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C. K. McCoy Vice President, Nuclear Vogtle Project

November 8, 1996

LCV-0905

Docket No. 50-425

U. S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D. C. 20555

Ladies and Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT LICENSEE EVENT REPORT 2-96-6 REACTOR TRIP DUE TO MAIN FEEDWATER REGULATING VALVE CLOSURE

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed report associated with an event that occurred on October 14, 1996.

Sincerely,

C. K. McCov

CKM/TEW/AFS

Enclosure: LER 2-96-6

cc: Georgia Power Company Mr. J. B. Beasley, Jr. Mr. M. Sheibani NORMS

U. S. Nuclear Regulatory Commission
Mr. S. D. Ebneter, Regional Administrator

Mr. L. L. Wheeler, Licensing Project Manager, NRR

Mr. C. R. Ogle, Senior Resident Inspector, Vogtle

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U.S.NUCLEAR REGULATORY COMMISSION (4-95). LICENSEE EVENT REPORT (LER)												ION	EXPIRES: 04/30/98 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REQUIRED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENT'S REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33). U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.															
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On October 14, 1996, power ascension was in progress following a refueling outage. The steam generator (SG) #3 main feedwater regulating valve (MFRV) went from being mostly open to the 25 percent open position and SG #3 water level began to decrease. Personnel were unsuccessful in attempts to re-open the MFRV. At 1925 EDT, SG #3 level had dropped to 43 percent (narrow range) and a manual reactor trip was initiated. Isolation of the main feedwater system and actuation of the auxiliary feedwater system occurred as designed. Operators stabilized SG water levels and transitioned the unit to normal operation in Mode 3 (hot standby).

The cause of this event was a failure of the MFRV positioner mechanism. The positioner was replaced and the valve was returned to service.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(iv) because an unplanned reactor protection system actuation occurred.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was operating in Mode 1 (power operation) at 53 percent of rated thermal power. Other than that described herein, there was no inoperable equipment that contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On October 14, 1996, power ascension was in progress following a refueling outage. Control room operators were manually exercising steam generator (SG) #3 main feedwater regulating valve (MFRV) 2FV-0530. The valve had been exhibiting sluggish and erratic responses to demands for both opening and closing. At 1920 EDT, the MFRV went from being mostly open to the 25 percent open position and SG #3 water level began to decrease when the valve would not open further. Although the bypass feedwater regulating valve (BFRV) was opened to supply SG #3, its flow capacity is unable to maintain water level in the SG at this power level. Operators were unsuccessful in attempts to re-open the MFRV and SG #3 water level continued dropping. By 1925 EDT, SG #3 level had dropped to 43 percent (narrow range) and a manual reactor trip was initiated. Isolation of the main feedwater system and actuation of the auxiliary feedwater (AFW) system occurred as designed. Operators stabilized SG water levels and transitioned the unit to normal operation in Mode 3 (hot standby).

D. CAUSE OF EVENT

The cause of this event was a failure of the MFRV positioner mechanism. Personnel found that a valve stem inside the positioner's pilot valve was slightly worn and misshapen. The investigation is continuing to determine if any other anomalies contributed to the erratic valve responses.

NRC	FORM	366A
(4.95)		-

U.S.NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

E. ANALYSIS OF EVENT

Control room operators properly responded to the decline in SG water levels by manually tripping the reactor. AFW actuated to supply water to the steam generators and operators again responded properly to control AFW flow and regain normal SG water levels. No problems arose following the trip that prevented operators from transitioning the plant to stable operation in Mode 3. Based on these considerations, there was no adverse effect on plant safety or on the health and safety of the public as a result of this event.

F. CORRECTIVE ACTIONS

- 1) The MFRV positioner was replaced and the valve was returned to service.
- 2) The original positioner is being sent to the vendor for further investigation into the cause of the valve stem anomalies and their potential for causing the valve's erratic responses. The plan to implement the corrective actions that result from this investigation will be completed by March 17, 1997.

G. ADDITIONAL INFORMATION

- Failed Components: Valve positioner manufactured by Bailey Controls. Model #AV1-12000
- Previous Similar Events: None
- Energy Industry Identification System Code: Main Feedwater System - SJ Auxiliary Feedwater System - BA