

U. S. NUCLEAR REGULATOR COMMITTEE

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

REPORT SOURCE L 6 0 5 0 0 0 3 6 6 7 0 9 1 8 8 0 8 0 9 3 0 8 0 9

60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

SYSTEM CODE S A 11		CAUSE CODE E 12		CAUSE SUBCODE B 13		COMPONENT CODE V A L V E X 14				SUBCODE X 15		SUBCODE C 16							
7 8		9 10		11 12		13 14 15 16 17 18				19 20		21 22							
17 LER/RO REPORT NUMBER		EVENT YEAR 8 0 21 22		SEQUENTIAL REPORT NO. 1 2 9 23 24 25 26		OCCURRENCE CODE 0 3 27 28 29				REPORT TYPE L 30 31		REVISION NO. 0 32							
ACTION TAKEN Z 18		FUTURE ACTION X 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22 23 24 25 26 27 28 29 30 31 32				ATTACHMENT SUBMITTED Y 23 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47		NPRD-4 FORM SUB. N 24 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99		PRIME COMP. SUPPLIER N 25 91 92 93 94 95 96 97 98 99		COMPONENT MANUFACTURER G 2 0 2 26 91 92 93 94 95 96 97 98 99	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

7 8 9
FACILITY STATUS (28) 1 5 E 0 7 8 29 % POWER 1.0 1.2 1.3 44 OTHER STATUS (30) NA 45 METHOD OF DISCOVERY (31) B 46 DISCOVERY DESCRIPTION (32) Operator observation 80

PERSONNEL EXPOSURES										
NUMBER				TYPE	DESCRIPTION					
1	7	0	0	0	(37) Z	(38)	NA			80

19		LOSS OF OR DAMAGE TO FACILITY		43	
TYPE		DESCRIPTION			
1	9	Z	42	NA	

7 8 9 10
PUBLICITY
ISSUED DESCRIPTION (45) 8010080382 NA
2 0 N (44) 68 69 80
NRC USE ONLY

PHONE: 912-367-7781

LER #: 50-366/1980-129
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1980-129.

On September 11, 1980, with the reactor at 78% power, while performing increased surveillance on the Torus/Drywell Vacuum Breaker Valves per Tech Spec 3.6.4.1, action a, the 2T48-F323G valve failed to open upon actuation of the test switch. The cause of this occurrence is unknown at this time due to the inaccessibility of the valves. This valve and the other inoperable valves, reported on Reportable Occurrence Report No. 50-366/1980-124, will be inspected and repaired as necessary during the next reactor cold shutdown. Testing of the operable vacuum breaker valves every 15 days will be continued per Tech Specs 3.6.4.1, action c, until the next reactor cold shutdown.

Although this was a repetitive occurrence, there has not been a previous failure that would have prevented the vacuum breaker from performing its intended function. The past failures were due to problems in the test circuits used to prove operability or valve position switches.

Final action on the failure of the 2T48-F323G valve is pending on the results of an investigation that is to be conducted during the next reactor cold shutdown. A follow-up report will be submitted when the valve is repaired. Public health and safety were not affected by this incident.