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February 25, 1991

W. G. Hairston, III
Senior Vice President
Nuclear Operations

ELV-02566
0850

Docket No. 50-424

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

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
LICENSEE EVENT REPORT
PERSONNEL ERROR RESULTS IN AUXILIARY FEEDWATER
SYSTEM ACTUATION

In accordance with 10 CFR 50.73, Georgia Power Company hereby submits the enclosed report related to an event which occurred on February 4, 1991.

Sincerely,

C. K. McCoy FOR

W. G. Hairston, III

WGH,III/NJS/gm

Enclosure: LER 50-424/1991-002

xc: Georgia Power Company
Mr. C. K. McCoy
Mr. W. G. Shipman
Mr. P. D. Rushton
Mr. R. M. Odom
NORMS

U. S. Nuclear Regulatory Commission
Mr. S. D. Ebneter, Regional Administrator
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NRC Form 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
VOGTLE ELECTRIC GENERATING PLANT - UNIT 1	0 5 0 0 0 4 2 4	1 OF 3

TITLE (4)
PERSONNEL ERROR RESULTS IN AUXILIARY FEEDWATER SYSTEM ACTUATION

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQ NUM	REV	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
										0 5 0 0 0
0 2	0 4	9 1	9 1	0 0 2	0 0	0 2	2 5	9 1		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)			
POWER LEVEL	1 0 0	20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below)
		20.405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
R. M. UDOM, NUCLEAR SAFETY AND COMPLIANCE	404	826-3201

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)

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

ABSTRACT (16)

On 2-4-91, plant personnel were performing surveillance testing in the Train B Safeguards Test Cabinet (STC). The Balance of Plant (BOP) Operator and a trainee were in the process of testing a slave relay. The trainee placed his hand on the test button, S935, then removed it to re-verify the step in the procedure. He then erroneously put his hand on the button directly below the proper button, placed it in the test position, and manually depressed it at 0036 CST, before either the trainee or the BOP operator recognized the error. This button (S928) energized a different slave relay which caused the steam inlet valve to the Turbine Driven Auxiliary Feedwater Pump (TDAFWP) to open, starting the pump. The Reactor Operator (RO) in the control room observed the alarm, checked that steam generator (SG) water levels were normal, and took action to limit the TDAFWP discharge to the SGs. After determining the reason for the TDAFWP actuation, the RO secured the TDAFWP and restored the Auxiliary Feedwater System to standby readiness at 0119 CST.

The trainee committed a personnel error by inadvertently failing to follow procedure and in not employing self-checking to verify the button number prior to depressing it. Also, the BOP operator did not exercise sufficient supervision of the trainee. The trainee and the BOP operator have been counseled.

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(iv) because an unplanned Engineered Safety Feature actuation occurred.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was operating in Mode 1 (Power Operations) at 100% of rated thermal power. There was no inoperable equipment which contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On 2-4-91, plant personnel were performing Solid State Protection System (SSPS) surveillance testing in the Train B Safeguards Test Cabinet (STC), per procedure 14649-1, "SSPS Slave Relay K746 Train B Test Containment Ventilation Isolation." The Balance of Plant (BOP) Operator and a trainee were in the process of testing a slave relay which is used to actuate containment ventilation isolation. The trainee placed his hand on the correct test button, S935, then removed it to re-verify the step in the procedure. He then erroneously put his hand on the button directly below the proper button, placed it in the test position, and manually depressed it at 0036 CST, before either the trainee or the BOP operator recognized the error. This button (S928) energized slave relay K641 and sequentially, the AX2 relay. This created an opening permissive for steam inlet valve 1HV-5106, which started the Turbine Driven Auxiliary Feedwater Pump (TDAFWP). The Reactor Operator (RO) in the control room acknowledged an alarm which indicated that the inlet valve was opening, checked to determined that steam generator (SG) water levels were normal, and took action to limit the TDAFWP discharge to the SGs. This action included decreasing the TDAFWP speed and manually closing the TDAFWP discharge valves As a result, there was no noticeable change in steam generator water levels or reactor power as a consequence of the pump start. After determining the reason for the TDAFWP actuation, the RO secured the TDAFWP and restored the Auxiliary Feedwater System (AFW) to standby readiness at 0119 CST.

D. CAUSE OF EVENT

The causes of the event are:

1. The Georgia Power Company trainee committed a cognitive personnel error by inadvertently failing to follow procedure 14649-1 and in not employing self-checking to verify the button number prior to depressing it. The BOP operator committed a cognitive personnel error by failing to exercise sufficient supervision over the trainee. There were no unusual characteristics of the work location which contributed to the occurrence of these errors.

2. Although a lesson plan in self-checking/verification practices had been developed and training was in progress, the trainee was one of a small group of personnel who had not yet attended the associated training class.

3. The display on the STC panel, although properly labeled, was not user friendly.

E. ANALYSIS OF EVENT

The AFW system started as designed and the control room personnel responded properly to throttle flow to the SGs and prevent a plant transient. Based on these considerations, there was no adverse effect on plant safety or the health and safety of the public as a result of this event.

F. CORRECTIVE ACTIONS

1. The trainee has been counseled regarding the importance of self-checking. The BOP operator has been counseled on the importance of exercising proper supervision of trainees and his responsibility for all trainee actions. By 4-1-91, a summary of this event will become required reading, or will be discussed in group meetings, for Operations, Maintenance, HP/Chemistry and Engineering Support departments' personnel, stressing the importance of self-checking and attention to detail.

2. By 5-1-91, self-checking/verification training will be sequenced into the initial licensed operator training program for on the job training in the control room.

3. Each SSPS actuation switch will be border marked to visually block in its nameplate, switch, and switch number (both units) by 5-1-91.

G. ADDITIONAL INFORMATION

1. Failed Components:

None

2. Previous Similar Events:

LER 50-424/1987-015, dated 5-13-87.
Corrective actions included counseling.

3. Energy Industry Identification System Code:

Solid State Protection System - JG

Auxiliary Feedwater System - BA

Containment Isolation Control System - JM