

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) EDWIN I. HATCH, UNIT II										DOCKET NUMBER (2) 0 5 0 0 0 3 6 6				PAGE (3) 1 OF 0 3				
TITLE (4) Failure to Fully Document Reactor Scrams																		
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)								
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES				DOCKET NUMBER(S)					
1	2	1	3	8	4	8	4	0	1	1	2	8	5	0	5	0	0	0
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																
1		20.402(b)				20.406(z)				<input checked="" type="checkbox"/> 60.73(a)(2)(iv)				73.71(b)				
POWER LEVEL (10)		20.406(a)(1)(i)				60.36(c)(1)				60.73(a)(2)(v)				73.71(c)				
0 9 9		20.406(a)(1)(ii)				60.36(c)(2)				60.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)				
		20.406(a)(1)(iii)				60.73(a)(2)(i)				60.73(a)(2)(viii)(A)								
		20.406(a)(1)(iv)				60.73(a)(2)(ii)				60.73(a)(2)(viii)(B)								
		20.406(a)(1)(v)				60.73(a)(2)(iii)				60.73(a)(2)(ix)								
LICENSEE CONTACT FOR THIS LER (12)																		
NAME T. L. Elton, Acting Superintendent of Regulatory Compliance										TELEPHONE NUMBER AREA CODE 9 1 2 3 6 7 7 8 5 1								
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																		
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC								
X	B/H	R/L	Y G 0 8 0	Y														
X	A/D	S/I	C G 0 8 0	Y														
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR		
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO						

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

On 9-30-84, a loss of condenser vacuum resulted in the closing of the turbine stop valves and a reactor scram.

On 11-17-84, a reactor recirculation pump (2B31-C001B) overspeed condition caused a reactor scram.

Both events resulted from material failure. These events were not reported in a licensee event report because deficiency reports were not initiated as required by the "DEFICIENCY CONTROL SYSTEM" procedure (HNP-444).

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

FACILITY NAME (1) EDWIN I. HATCH, UNIT II	CCKET NUMBER (2) 0 5 0 0 0 3 6 6 8 4 - 0 3 3 - 0 0 0 2 OF 0 3	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

This 30 day LER is required by 10CFR50.73(a)(2)(iv) because these events show that the reactor protection system (RPS), which is an engineered safety feature (ESF), experienced unplanned actuations. Additionally, these events were not reported (via an LER) within 30 days as required by 10CFR50.73(a)(1).

On 9-30-84 at approximately 1145 CDT, with the reactor operating at 2431 MWt (approximately 99% power), a loss in condenser vacuum resulted in the closing of the turbine stop valves and a reactor scram.

On 11-17-84 at approximately 0013 CST, the reactor was in operation at a reduced power level of 1453 MWt (approximately 59% power) for the performance of the "TURBINE CONTROL VALVE FAST CLOSURE INSTRUMENT F.T" procedure (HNP-2-3007). At approximately 0400 CST reactor recirculation pump 2B31-C001B went into an overspeed condition and caused the reactor to scram.

In both these events 1 hour notification was made to the NRC.

During investigation of this year's scrams, the senior STA discovered that neither of these events were reported in a deficiency report as required by the "DEFICIENCY CONTROL SYSTEM" procedure (HNP-444); consequently, LERs were not previously submitted. He wrote a deficiency on 12/13/84 to document his findings.

During an investigation of the first event plant personnel determined that the off gas condenser (2N62-B002) had accumulated sufficient water to restrict the steam jet air ejector's discharge flow which resulted in a low condenser vacuum; consequently, the turbine stop valves closed and caused a reactor scram. After further investigation, plant personnel determined that the off gas condenser's moisture drain valve 2N62-F019A was not opening to drain accumulated moisture because the drain valve's solenoid power relay (2N62-K3) had failed. The off gas condenser's drain valve solenoid relay (2N62-K3a) was replaced, and the drain valve (2N62-F019A) was then satisfactorily functionally tested. Normal reactor startup began, and control rod withdrawal commenced on 9-30-84 at approximately 1950 CDT. This event is the result of component (2N62-K3) failure.

In the second event, the reactor recirculation pump's (2B21-C001B) motor generator scoop tube was locked in position for repair of the recirculation pump speed limit controller (2B31-K634B). After the speed limit controller was repaired, the recirculation pump's motor generator scoop tube was unlocked. At that time the reactor recirculation pump ran up to its high speed stop and caused the reactor to scram. After further investigation plant personnel determined that the percent speed demand indicator (2B31-R621-001B) was out of calibration and it was also giving a nonlinear indication. Operating personnel were relying on this indicator to accurately balance the motor generator's scoop tube position with the percent speed demand indicator's percent signal before unlocking the motor generator's scoop tube position. This resulted in the recirculation pump's overspeed which caused the reactor scram. The percent speed demand indicator was replaced and satisfactorily functionally tested per the "G.E. TYPE 180 INDICATOR" procedure (HNP-2-5233) on 11-17-84. This event is the result of component (2B31-R621-001B) failure.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

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

No actual or potential safety consequences or implications resulted from these events. These events had no impact on any other system in Unit 2, or Unit 1. The health and safety of the public were not affected by these non-repetitive events.

As the result of other events that happened before this event, instructions were provided for presentation to plant personnel. This stressed the requirement to properly complete deficiencies in a timely manner.

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Edwin I. Hatch Nuclear Plant

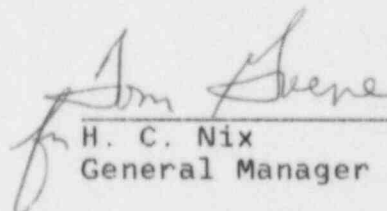
January 12, 1985

GM-84-012

PLANT E. I. HATCH
Licensee Event Report
Docket No. 50-366

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D. C. 20555

Attached is Licensee Event Report No. 50-366/1984-033. This report is required by 10CFR 50.73(a)(2)(iv).



H. C. Nix
General Manager

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