771 LICENSEE EVENT REPORT (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) CONTROL BLOCK: 0 0 0 LICENSE NUMBER ON'T 0 0 0 3 6 6 7 0 6 1 3 8 0 8 0 6 2 6 8 0 9 1 EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) While performing routine surveillance on the Torus-Drywell Vacuum Breaker 0 2 Valves per Tech Spec 4.6.4.1.a, Valve 2T48-F323B would not open. The re-0 3 quired surveillance on the operable vacuum breaker valves was immediately 0 4 performed per Tech Spec 3.6.4.1, action a. There was no effect on public 0 5 health or safety as a result of this incident nor was safe plant operation 0 6 affected. This is a repetitive event as last reported on Reportable Occur-0 7 rence Report No. 50-366/1980-062. 0 8 COMP SYSTEM COMPONENT CODE SUBCODE A | L | V | E | X | (14 A 0 9 REVISION REPORT OCCURRENCE SEQUENTIAL REPORT NO. CODE NO. LER/RO 0 COMPONENT ATTACHMENT SUBMITTED HOURS (22) FORM SUB SUPPLIER G 2 0 2 N (25 0 0 0 0 0 N (24) Z (21 CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause of the occurrence is unknown at this time due to the inaccessi-1 0 bility of the valve. The inoperable vacuum breaker valve will be inspect-1 1 ed and repaired during the next reactor cold shutdown. Testing of the 1 2 operable vacuum breaker valves every 15 days will be continued per Tech 1 3 Spec 3.6.1.4, action a, until the next reactor cold shutdown. 1 4 METHOD OF DISCOVERY OTHER STATUS (30) DISCOVERY DESCRIPTION (32) B (31) Operator observation 0 0 (29 CONTENT LOCATION OF RELEASE (36) AMOUNT OF ACTIVITY (35) RELEASED OF RELEASE 1 6 Z (33) Z (34) PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER NA 0 0 0 37 2 38 1 7 PERSONNEL INJURIES DESCRIPTION (41) NUMBER NA 0 0 (40) 1 8 LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION NA 1 9 NRC USE ONLY PUBLICITY DESCRIPTION (45) N (44) NA 2 0 80070 AMO OF PREPARER R. T. NIX 912-367-7781 PHONE:

NARRATIVE REPORT

Georgia Power Company Plant E. I. Hatch Baxley, Georgia 31513

Reportable Occurrence Report No. 50-366/1980-094.

On June 13, 1980, with the reactor at 100% power, while performing routine surveillance on the torus-drywell vacuum breaker valves, the 2T48-F323B valve failed to open. The required surveillance was performed on the operable vacuum breaker valves per Tech Spec 3.6.4.1, action a. The cause of the occurrence is unknown at this time due to the inaccessibility of the valve. The inoperable vacuum breaker valve will be inspected and repaired as necessary during the next reactor cold shutdown.

A similar event occurred on April 19, 1980, and was reported on Reportable Occurrence Report No. 50-366/1980-094. At this time all of the Unit II vacuum breaker valves were rebuilt, using new seals and gaskets. New limit switches were also installed.

Final action on the failure of the 2T48-F323B valve is pending on the result of the investigation that is to be conducted during the next cold shutdown. A follow-up report will be submitted when the valve repair is complete.

Public health and safety were not affected as a result of this incident.