

## LICENSEE EVENT REPORT

CONTROL BLOCK

USNRC REGION I  
ATLANTA, GEORGIA

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 G A E I H 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5  
7 8 9 14 15 25 26 30 57 CAT 58

CON'T 83 AUG 2 AIO: 25  
0 1 REPORT SOURCE L 0 5 0 0 0 3 6 6 7 0 7 1 4 8 3 8 0 7 2 8 8 3 9  
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During normal startup activities, the Unit started losing condenser  
0 3 vacuum. In an effort to quickly reduce reactor power, control room  
0 4 personnel scrambled individual rods with the scram switches at the scram  
0 5 timing panel. After several insertions, one rod was found out of seq-  
0 6 uence and the Unit was manually scrambled per the "CONTROL ROD MOVEMENT"  
0 7 (HNP-2-9207). This is reportable per T.S. 6.9.1.9.c. The health and  
0 8 safety of the public were not affected by this non-repetitive event.  
7 8 9 80

0 9 SYSTEM CODE R A 11 CAUSE CODE A 12 CAUSE SUBCODE Z 13 COMPONENT CODE Z Z Z Z Z Z 14 COMP. SUBCODE Z 15 VALVE SUBCODE Z 16  
7 8 9 10 11 12 13 18 19 20  
17 LER/RO REPORT NUMBER 8 3 21 22 SEQUENTIAL REPORT NO. 0 4 2 24 26 OCCURRENCE CODE 0 1 28 29 REPORT TYPE T 30 31 REVISION NO. 0 32  
ACTION TAKEN X 18 FUTURE ACTION X 19 EFFECT ON PLANT B 20 SHUTDOWN METHOD B 21 HOURS 0 0 9 4 37 40 ATTACHMENT SUBMITTED Y 23 NPRD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER Z 25 COMPONENT MANUFACTURER Z 9 9 9 9 26  
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this event was a combination of inexplicit procedures and  
1 1 personnel error. Personnel were counselled on their improper actions.  
1 2 Applicable procedures are being revised and plant personnel are being  
1 3 trained to prevent recurrence. The corrective actions taken constituted  
1 4 justification for restart of the unit.  
7 8 9 80

1 5 FACILITY STATUS D 28 % POWER 0 0 7 29 OTHER STATUS NA 30 METHOD OF DISCOVERY A 31 DISCOVERY DESCRIPTION Operator Observation 32  
7 8 9 10 12 13 44 45 46 80

1 6 ACTIVITY CONTENT RELEASED OF RELEASE Z 33 Z 34 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36  
7 8 9 10 11 44 45 80

1 7 PERSONNEL EXPOSURES NUMBER 0 0 0 37 TYPE Z 38 DESCRIPTION NA 39  
7 8 9 10 11 12 13 80

PERSONNEL INJURIES NUMBER 0 0 0 40 DESCRIPTION NA 41  
7 8 9 10 11 12 80

1 9 LOSS OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43  
7 8 9 10 80

2 0 PUBLICITY ISSUED N 44 DESCRIPTION NA 45  
7 8 9 10 80

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PDR ADOCK 05000366  
S PDR

NRC USE ONLY

NAME OF PREPARER S. B. Tipps

PHONE: (912) 367-7851

NARRATIVE REPORT  
FOR LER 50-366/1983-042

LICENSEE AIO: 25 GEORGIA POWER COMPANY  
FACILITY NAME : EDWIN J. HATCH  
DOCKET NUMBER : 50-366

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

This 14 day LER is required by Tech. Specs. section 6.9.1.9.c.

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

On July 14, 1983, the plant was starting up from a refueling outage and was at 180 MWT (approximately 7% power).

Detailed description of the event(s):

During startup, the unit started losing condenser vacuum. The turbine was tripped. Control rods were being rapidly inserted to reduce power. Reactor power had to be quickly lowered so that the mechanical vacuum pump could be placed in service before the decreasing vacuum reached the reactor feed pump low vacuum trip point. A reactor feed pump low vacuum trip would cause a loss of feedwater flow to the vessel. The reactor core isolation cooling (RCIC) system was inoperable, but the high pressure coolant injection (HPCI) system was operable. The rod worth minimizer was bypassed, and at one point the emergency rod in position switch, was used to achieve the greatest possible insertion rate. A decision was made to manually insert the rods by using the individual scram switches at the scram timing panel which was already set up for scram time testing. The plant operator continued inserting rods at the front panel while two other operators went to the scram timing panel to insert rods with the individual scram switches. When the front panel operator observed rods going in, he stopped inserting and verified further insertions from the scram panel. After several rods had been inserted, one rod was found in an "out of sequence" position at notch 12 instead of fully withdrawn. The reactor was then manually scrammed as required by the "CONTROL ROD MOVEMENT" procedure (HNP-2-9207).

Consequences of the event(s):

The event is still being investigated by Georgia Power Management and the NRC Region II. Recommendations from this investigation are outlined in the corrective action section.

Status of redundant or backup subsystems and/or systems:

The rod sequence control system was operable but compromised as a backup to the reactor manual control system. The rod worth minimizer was bypassed with a second licensed operator verifying control rod movement.

Narrative Report for LER 50-366/1983-042

Page Two

83 AUG 2 AIO: 25

Justification for continued operation:

The unit was scrambled. No justification for continued operation was required at that time. The corrective actions taken constituted justification for allowing restart of the unit..

If repetitive, number of previous LER:

This is a non-repetitive event.

Impact to other systems and/or Unit:

There was no impact to Unit 1 or any other Unit 2 system.

Cause(s) of the event(s):

The cause of this event is a combination of inexplicit procedures and personnel error.

Immediate Corrective Action:

1. All involved operators and STA's were relieved of control room duties and a hold was placed on startup of Unit 2 by Plant Management.
2. Standing orders covering operation of the emergency rod in switch and the rod worth minimizer were placed in effect.
3. A standing order requiring plant general manager or deputy general manager approval for SRO changes was placed in effect.
4. Each licensed operator and STA has been briefed by the Operations Manager concerning the description of the event, lessons learned, operational philosophy and corrective actions completed or planned when returning to shift duties.
5. The operators, STA's and senior personnel directly involved in the control room were counselled on their improper actions during this incident by the Vice President, Nuclear Generation and the Chairman of the Safety Review Board on July 15, 1983.
6. Reactor coolant water samples were taken and a core physics review was conducted to verify that no core damage occurred during the event.

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83 AUG 2 AIO: 25  
Edwin I. Hatch Nuclear Plant

USNRC REGION II  
ATLANTA, GEORGIA  
83 AUG 2 AIO: 12  
Georgia Power

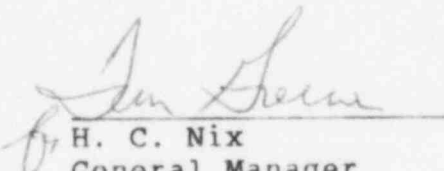
July 28, 1983  
GM-83-713

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

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. 50-366/1983-042. This report is required by Hatch Unit 2 Technical Specifications Section 6.9.1.9.c.

  
H. C. Nix  
General Manager

HCN/SBT/djs

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