

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Virgil C. Summer Nuclear Station DOCKET NUMBER (2) 050003951 OF 02

TITLE (4) Reactor Trip

EVENT DATE (5)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)				
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)			
0	4	25	84	84	025	00	05	25	84		05000		

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

OPERATING MODE (8) 0	20.402(b)	20.408(e)	<input checked="" type="checkbox"/> 80.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 000	20.408(a)(1)(i)	80.38(a)(1)	<input type="checkbox"/> 80.73(a)(2)(v)	73.71(e)
	20.408(a)(1)(ii)	80.38(a)(2)	<input type="checkbox"/> 80.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 368A)
	20.408(a)(1)(iii)	80.73(a)(2)(i)	<input type="checkbox"/> 80.73(a)(2)(vii)(A)	
	20.408(a)(1)(iv)	80.73(a)(2)(ii)	<input type="checkbox"/> 80.73(a)(2)(vii)(B)	
	20.408(a)(1)(v)	80.73(a)(2)(iii)	<input type="checkbox"/> 80.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
A. R. Koon, Jr., Asso. Mgr., Reg. Compliance	AREA CODE 803 345-5209

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
A	I	T		N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (if yes, complete EXPECTED SUBMISSION DATE)  NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At approximately 0247 hours, April 25, 1984, the reactor tripped from 100% indicated power as a result of a main turbine trip. The trip occurred as the Main Turbine Thrust Bearing Wear Detector was being returned to service following a modification. Following the scram, Feedwater Regulating Valves A and B did not automatically close upon the Reactor Trip coincident with Low Tavg. Feedwater isolation was established by the automatic closure of the Main Feedwater Isolation Valves. The cause of this event was due to personnel error. The technician did not adequately review the system status prior to performing the work. This event was discussed with the individual involved, and the importance of fully understanding a job, no matter how simple, was emphasized.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Virgil C. Summer Nuclear Station	DOCKET NUMBER (2)  3 9 5 0   5   0   0   0	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 4	0 2 5	0 0	0 2	0 2
					OF	

TEXT (If more space is required, use additional NRC Form 366A's) (17)

During the spring outage, a modification was made to the Main Turbine Thrust Bearing Wear Detector circuit. During the subsequent startup of the unit, the thrust bearing turbine trip was defeated by opening the proper terminal board link. Startup and power increase continued with actual rotor movement monitored by Instrument and Controls (I&C) and Operations Groups. The thrust bearing wear detector measurement device was normal with the exception of having a Fluke digital multi-meter across the contacts of the pressure switches. The multi-meter was left installed (power off) during testing to save the trouble of installing and removing the meter every time a measurement was made. On the midshift, April 25, 1984, the decision was made to reinstate the thrust bearing wear detector trip because the plant was at 100% power. The technician performing the closure of the link did not adequately review the system status. When the link was closed, the input impedance (with power off) of the meter was seen in the Electro Hydraulic Control as a closed contact which initiated a turbine trip which caused a reactor trip.

During the trip, the Feedwater Regulating Valves A and B did not automatically close upon Reactor Trip coincident with Low Tavg. Feedwater isolation was accomplished by the automatic closure of the Main Feedwater Isolation Valves. The Feedwater Regulating Valves were subsequently closed remote-manually from the Main Control Board. Inspection of the valves revealed that one (1) of the air bleedoff valves on each valve was improperly adjusted. The valves were re-adjusted and successfully tested to close on an automatic signal.

The cause of this event was personnel error. The technician did not adequately review the system status prior to performing the work. This event was discussed with the individual involved, and the importance of fully understanding a job, no matter how simple, was emphasized.

SOUTH CAROLINA ELECTRIC & GAS COMPANY

POST OFFICE 764

COLUMBIA, SOUTH CAROLINA 29218

O. W. DIXON, JR.  
VICE PRESIDENT  
NUCLEAR OPERATIONS

May 25, 1984

U.S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, DC 20555

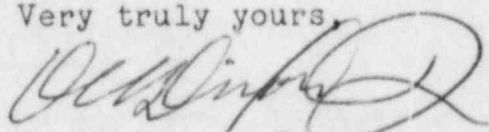
SUBJECT: Virgil C. Summer Nuclear Station  
Docket No. 50/395  
Operating License No. NPF-12  
LER 84-025

Dear Sir:

Please find attached Licensee Event Report #84-025 for the Virgil C. Summer Nuclear Station. This Report is submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(iv).

Should there be any questions, please call us at your convenience.

Very truly yours,



O. W. Dixon, Jr.

RJB:OWD/dwf  
Attachment

cc: V. C. Summer	J. F. Heilman
T. C. Nichols, Jr./O. W. Dixon, Jr.	C. L. Ligon (NSRC)
E. H. Crews, Jr.	K. E. Nodland
E. C. Roberts	R. A. Stough
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