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August 1, 2005

Docket No.: 50-425

NL-05-1296

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

Vogtle Electric Generating Plant - Unit 2
Licensee Event Report 2-2005-001
High Flux At Shutdown Alarm Inoperable – Operation In A Condition Prohibited By The
Technical Specifications

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 was determined to be reportable on June 2, 2005.

Sincerely,

A handwritten signature in black ink, appearing to read "D. E. Grissette", written over a horizontal line.

Don E. Grissette

DEG/TDH/daj

Enclosure: LER 2-2005-001

cc: Southern Nuclear Operating Company
Mr. J. T. Gasser, Executive Vice President
Mr. T. E. Tynan, General Manager – Plant Vogtle
RType: CVC7000

U. S. Nuclear Regulatory Commission
Dr. W. D. Travers, Regional Administrator
Mr. C. Gratton, NRR Project Manager – Vogtle
Mr. G. J. McCoy, Senior Resident Inspector – Vogtle

LICENSEE EVENT REPORT (LER)

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

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Vogtle Electric Generating Plant – Unit 2	2. DOCKET NUMBER 05000-425	3. PAGE 1 OF 4
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4. TITLE
High Flux At Shutdown Alarm Inoperable – Operation In A Condition Prohibited By The Tech. Specs.

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER(S)
06	02	2005	2005	001	00	08	01	2005		05000
									FACILITY NAME	DOCKET NUMBER(S)
										05000

9. OPERATING MODE 5	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § : (Check all that apply)													
	20.2201(b)			20.2203(a)(3)(i)			50.73(a)(2)(i)(C)			50.73(a)(2)(vii)				
	20.2201(d)			20.2203(a)(3)(ii)			50.73(a)(2)(ii)(A)			50.73(a)(2)(viii)(A)				
	20.2203(a)(1)			20.2203(a)(4)			50.73(a)(2)(iii)(B)			50.73(a)(2)(viii)(B)				
10. POWER LEVEL 0%	20.2203(a)(2)(i)			50.36(c)(1)(A)			50.73(a)(2)(iii)			50.73(a)(2)(ix)(A)				
	20.2203(a)(2)(ii)			50.36(c)(1)(ii)(A)			50.73(a)(2)(iv)(A)			50.73(a)(2)(x)				
	20.2203(a)(2)(iii)			50.36(c)(2)			50.73(a)(2)(v)(A)			73.71(a)(4)				
	20.2203(a)(2)(iv)			50.46(a)(3)(ii)			50.73(a)(2)(v)(B)			73.71(a)(5)				
	20.2203(a)(2)(v)			50.73(a)(2)(i)(A)			50.73(a)(2)(v)(C)			OTHER				
20.2203(a)(2)(vi)			X			50.73(a)(2)(i)(B)			50.73(a)(2)(v)(D)			Specify in Abstract below or in NRC Form 366A		

12. LICENSEE CONTACT FOR THIS LER											
FACILITY NAME Tom Webb, Performance Analysis						TELEPHONE NUMBER (Include Area Code) (706) 826-3105					

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	

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

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

On June 2, 2005, Unit 2 was in Mode 5 (Cold Shutdown) and personnel were performing surveillance testing of neutron flux instrumentation. The high flux at shutdown alarm (HFASA) annunciator did not actuate when tested. At 0115 EDT, it was found that both trains of the solid state protection system (SSPS) were in "input error inhibit," which rendered both channels of HFASA inoperable. Further review determined that this condition had existed since May 25, 2005. Because the alarm was inoperable longer than the completion time for the required actions of Technical Specification (TS) LCO 3.3.8 Condition B, the unit had operated in a condition prohibited by the TS. Following the discovery of this event at 0115 EDT, on June 2, 2005, TS action requirements were met by 0417 EDT, and HFASA was returned to service at 1100 EDT.

The cause of this event is the improper use of a procedure on May 25, 2005, when SSPS was removed from service while the unit was shutdown. The procedure, 13503-2, "Reactor Control Solid State Protection System," did not have a section written specifically for placing both trains of SSPS in TEST. A portion of the procedure section for de-energizing both trains of SSPS was used, thereby rendering both trains of HFASA inoperable. Procedures 13503-1/2 have been revised, other procedures utilizing SSPS will be reviewed and revised as appropriate, and this event will be addressed in operator training.

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

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(i)(B). The unit operated in a condition prohibited by the Technical Specifications (TS) when the high flux at shutdown alarm was inoperable for a period of time greater than that allowed by the action requirements.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was in Mode 5 (Cold Shutdown) at 0% 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 May 25, 2005, plant operators were attempting to remove the solid state protection system (SSPS) from service by placing it in TEST using procedure 13503-2, "Reactor Control Solid-State Protection System." Prior to disabling the SSPS, the operators realized that the procedure did not have a section written specifically for placing both trains of SSPS in TEST. A timeout was called to evaluate the available procedural guidance. After multiple reviews, the operating crew determined that it would be acceptable to use a section of the procedure that was written for de-energizing the solid-state protection system cabinets. This procedure section resulted in both trains of SSPS Input Error Inhibit Switches being in the INHIBIT position. Therefore, both channels of HFASA were disabled at 1016 EDT on May 25, 2005 by placing the Input Error Inhibit Switches in INHIBIT.

On June 2, 2005, personnel were performing surveillance testing of neutron flux instrumentation. The high flux at shutdown alarm (HFASA) annunciator did not actuate when tested. At 0115 EDT, it was found that both trains of the solid state protection system (SSPS) were in "input error inhibit," which rendered both channels of HFASA inoperable. Further review determined that this condition had existed since May 25, 2005, when SSPS was removed from service, as is normally the case when the unit is shutdown. With the Input Error Inhibit Switch of one train in the INHIBIT position, the Input Error Inhibit Switch of the other train must be in the NORMAL position in order for HFASA to function. Because the alarm was inoperable longer than the completion time for the required actions of Technical Specification LCO 3.3.8 Condition B, the unit had operated in a condition prohibited by the TS. Following the discovery of this event at 0115 EDT, on June 2, 2005, TS action requirements were met by 0417 EDT, and HFASA was returned to service at 1100 EDT by placing the Input Error Inhibit Switch of one train of SSPS in the NORMAL position.

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

D. CAUSE OF EVENT

The cause of this event is the improper use of a procedure on May 25, 2005, when SSPS was removed from service while the unit was shutdown. The procedure section that was used was written for de-energizing the solid-state protection cabinets, not for placing both trains of SSPS in TEST.

E. ANALYSIS OF EVENT

Had a high flux condition occurred with HFASA inoperable, redundant visual indication is available to control room operators that would have allowed them to take necessary actions. Additionally, no reactor coolant system dilutions occurred during the time HFASA was inoperable and shutdown margin verification was performed in accordance with the surveillance requirement of LCO 3.1.1. 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) Upon discovery, actions were taken to comply with TS action requirements, and HFASA was restored to service shortly thereafter.
- 2) Procedures 13503-1/2 have been revised to address the proper disabling of both trains concurrently. Procedure 12006-C will be revised by August 5, 2005 to provide guidance to place SSPS in TEST while HFASA remains operable. Other procedures utilizing SSPS will be reviewed and revised by September 16, 2005, to address the proper disabling of both trains concurrently.
- 3) By August 17, 2005, this event will be addressed in licensed operator re-qualification training.
- 4) A broadness review was conducted of Condition Reports over the last three years and discussions were held with responsible personnel for repeat events. It was determined loss of both channels of HFASA has not occurred previously.

G. ADDITIONAL INFORMATION

- 1) Failed Components:
None

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

2) Previous Similar Events:

There have been no previous similar events in the past three years.

3) Energy Industry Identification System Code:

Solid State Protection System - JG