NRC FOR (7-77)	M 366 U. S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT
6	CONTROL BLOCK:
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	$\begin{array}{c c c c c c c c c c c c c c c c c c c $
	Drywell Temperature Recorder, were found to be reading higher than
0 3	
0 4	redundant recorder 1T47-R612. Tech Spec 4.2-1 requires two operable
0 5	instrument channels. The unit was placed in a 30 day limiting condition
0 6	of operation as a result of this event. This a repetitive event as last
0 7	reported on Reportable Occurrence Report No. 50-321/1980-75. The health
08	and safety of the public was not affected by this event.
7 <u>9</u> 78	SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP VALVE SUBCODE I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I I <td< td=""></td<>
10	$\begin{array}{c c c c c c c c c c c c c c c c c c c $
1 1	Ltacts and printhead mechanism. New parts were installed, the instrument
1 2	was recalibrated and returned to service. Because of the poor relia-
1 3	bility of this recorder, a design change has been implemented to re-
1 4	place it with a more reliable instrument.
7 8 F	9 Method of Biscovery Discovery description 32 E 28 0 7 9 29 N/A B 31 Operator Observation 32
	9 CTIVITY CONTENT LEASED OF RELEASE AMOUNT OF ACTIVITY (35) 2 (33) [2] (34) [N/A] 44 45 46 BO LOCATION OF RELEASE (36) N/A 44 45 46 BO N/A 44 45 46 BO N/A 44 45 46 BO N/A 46 BO
1 7	NUMBER DESCRIPTION (39)
1 8	9 11 12 13 PERSONNEL INJURIES NUMBER DESCRIPTION (41)
19	N/A
2 0 7 8	PUBLICITY STORED DESCRIPTION 45 8101060669 N/A
	NAME OF PREPARER R. T. NIX PHONE 912-367-7781

LER No.: 50-321/1980-121 Licensee: Georgia Power Company Facility Name: Edwin I. Hatch Docket No.: 50-321

Narrative Report for LER 50-321/1980-121

With the plant in steady operation at 1942 MWT, all points of 1T47-R611, Drywell Temperature Recorder, were found to be reading higher than redundant recorder 1T47-R612. Tech Spec 4.2-1 requires two operable instrument channels. The unit was placed in a 30 day limiting condition of operation as a result of this event. This is a repetitive event as last reported on Reportable Occurrence No. 50-321/1980-75. The health and safety of the public was not affected by this event.

The cause of this event has been attributed to faulty slidewire contacts and printhead mechanism. New parts were installed and the instrument was recalibrated and returned to service. Because of the poor reliability of this recorder, a design change has been implemented to replace it with a more reliable instrument.

The generic review did not reveal any inherent problems. Unit II does not use this type of recorder.