

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) EDWIN I. HATCH, UNIT II										DOCKET NUMBER (2) 0 5 0 0 0 3 6 6 1 OF 0 2										PAGE (3) 1 OF 0 2													
TITLE (4) LOW PRESSURE COOLANT INJECTION ACTUATION																																	
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)					
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0 5			1 5			8 5			8 5		0 2		3		0 0		0 6			0 7			8 5							0 5 0 0 0 0			
OPERATING MODE (9) 4						THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																											
POWER LEVEL (10) 0 0 0						20.402(b)				20.406(c)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)				73.71(b)															
						20.406(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)															
						20.406(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)															
						20.406(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(viii)(A)																			
						20.406(a)(1)(iv)				50.73(a)(2)(ii)				50.73(a)(2)(viii)(B)																			
						20.406(a)(1)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)																			
LICENSEE CONTACT FOR THIS LER (12)																																	
NAME Steven B. Tipps, Superintendent of Regulatory Compliance										TELEPHONE NUMBER 9 1 2 3 6 7 1 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													
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 05/15/85 at approximately 0640 CDT with the reactor mode switch in the shutdown position and the unit shutdown, Instrumentation and Controls (I & C) personnel in the process of performing the "CHANNEL LOGIC RESPONSE TIME" procedure (HNP-2-3191) caused a Low Pressure Coolant Injection (LPCI) system actuation to occur.

The procedure mistakenly called for a jumper to be placed between AA3 and AA4 in panel 2H11-P617, when in fact it should have called for the jumper to be placed between AA3 and AA4 in panel 2H11-P627.

At the time of the event, Residual Heat Removal (RHR) pump "C" was running in the Shutdown Cooling (SDC) mode. The improperly installed jumper initiated a loop "A" LOCA signal which caused RHR pumps "B" and "D" to start in the LPCI mode and inject water from the torus into the reactor pressure vessel (RPV). Operations personnel immediately secured all RHR pumps and the I & C personnel involved terminated their test.

After reviewing and correcting the uncompleted portion of the procedure, plant personnel successfully completed it.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

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

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

This 30 day LER is required by 10CFR 50.73 (a)(2)(iv) because an unplanned actuation of an Engineered Safety Feature occurred.

On 05/15/85 at approximately 0640 CDT with the reactor mode switch in the shutdown position and the unit shutdown, Instrumentation and Controls (I & C) personnel in the process of performing the "CHANNEL LOGIC RESPONSE TIME" procedure (HNP-2-3191) caused a Low Pressure Coolant Injection (LPCI) system actuation to occur.

The procedure mistakenly called for a jumper to be placed between AA3 and AA4 in panel 2H11-P617, when in fact it should have called for the jumper to be placed between AA3 and AA4 in panel 2H11-P627. Properly placed, the jumper would have allowed for the testing of the Core Spray Loss of Coolant Accident (LOCA) logic circuitry via a signal from 2E11-N094A (Drywell High Pressure instrument). As placed (jumper in 2H11-P617), the jumper bypassed both the High Drywell Pressure and Reactor Low Level contacts in loop "A" of the RHR LOCA logic circuitry, thus initiating a LPCI actuation.

At the time of the event, Residual Heat Removal (RHR) pump "C" was running in the Shutdown Cooling (SDC) mode. The improperly installed jumper initiated a loop "A" LOCA signal which caused RHR pumps "B" and "D" to start in the LPCI mode and inject water from the torus into the reactor pressure vessel (RPV). Operations personnel immediately secured all RHR pumps, and the I & C personnel involved terminated their test. RPV level increased from approximately +36 inches to +100 inches (referenced to instrument zero) as a result of the injection.

The cause of this event was a defective procedure. The error was introduced in a revision to the procedure (July, 1984) that incorporated the Analog Transmitter Trip System (ATTS) and was not detected in the review. After reviewing and correcting the uncompleted portion of the procedure, plant personnel successfully completed it.

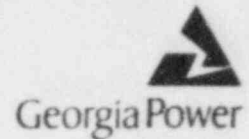
A previous similar event occurred on 7/11/84 and was reported in LER 50-366/1984-009. At that time, the error in HNP-2-3191 which caused the actuation of the ESF logic was corrected and the uncompleted portion of the procedure was reviewed, corrected and successfully completed. The defective step which caused the LPCI actuation on 5/15/85 was not detected in July, 1984 because the RHR pump breakers were racked out (no fuel in vessel).

Engineering and I & C personnel will conduct a thorough review of the entire procedure (HNP-2-3191) to prevent recurrence of events of this type.

There was no significant effect on reactor water chemistry. There were no actual or potential safety consequences resulting from this event, nor were the health and safety of the public affected since the event occurred while the unit was shutdown. This procedure would not be performed with the unit at power.

There is no special report required by Tech. Specs. section 3.5.3.2.a since the plant was in condition 4 at the time of the event.

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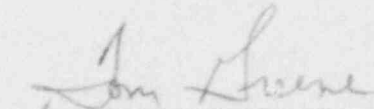
Edwin I. Hatch Nuclear Plant

June 7, 1985
GM-85-553

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. 50-366/1985-023. This report is required by 10CFR 50.73(a)(2)(iv).


H. C. Nix
General Manager

HE
HCN/SBT/vlz

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11