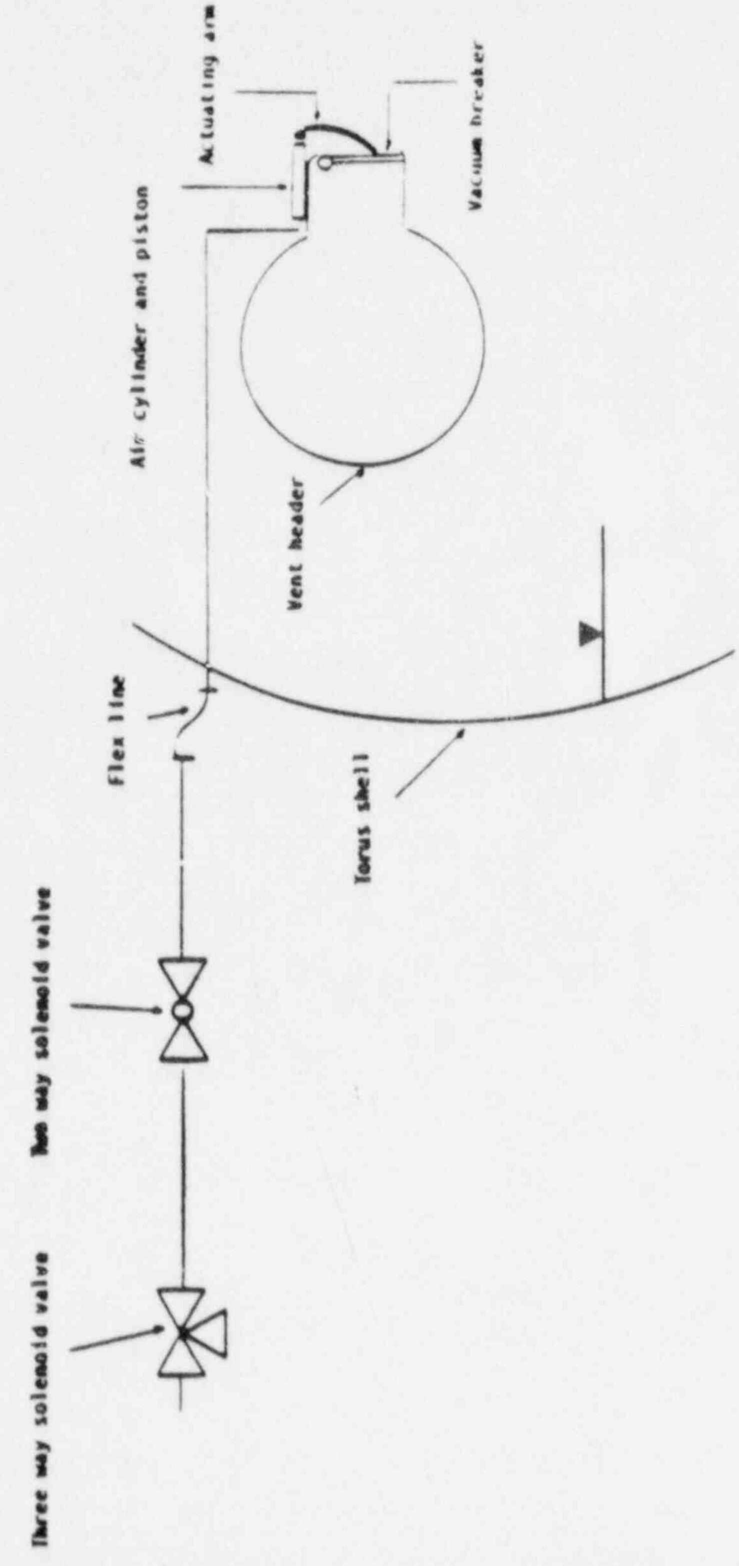
TEXT (If more space is required, use additional NRC Form 366A's) (17)

Figure 1



Simplified Elevation View
Air Supply Lines and Torus
Internal Components (NTS)

NRC Form 366A
(9-83)

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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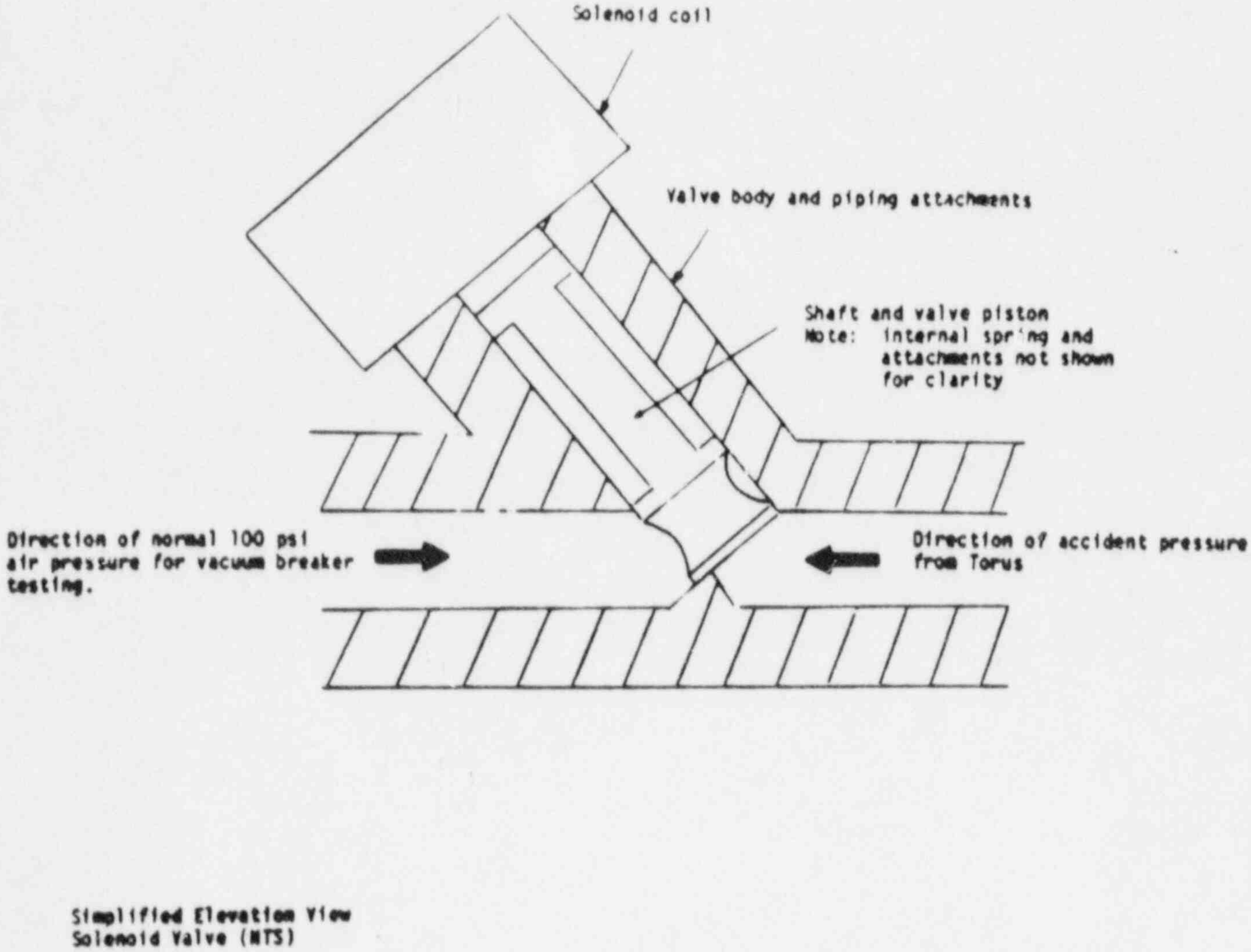
Figure 2



Simplified Elevation View
Solenoid Valve (NTS)

Georgia Power Company
333 Piedmont Avenue
Atlanta, Georgia 30308
Telephone 404 526 6526

Mailing Address:
Post Office Box 4545
Atlanta, Georgia 30302

Nuclear Operations Department

Georgia Power
the southern electric system

SL-4727
0303I
X7GJ17-H310

July 11, 1988

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

PLANT HATCH - UNIT 2
NRC DOCKET 50-366
OPERATING LICENSE NPF-5
LICENSEE EVENT REPORT
FAILED VALVES DISCLOSE DESIGN DEFICIENCIES
AND TECHNICAL SPECIFICATION VIOLATION

Gentlemen:

In accordance with the requirements of 10 CFR 50.73(a)(2)(i) and 10 CFR 50.73 (a)(2)(ii), Georgia Power Company is submitting the enclosed, revised, Licensee Event Report (LER) concerning an event where a portion of a plant system was outside of its design basis. This disclosed a condition prohibited by the plant's Technical Specifications. The event occurred in February of 1988 at Plant Hatch - Unit 2. It was later determined that some of these conditions were present on Unit 1.

Sincerely,

W. G. Hairston, III

W. G. Hairston, III
Senior Vice President

LGB/lg

Enclosure: LER 50-366/1988-007 Rev 1

c: (see next page)

IE22
1/1

Georgia Power

c: Georgia Power Company
Mr. J. T. Beckham, Jr., Vice President - Plant Hatch
Mr. L. T. Gucwa, Manager Nuclear Safety and Licensing
GO-NORMS

U. S. Nuclear Regulatory Commission, Washington, D. C.
Mr. L. P. Crocker, Licensing Project Manager - Hatch

U. S. Nuclear Regulatory Commission, Region II
Dr. J. N. Grace, Regional Administrator
Mr. J. E. Menning, Senior Resident Inspector - Hatch

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