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Georgia Power

*The South's electric system*

HL-2063  
002968

February 19, 1992

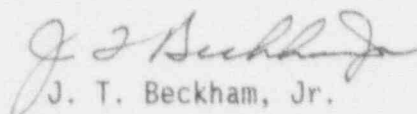
U.S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, D.C. 20555

PLANT HATCH - UNIT 2  
NRC DOCKET 50-366  
OPERATING LICENSE NPF-5  
LICENSEE EVENT REPORT  
PERSONNEL ERROR RESULTS IN  
AN UNPLANNED ESF ACTUATION

Gentlemen:

In accordance with the requirements of 10 CFR 50.73(a)(2)(iv), Georgia Power Company is submitting the enclosed Licensee Event Report (LER) concerning a personnel error which resulted in an unplanned Engineered Safety Feature (ESF) actuation. This event occurred at Plant Hatch - Unit 2.

Sincerely,

  
J. T. Beckham, Jr.

JKB/cr

Enclosure: LER 50-366/1992-002

cc: (See next page.)

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U.S. Nuclear Regulatory Commission

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cc: Georgia Power Company  
Mr. H. L. Sumner, General Manager - Nuclear Plant  
NORMS

U.S. Nuclear Regulatory Commission, Washington, D.C.  
Mr. K. Jabbour, Licensing Project Manager - Hatch

U.S. Nuclear Regulatory Commission, Region II  
Mr. S. D. Ebner, Regional Administrator  
Mr. L. D. Wert, Senior Resident Inspector - Hatch

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1) <b>PLANT HATCH, UNIT 2</b>	DOCKET NUMBER (2) <b>05000366</b>	PAGE (3) 1 OF 4
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TITLE (4)  
**PERSONNEL ERROR RESULTS IN AN UNPLANNED ESF 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)
01	27	92	92	002	00	02	19	92		05000
										05000

OPERATING MODE (9) 4	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)									
POWER LEVEL 000	20.402(b)	20.405(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)					
	20.405(a)(1)(i)	50.36(c)(1)	<input type="checkbox"/>	50.73(a)(2)(v)	73.71(c)					
	20.405(a)(1)(ii)	50.36(c)(2)	<input type="checkbox"/>	50.73(a)(2)(vii)	OTHER (Specify in					
	20.405(a)(1)(iii)	50.73(a)(2)(i)	<input type="checkbox"/>	50.73(a)(2)(viii)(A)	Abstract below)					
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	<input type="checkbox"/>	50.73(a)(2)(viii)(B)						
	20.405(a)(1)(v)	50.73(a)(2)(iii)	<input type="checkbox"/>	50.73(a)(2)(x)						

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>STEVEN B. TIPPS, MANAGER NUCLEAR SAFETY AND COMPLIANCE, HATCH</b>	TELEPHONE NUMBER 912 367-7851
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COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO
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EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (16)

On 1/27/92 at 1017 CST, Unit 2 was in the Cold Shutdown mode. At that time, Group 5 Primary Containment Isolation System valve 2G31-F001 closed on a Reactor Water Cleanup (RWCU) system high differential flow isolation signal. Licensed Operations personnel verified that the automatic isolation signal was not valid. No actual system leakage occurred. The signal occurred as Instrument & Control (I&C) technicians were performing a monthly scheduled surveillance on RWCU differential flow instruments 2G31-N603A & B in accordance with procedure 57SV-G31-002-2S, "RWCU System Differential Flow Instrument FT&C." Per the procedure, jumpers had been placed in the high differential flow trip logic to preclude closure of Group 5 isolation valves 2G31-F001 and F004 during the surveillance. While closing a link in the isolation logic for 2G31-F001, the jumper in that circuit was accidentally bumped, causing it to disengage from the circuit. This resulted in a closure signal being generated by the isolation logic and the valve closed per design. By approximately 1032 CST, the isolation signal was reset; valve 2G31-F001 was reopened; procedure 57SV-G31-002-2S was completed satisfactorily; and the RWCU system was returned to service.

The cause of the event was personnel error. A non-licensed I&C technician performing the surveillance inadvertently bumped and disengaged a jumper resulting in closure of the valve. The involved technician was counseled. It should be noted that the involved jumper was a shielded banana plug type which is specifically intended to minimize the potential for this type event.

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TEXT CONTINUATION

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PLANT HATCH, UNIT 2	05000366	92	002	00	2	OF 4

TEXT

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor  
Energy Industry Identification System codes are identified in the text as (EIIS Code XX).

DESCRIPTION OF EVENT

On 1/27/92 at 0810 CST, Unit 2 was in the Cold Shutdown mode with reactor pressure at atmospheric. The Reactor Water Cleanup (RWCU, EIIS Code CE) system was in service with pump 2G31-C001B running. At that time, non-licensed Instrument & Control (I&C) technicians were performing functional testing of RWCU differential flow instruments 2G31-N603A and -N603B per procedure 57SV-G31-002-2S, "RWCU System Differential Flow Instrument FT&C." These instruments are tested every 31 days to comply with Unit 2 Technical Specifications Table 4.3.2-1, item 3.a. Per the procedure, the technicians placed a jumper across links HH-21 and HH-22 in the isolation logic for inboard Group 5 Primary Containment Isolation System (PCIS, EIIS Code JM) valve 2G31-F001. Similarly, a jumper was placed across links CCC-1 and CCC-2 in the isolation logic for outboard Group 5 PCIS valve 2G31-F004. These jumpers prevent an automatic isolation from occurring due to high differential flow signals which are generated during the surveillance.

At 1017 CST, while closing one of the links in the isolation logic for the inboard valve, the technician performing the surveillance inadvertently bumped the jumper, causing it to disengage from that link. At this time, licensed Control Room personnel received the RWCU leak detection system (LDS, EIIS Code LJ) annunciator on Panel 2H11-P602. The LDS alarm was followed by the trip of the RWCU pump and an actuation of the Group 5 PCIS involving only the inboard isolation valve 2G31-F001. Disengaging the jumper from its link resulted in a closure signal being generated by the 2G31-F001 isolation logic, and the valve closed per design. The isolation logic systems for the inboard and outboard valves are independent of each other; consequently, removing the jumper from the inboard logic affected only the inboard valve. The outboard valve was not affected.

Operations personnel entered abnormal operating procedure 34AB-OPS-050-2S, "RWCU System Isolation," and verified no actual system leakage had occurred. By approximately 1023 CST, the isolation signal was reset and valve 2G31-F001 was reopened. Procedure 57SV-G31-002-2S was then completed satisfactorily. The RWCU system was placed back in service in accordance with procedure 34SO-G31-003-2S, "Reactor Water Cleanup System," on 1/27/92 at approximately 1032 CST.

CAUSE OF EVENT

The root cause of this event was personnel error. While performing procedure 57SV-G31-002-2S, a non-licensed I&C technician inadvertently bumped and disengaged a jumper resulting in closure of isolation valve 2G31-F001. It should be noted that the involved jumper was a shielded banana plug type which is specifically intended to minimize the potential for this type event.

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TEXT

REPORTABILITY ANALYSIS AND SAFETY ASSESSMENT

This event is reportable per 10 CFR 50.73(a)(2)(iv) because an unplanned actuation of an Engineered Safety Feature (ESF) occurred. Specifically, the PCIS Group 5 inboard isolation valve, 2G31-F001, closed in response to a high differential flow isolation signal. The isolation signal was generated when a jumper was inadvertently disengaged during the performance of a routine functional test of the RWCU high differential flow logic system.

The purpose of the RWCU Leak Detection System is to detect leakage in the process flow of the RWCU system external to the primary containment (EHS Code NH) and to mitigate the consequences of such leakage. This is accomplished by using leak detection instrumentation which initiates closure of the Group 5 PCIS isolation valves upon detecting a parameter indicative of a system leak.

One of the methods used for detecting system leakage is flow comparison of the RWCU system influent and effluent. If the influent exceeds the effluent by a predetermined amount, a high differential flow condition exists and an isolation of the Group 5 PCIS valves is initiated. In the event addressed in this report, a condition of high differential flow was sensed when an I&C technician inadvertently disengaged a jumper, sealing in an isolation signal and actuating the inboard channel of the isolation logic. No actual system leakage occurred as was verified by the Control Room personnel.

Based on the above, it is concluded that this event had no adverse impact on nuclear safety. This analysis is applicable to all operating conditions.

CORRECTIVE ACTIONS

1. The Group 5 PCIS isolation signal for valve 2G31-F001 was reset; 2G31-F001 was reopened, and the RWCU system was returned to service.
2. Procedure 57SV-G31-002-2S was completed satisfactorily.
3. The involved I&C technician was counseled.

ADDITIONAL INFORMATION

No systems other than the RWCU system and the PCIS were affected by this event.

No failed components caused or resulted from this event.

**LICENSEE EVENT REPORT (LER)  
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Events reported in the last two years in which an unplanned ESF actuation occurred when personnel inadvertently bumped equipment were described in the following LERs:

50-321/91-002, dated 03/01/91  
 50-321/91-003, dated 07/09/91

Corrective actions for these events would not have prevented this event because they involved different personnel.