LICENSEE EVENT REPORT
CONTROL BLOCK: [ ] [ ] (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)
0 1 6 A E I H 2 2 0 0 - 0 0 0 0 - 0 0 3 4 1 1 1 1 1 4 5 CAT 58 5
HEPORT   L   G   O   S   O   O   O   O   O   O   O   O
[0]2 [With the unit in cold shutdown, while performing MSIV leakage control
[0] [system LSFT per HNP-2-3016, bleed valve 2E32-F001B indicating lights
[0]4] [went out. This valve is essential for "B" system operability. The red-]
ols undant outboard system was found to be operable. This is a nonrepetit-
[0]6] [ive occurrence. This event posed no threat to public health or safety.]
0 7
0 8 1
SYSTEM CAUSE CAUSE SUBCODE COMPONENT CODE SUBCODE SUBC
CODE   REPORT   NUMBER   NUM
ACTION FUTURE OF PLANT SHUTDOWN HOURS 22 ATTACHMENT SUBMITTED FORM SUB. PRIME COMP. COMPONENT MANUFACTURER  ACTION FUTURE OF PLANT SHUTDOWN HOURS 22 ATTACHMENT SUBMITTED FORM SUB. PRIME COMP. SUPPLIER MANUFACTURER  Y 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
The cause of this event was an undersized thermal overload switch. A
[1]
[1] [replaced, and the valve functioned properly. All other similar valves ]
[1]3 [in this system functioned properly.
7 8 9
FACILITY STATUS SPOWER OTHER STATUS 30 METHOD OF DISCOVERY DISCOVE
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY 35  1 6 Z 33 Z 34 NA
PERSONNEL EXPOSURES  NUMBER  TYPE  DESCRIPTION (39)  NA  NA  80
PERSONNEL INJURIES NUMBER DESCRIPTION 41
7 8 9 11 12 LOSS OF OR DAMAGE TO FACILITY 43 TYPE DESCRIPTION 43
1 9 Z 42 NA
7 8 9 10 8005220554 NRC USE ONLY  1SSUED DESCRIPTION 45 NA
NAME OF PREPARER C. L. Coggin, Supt. Plt. Eng. Serv. PHONE: 912-367-7781

LER #: 50-366/1980-064

Licensee: Georgia Power Company Facility Name: Edwin I. Hatch

Docket #: 50-366

Narrative Report for LER 50-366/1980-064

With the unit in cold shutdown, the MSIV leakage control system LSFT was being performed per HNP-2-3016. After successfully cycling inboard bleed valve 2E32-F001B per procedure, the position indicating lights went out. Upon investigation, it was found that the thermal overload switch in the valve's motor control center was undersized. This caused a circuit overload and a trip of the circuit breaker. The switch was replaced and the motor was retested. The valve was found to function properly after repair was complete. All other valves of this type in the system were cycled during performance of HNP-2-3016 and were found to be functioning properly.

This valve is essential to operability of the "B" part of the inboard system which serves main steam line "A". However, the entire outboard system was found to be operable and would have been capable of serving main steam line "A" had this event occurred during power operation. Since this event occurred and was resolved during unit shutdown, no threat was posed to public health or safety. This is a non-repetitive occurrence. Unit 1 does not have this system, and this event is not generic.