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November 30, 1990

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

ELV-02285
0720

Docket No. 50-425

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

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
LICENSEE EVENT REPORT
PERSONNEL ERROR LEADS TO 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 November 8, 1990.

Sincerely,

W. G. Hairston, III

WGH,III/NJS/gm

Enclosure: LER 50-425/1990-016

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

U. S. Nuclear Regulatory Commission
Mr. S. D. Ebneter, Regional Administrator
Mr. D. S. Hood, Licensing Project Manager, NRR
Mr. B. R. Bonser, Senior Resident Inspector, Vogtle

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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 2	0 5 0 0 0 4 2 5	1 OF 3

TITLE (4)
PERSONNEL ERROR LEADS TO 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
1 1	0 8	9 0	9 0	0 1 6	0 0	1 1	3 0	9 0		0 5 0 0 0

OPERATING MODE (9)	3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)			
POWER LEVEL	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. ODOM, 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 11-8-90, the Unit Shift Supervisor (USS), Shift Superintendent, and the Duty Engineer were discussing details associated with coordination of Turbine Driven Auxiliary Feedwater (TDAFW) pump maintenance and engineering response time testing of the pump. The decision was made to prepare for the response time testing to be performed following completion of re-packing of the TDAFW pump. In preparation for the test at 0311 CST, technicians connected a recorder in the Auxiliary Relay Panel at the direction of the Duty Engineer. This led to energization of the AX1 relay in the Engineered Safety Features Actuation System (ESFAS) logic circuit, which allowed the TDAFW pump steam admission valve to open. The USS in the control room noticed that the TDAFW pump steam admission valve opened, and that the pump had started. Operators closed the TDAFW pump discharge valves and slowed the pump to minimum flow operation as personnel began to investigate the cause of the valve opening. At 0333 CST, the TDAFW pump was stopped and returned to standby.

The cause of this event was a failure to follow procedure. The testing procedure gives directions for the recorder hook-up and contains prerequisites which would have prevented the recorder connection from causing the steam admission valve to open, had the procedure been explicitly followed.

The engineer involved with directing the performance of this procedure has been counseled. In addition, other appropriate personnel will be directed to read a summary of this event and will be reminded of the importance of performing a procedure in sequence and maintaining a questioning attitude.

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(iv) because an unplanned Engineered Safety Feature (ESF) actuation occurred when a Turbine Driven Auxiliary Feedwater (TDAFW) pump started.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was in Mode 3 (Hot Standby) at 0% of rated thermal power. There was no inoperable equipment which contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On 11-8-90, the Unit Shift Supervisor (USS), Shift Superintendent, and the Duty Engineer were discussing details associated with coordination of TDAFW pump maintenance and engineering response time testing of the pump. The decision was made to prepare for the response time testing to be performed following completion of re-packing of the TDAFW pump. In preparation for the test at 0311 CST, technicians connected a recorder in the Auxiliary Relay Panel at the direction of the Duty Engineer. This led to energization of the AX1 relay in the Engineered Safety Features Actuation System (ESFAS) logic circuit, which allowed the TDAFW pump steam admission valve to open. The USS in the control room noted that the TDAFW pump steam admission valve opened, and that the pump had started. Operators closed the TDAFW pump discharge valves and slowed the pump to minimum flow operation. The pump was allowed to operate at minimum flow while control room personnel investigated the cause of the valve opening. At 0333 CST, the TDAFW pump was stopped and returned to standby.

D. CAUSE OF EVENT

The cause of this event was a failure to follow procedure. The testing procedure gives directions for the recorder hook-up and contains prerequisites which would have prevented the recorder connection from causing the steam admission valve to open, had the procedure been explicitly followed. The Georgia Power Company Duty Engineer committed a cognitive personnel error by not ensuring the procedure was performed in sequence. There were no unusual characteristics of the work location which contributed to the occurrence of this error.

Contributing to the occurrence of the event was a miscommunication between the Shift Superintendent and the Duty Engineer regarding an activity being conducted on the unit. The Shift Superintendent permitted the hook-up of the recorder without ensuring an adequate review of the procedure prior to its implementation.

E. ANALYSIS OF EVENT

The automatic actuation of the TDAFW pump occurred as expected when the steam admission valve was opened. Operators responded properly by shutting the valves which stopped flow to the steam generators. Finally, there was no emergency condition which necessitated the use of the TDAFW pump. Based on these considerations, there was no adverse impact on plant safety or public health and safety as a result of this event.

F. CORRECTIVE ACTIONS

1. The engineer involved with directing the performance of this procedure has been counseled.

2. Appropriate personnel will be reminded of the rules for performing procedures, including following steps in sequence unless deviations are allowed by procedure. This will be done by 12-15-90.

3. A copy of this report will be placed in the Operations Reading Book to share lessons learned from this event.

4. The test procedure will be revised to add a warning that failure to follow steps in sequence may result in an ESF actuation. Similar procedures will be reviewed and revised as necessary. This will be done by 1-15-91.

5. Plant management has identified a weakness in the area of procedural compliance and steps will be taken in the upcoming year to improve performance in this area.

G. ADDITIONAL INFORMATION

1. Failed Components:

None.

2. Previous Similar Events:

None.

3. Energy Industry Identification System Code:

Auxiliary Feedwater System - BA

Main Steam System - SB