

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)

Virgil C. Summer Nuclear Station

DOCKET NUMBER (2)

0 5 0 0 0 3 9 5 1 OF 0 2

PAGE (3)

TITLE (4)

Reactor Trip

EVENT DATE (5)

LER NUMBER (6)

REPORT DATE (7)

OTHER FACILITIES INVOLVED (8)

MONTH	DAY	YEAR	YEAR	SEQUENTIA NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)													
0	4	2	5	8	4	0	2	5	0	1	0	7	0	2	8	4	0	5	0	0	0	0	0

OPERATING
MODE (9)

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8. (Check one or more of the following) (11)

POWER
LEVEL
(10)

11010

20.402(b)

20.405(a)(1)(i)

20.405(a)(1)(ii)

20.405(a)(1)(iii)

20.405(a)(1)(iv)

20.405(a)(1)(v)

20.405(e)

50.36(a)(1)

50.36(a)(2)

50.73(a)(2)(i)

50.73(a)(2)(ii)

50.73(a)(2)(iii)

50.73(a)(2)(iv)

50.73(a)(2)(v)

50.73(a)(2)(vi)

50.73(a)(2)(vi)(A)

50.73(a)(2)(vi)(B)

50.73(a)(2)(x)

73.71(b)

73.71(e)

OTHER (Specify in Abstract
below and in Text, NRC Form
306A)

LICENSEE CONTACT FOR THIS LER (12)

NAME

TELEPHONE NUMBER

AREA CODE

A. R. Koon, Jr., Assoc. Mgr., Regulatory Compliance

8 0 1 3 3 1 4 5 1 - 5 1 2 1 0 9

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

CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPDOS
A	IIT			N					

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED
SUBMISSION
DATE (15)

MON

DAY

YEAR

YES (If yes, complete EXPECTED SUBMISSION DATE)

XXXXX

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

APPROVED OMB NO. 3150-0104

EXPIRES 2/31/85

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

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

July 2, 1984

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

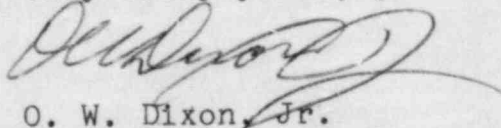
SUBJECT: Virgil C. Summer Nuclear Station
Docket No. 50/395
Operating License No. NPF-12
LER 84-025, Revision 1

Dear Sir:

Please find attached Revision 1 to Licensee Event Report #84-025 for the Virgil C. Summer Nuclear Station. The changes are denoted by the bar lines in the right hand margin on pages 1 and 2. This Report was previously submitted on May 25, 1984, in accordance with 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.

ARK:RJB:OWD/dwf
Attachment

cc: V. C. Summer
T. C. Nichols, Jr./O. W. Dixon, Jr.
E. H. Crews, Jr.
E. C. Roberts
W. A. Williams, Jr.
D. A. Nauman
J. P. O'Reilly
Group Managers
O. S. Bradham
C. A. Price
D. A. Lavigne

J. F. Heilman
C. L. Ligon (NSRC)
K. E. Nodland
R. A. Stough
G. Percival
C. W. Hehl
J. B. Knotts, Jr.
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