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SOUTHERN COMPANY
Energy to Serve Your World℠

January 4, 2001

Docket No.: 50-424

LCV-1504

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

VOGTLE ELECTRIC GENERATING PLANT
LICENSEE EVENT REPORT 1-2000-04
PROCEDURE INADEQUACY LEADS TO
REACTOR TRIP DURING SURVEILLANCE TESTING

Ladies and Gentlemen:

In accordance with the requirements of 10 CFR 50.73, Southern Nuclear Operating Company hereby submits a Vogtle Electric Generating Plant licensee event report for a condition that occurred on Unit 1 on December 9, 2000.

Please contact this office if you have any questions.

Sincerely,

J. B. Beasley, Jr.

JBB/BHW

Enclosure: LER 1-2000-04

cc: Southern Nuclear Operating Company
Mr. J. T. Gasser
Mr. M. Sheibani
SNC Document Management

U. S. Nuclear Regulatory Commission
Mr. L. A. Reyes, Regional Administrator
Mr. Ramin R. Assa, Vogtle Project Manager, NRR
Mr. J. Zeiler, Senior Resident Inspector, Vogtle

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NRC FORM 366 (6-1998)

U.S.NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

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TITLE (4)

PROCEDURE INADEQUACY LEADS TO REACTOR TRIP DURING SURVEILLANCE TESTING

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 NAME	DOCKET NUMBER
1 2	0 9	2 0 0 0	2 0 0 0	0 0 4	0 0					0 5 0 0 0
									FACILITY NAME	0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR •: (Check one or more) (11)

	20.2201(b)		20.2203(a)(2)(v)		50.73(a)(2)(i)		50.73(a)(2)(viii)
	20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
	20.2203(a)(2)(ii)		20.2203(a)(4)	X	50.73(a)(2)(iv)		OTHER
	20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		*Specify in Abstract below*
	20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		*or in NRC Form 366A*

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (include area code)
Mehdi Sheibani, Nuclear Safety and Compliance	7 0 6 - 8 2 6 - 3 2 0 9

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-space typewritten lines) (16)

On December 9, 2000, plant personnel were conducting a test of the solid state protection system (SSPS), Train B, per procedure 14421-1, "Solid State Protection System And Reactor Trip Breaker Train B Operability Test." The Balance of Plant operator (BOP) proceeded through the procedure steps in an orderly fashion to section 5.3. When the BOP performed step 5.3.1, "PLACE the MEMORIES Switch to Position 9," an automatic reactor trip occurred at 1015 EST.

The root cause of this event was a procedure inadequacy. A recent change to procedure 14421-1 had moved a portion of the testing from procedure section 5.8 to section 5.3. However, this change bypassed a procedure step to place the Input Error Inhibit switch in the "Inhibit" position, which had previously been performed prior to beginning the section 5.8 testing. The failure to place this switch into "Inhibit" allowed the reactor trip test signals to enter SSPS trip logic and complete an actual reactor trip. Procedure 14421-1 was revised to move the section 5.3 testing back to section 5.8 and testing was completed satisfactorily.

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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 actuation of the reactor protection system (RPS) occurred.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was in Mode 1 (Power Operation) at 100 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 December 9, 2000, plant personnel were conducting testing of the solid state protection system (SSPS), Train B, per procedure 14421-1, "Solid State Protection System And Reactor Trip Breaker Train B Operability Test." The Balance of Plant operator (BOP) proceeded through the procedure steps in an orderly fashion to section 5.3, "SAFETY INJECTION RESET TIMING CIRCUIT TEST." When the BOP performed step 5.3.1, "PLACE the MEMORIES Switch to Position 9," an automatic reactor trip occurred at 1015 EST.

All control rods inserted. The main feedwater system isolated and the auxiliary feedwater (AFW) system actuated as designed. Control room operators throttled flow to the steam generators to control water levels and limit the reactor coolant system's cooldown rate. The unit was stabilized in Mode 3 (hot standby). The NRC Operations Center was notified of this event at 1240 EST.

D. CAUSE OF EVENT

The direct cause of the event was placing the Memories switch to position 9. This allowed reactor trip test signals to process through the SSPS and trip the reactor. The root cause of this event was a procedure inadequacy. A recent change to procedure 14421-1 had moved the SAFETY INJECTION RESET TIMING CIRCUIT TEST from procedure section 5.8 to section 5.3. This was done to accommodate more efficient use of instrument and controls (I&C) personnel. However, this bypassed a procedure step to place the Input Error Inhibit switch in the "Inhibit" position, which had previously been performed prior to beginning the section 5.8 testing. The failure to place this

switch into "Inhibit" allowed the reactor trip test signals to enter SSPS trip logic and complete an actual reactor trip.

Contributing to the procedure inadequacy were failures to:

1. Move the steps within the procedure accurately.
2. Utilize a departmental technical review.
3. Perform an adequate second person review.
4. Ensure an adequate procedure change process was being followed per procedural guidance.

E. ANALYSIS OF EVENT

When the automatic reactor trip occurred, the main feedwater system isolated and the auxiliary feedwater system actuated as designed. Control room operators responded properly to control feedwater to the steam generators and stabilize the unit 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) Procedure 14421-1 was revised to move the section 5.3 testing back to section 5.8. Testing was then completed satisfactorily. This and other SSPS testing procedures will be revised by March 22, 2001 to clarify the input error inhibit switch function.

2) The requirements and expectations of a quality technical review will be discussed with personnel that write or review procedures by March 31, 2001.

3) The procedure review matrix will be updated by March 31, 2001 to ensure that procedures requiring interdepartmental reviews are properly identified.

4) The Operations Training Advisory Committee will review the SSPS training segment and make necessary changes by February 22, 2001.

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

G. ADDITIONAL INFORMATION

1) Failed Components:
None

2) Previous Similar Events:
None

3) Energy Industry Identification System Code:
Solid State Protection System – JG
Main Feedwater System – SJ
Auxiliary Feedwater System – BA