**J. S. NUCLEAR REGULATORY COMMISSION** NRC FORM 366 (7.77) LICENSEE EVENT REPORT · CONTROL BLOCK: J(1)(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) 0 0 0 0 -0 0 3 4 1 1 1 1 4 57 26 LICENSE TYPE 30 57 0 10 0 G | A | E | I | H | 1 2 58 (5) 0 1 LICENSEE CODE 14 CON'T 8 0 9 0 9 8 3 74 75 REPORT DATE 0 8 2 7 8 69 EVENT DATE REPORT 11 015 10 10 10 13 12 (9) (6) 0 1 SOURCE DOCKET NUMBER EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) During maintenance activities in the drywell, it was determined that a 0 2 safety relief valve discharge line vacuum breaker (1B21-F037D) was 0 3 stuck partially open. Further investigation revealed that 9 other 0 4 vacuum breakers (as listed in narrative) failed to seat properly per 0 5 a manual functional test, and thus it was assumed the plant was not 0 6 complying with Tech. Specs. section 6.9.1.8.e. The health and safet, o. 0 7 the public were not affected by this non-repetitive event. 0 8 80 COMP. SUBCODE CAUSE VALVE SYSTEM CAUSE COMPONENT CODE CODE CODE SIA C (15 ALLIVIE X (14 B A (13) V BI (16 0 9 13 18 REVISION OCCURRENCE SEQUENTIAL REPORT EVENT YEAR REPORT NO. CODE TYPE NO. LER/RO (17) 8 0 9 1 0 1 0 3 Т REPORT NUMBER 30 21 32 ATTACHMENT NPRD-4 PRIME COMP COMPONENT ACTION EFFECT ON PLANT METHOD FUTURE HOURS (22) FORM SUB. MANUFACTURER SUPPLIER N 24 Y (23) (18) F 10 10 A (25 G 2 0 2 C Z Z 0 0 (20 (19 CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The cause of this event was due to an inadequate design of the vacuum 1 0 breakers' hinge pin. (See narrative for details) The affected safety 1 1 relief valve discharge line vacuum breakers were replaced with new 2 vacuum breakers. A Request for Engineering Assistance was initiated to 1 3 determine a solution to this event. 4 80 METHOD OF FACILITY (30) DISCOVERY DESCRIPTION (32) OTHER STATUS % POWER 0 0 (29) Personal Observation G (28 01 NA A (31) 45 80 9 10 ACTIVITY CONTENT AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36) RELEASED OF RELEASE NA Z (34) NA Z (33) 6 80 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER TYPE 0 0 0 (37) Z (38) NA 7 80 PERSONNEL INJURIES DESCRIPTION (41) NUMBER NA 0 0 0 (40) 2 80 LOSS OF OR DAMAGE TO FACILITY (43) DESCRIPTION TYPE 8309190362 830909 Z (42) NA 9 PDR ADOCK 05000321 80 PUBLICITY NRC USE ONLY PDR DESCRIPTION (45) JED N (44) NA 0 IE22 68 69 (912)367-7851 S. B. TIPPS PHONE .. NAME OF PREPARER \_

#### NARRATIVE REPORT FOR LER 50-321/1983-091

LICENSEE : GEORGIA POWER COMPANY FACILITY NAME : EDWIN I. HATCH DOCKET NUMBER : 50-321

#### Tech. Specs. section(s) which requires report:

This 14-day report is required by Tech. Specs. section 6.9.1.8.e due to the event.

### Plant conditions at the time of the event(s):

On August 27, 1983, the unit was in cold shutdown.

# Detailed description of the event(s):

During maintenance activities in the drywell, it was determined that a safety relief value discharge line vacuum breaker (1B21-F037D) was stuck partially open. This initial inspection revealed no other stuck open vacuum breakers; however, after a manual functional test, 9 other safety relief value discharge line vacuum breaker's (1B21-F037 A, B, F, H. J. K. L, and 1B21-F110 A, C) failed to seat properly.

#### Consequences of the event(s):

Plant conditions were not affected by this event. The health and safety of the public were not affected by this event.

# Status of redundant or backup subsystems and/or systems:

There are no redundant systems.

# Justification for continued operation:

The affected vacuum breakers were replaced prior to startup.

#### If repetitive, number of previous LER:

This is a non-repetitive event.

Narrative Report for LER 50-321/1983-091 Page Two

#### Impact to other systems and/or Unit:

The vacuum breakers are also installed on Unit 2.

#### Cause(s) of the event(s):

The cause of this event was due to an inadequate design of the vacuum breakers' hinge pin. An investigation revealed that the hinge pins on vacuum breakers 1821-F037 A, B, D, F, H, J, K, L, and 1821-F110 A, C were bent slightly at the pivot point where the valve disc arm is connected to the hinge pin. The vacuum breaker closure spring appears to be strong enough to cause the valve disc arm to force the disc to its seat. This same spring force (i.e., the one that is being exerted to properly seat the valve disc arm is connected to the hinge pin. It is postulated that the hinge pin is not strong enough to withstand the force being exerted upon it due to inadequate design.

#### Immediate Corrective Action:

The safety relief value discharge line vacuum breakers which did not seat properly were replaced with new ones.

#### Supplemental Corrective Action:

No supplemental corrective actio was required.

#### Scheduled (future) corrective action:

There is no scheduled corrective action at this time.

#### Action to prevent recurrence (if different from corrective actions):

A Request for Engineering Assistance was initiated to determine the proper and permanent solution for this event. When the solution to this event is determined and approved, the materials will be acquired and a schedule for implementation will be determined and implemented.

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Georgia Powe

# 83 SEP 15 P1:35

Edwin I. Hatch Nuclear Plant

September 9, 1983 GM-83-888

PLANT E. I. HATCH Licensee Event Report Docket No. 50-321

United States Nuclear Regulatory Commission Office of Inspection and Enforcement Region II Suite 3100 101 Marietta Street Atlanta, Georgia 30303

ATTENTION: Mr. James P. O'Reilly

Attached is Licensee Event Report No. 50-321/1983-091. This report is required by Hatch Unit 1 Technical Specifications Section 6.9.1.8.e.

H. C. Nix General Manager

122 HCN/SBT/djs

xc: R. J. Kelly G. F. Head J. T. Beckham, Jr. P. D. Rice K. M. Gillespie C. B. Tipps n. D. Baker Control Room Document Control

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