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SOUTHERN COMPANY
Energy to Serve Your World℠

May 29, 2001

LCV-1542

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 2-01-001
REACTOR TRIP WHILE TESTING
THE MAIN FEEDWATER PUMP TRIP SIGNALS

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 2 on April 7, 2001.

Sincerely,

J. B. Beasley, Jr.

JBB/JPC

Enclosure: LER 2-01-001

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, VEGP

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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)
REACTOR TRIP WHILE TESTING MAIN FEEDWATER PUMP TRIP SIGNALS

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
										0 5 0 0 0
0 4	0 7	2 0 0 1	2 0 0 1	0 0 1	0 0				FACILITY NAME	0 5 0 0 0

OPERATING MODE (9)	1	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)
POWER LEVEL (10)	4 6	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 April 7, 2001, Unit 2 was reducing power, preparing to enter a refueling outage. While steam generator (SG) feedwater pump A was out of service, personnel were testing the SG feedwater pump turbine (SGFPT) A trip signal. However, upon simulating a SG high water level signal, a trip of SGFPT B occurred. This resulted in both SGFPTs being out of service. Therefore, control room operators performed a manual reactor trip at 2123 EDT. A normal trip sequence ensued and plant operators transitioned the unit to stable operation in Mode 3 (hot standby).

An investigation of this event found that, prior to the SGFPT B trip, I&C technicians had opened a sliding link to disable the feed pump trip signal. A review determined that the sliding link had not been fully opened, thereby leading to the SGFPT B trip when a simulated high water level signal was processed. The root cause of the event was the man-machine interface that prohibited the technicians from visually determining the link position. The link position could only be determined by feel using a nut driver. Corrective actions include performing an engineering review to determine if the link should be moved to a more accessible location in the cabinet. Additionally, until completion of this review, this surveillance will only be performed when the SGFPTs are out of service.

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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 50.72 (a)(2)(iv) because an unplanned actuation of the reactor protection system occurred.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was operating in Mode 1 (power operation) at 46% of rated thermal power and was reducing power prior to entering a refueling outage. Steam generator main feedwater pump turbine (SGFPT) A had been removed from service.

C. DESCRIPTION OF EVENT

On April 7, 2001, personnel were verifying the operability of a SGFPT A trip signal, in accordance with procedure 14236-2, "SGFPT A and SGFPT B Trip TADOT." However, upon simulating a steam generator (SG) high level signal, a trip of SGFPT B occurred. This resulted in both SGFPTs being out of service. Therefore, control room operators performed a manual reactor trip at 2123 EDT. The reactor protection system actuated as designed and the auxiliary feedwater system began to provide feedwater to maintain SG water levels. There were no safety-related components that failed to perform their functions. Plant operators transitioned the unit to stable operation in Mode 3 (hot standby).

D. CAUSE OF EVENT

An investigation of this event found that, prior to the SGFPT B trip, I&C technicians had opened a sliding link, as required by the surveillance procedure, to disable the feed pump trip signal. A review determined that the sliding link had not been fully opened, thereby leading to the SGFPT B trip when a simulated high water level signal was processed. The link is difficult to access and visually confirm in the open position. The cabinet is narrow and cramped. Also, due to the layout of the panel, lighting may be less than adequate. Therefore, the root cause of the event was the man-machine interface that prohibited the technicians from visually determining the link position. The link position could only be determined by feel using a nut driver.

A contributing cause was the lack of a clear standard or policy for sliding link manipulation. The work is considered "skill of the craft," and it is left to technician discretion to decide whether or not to tighten a link in the open position. An accidental bump or vibration may cause a link to change position.

E. ANALYSIS OF EVENT

When the SGFPT B tripped, control room operators acted appropriately to manually trip the reactor and prevent a challenge to the automatic trip actuation circuitry. The reactor protection system and the auxiliary feedwater system performed as designed. The unit was stabilized in mode 3 (hot standby). 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.

This event does not represent a safety system functional failure.

F. CORRECTIVE ACTIONS

1. Perform an engineering review to determine if the link should be moved to a more accessible location in the cabinet.

2. Until completion of this review, this surveillance will only be performed when the SGFPTs are out of service.

3. Appropriate personnel were advised that the expected practice for manipulating sliding links is to tighten the nut to secure the links in both the closed and opened positions.

4. A standard for sliding link manipulation and for sliding link visual verification will be established by July 30, 2001.

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

G. ADDITIONAL INFORMATION

1. Previous Similar Events:
   None

2. Failed Components:
   None

3. Energy Industry Identification System Code:
   Main Feedwater System – SJ
   Reactor Protection System – JG
   Auxiliary Feedwater System – BA