NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
McGuire Nuclear Station Unit 1	0 5 0 0 0 3 6 9	1 OF 0 2

TITLE (4)
Inadvertent Actuation of Reactor Trip Breaker

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 NAMES	DOCKET NUMBER(S)
0 7	0 2	8 4	8 4	0 2 1	0 0	0 8	0 7	8 4		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)								
POWER LEVEL (10)	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 and in Text, NRC Form 366A)	
			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
Scott Gewehr - Licensing	AREA CODE 7 0 4 3 7 3 - 7 5 8 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

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 fifteen single-space typewritten lines) (16)

On July 2, 1984, at about 1430 hours, the reactor trip breaker of Train A (RTB-A) was inadvertently opened during testing. The train had been declared inoperable for the testing and bypass Breaker A of the solid state protection system (BYB-A) had been closed; therefore the unit which was operating at 100% power, did not trip. The cause of the event was twofold: 1) an Instrumentation and electrical (IAE) specialist misread a procedure, and 2) the procedure was deficient in that it used many "Notes" and "Cautions" which may require actions to be taken. The procedure has been rewritten, and all IAE personnel have reviewed the incident.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

At 1429 on July 2, 1984 the Train A reactor trip breaker (RTB-A) was inadvertently opened during the performance of Period Testing of the Solid Station Protection System (SSPS), by the appropriate procedure. The procedure was misread by Instrument and Electrical (IAE) Specialist A and communicated to IAE Specialist B, who was performing the steps. Specialist A read a "Note" as an action statement and placed the "Input Error Inhibit" switch into the "Normal" position. This action was completed prior to reading the "CAUTION", which required that blocks be installed. These blocks would be installed before placing the "Input Error Inhibit" switch in the "Normal" position. Not installing the blocks caused the "NIS Hi Flux I/R Reactor Trip" and "NIS Hi Flux Lo Setpoint P/R Reactor Trip" signals to open RTB-A. The reactor trip bypass breaker A, BYB-A, was closed at the start of the test, bypassing the RTB-A, and remained closed for the duration of the test. Therefore, opening the RTB-A did not result in a reactor trip.

IAE Specialist A failed to follow the procedure as he misread the "NOTE" statement and took action by placing the "Input Error Inhibit" switch into the "Normal" position, which was not be performed until the blocks were installed. A Procedural Deficiency is also assigned because the procedure uses numerous "NOTES" and "CAUTIONS" which may require the technician to take some action.

This test is performed four times per month (Train A and Train B on Unit 1 and 2) by qualified IAE technicians.

The two IAE Specialists who performed the test on July 2, had performed this test numerous times and were both very knowledgeable of the system and the procedure. IAE Specialist A was reading the procedure steps and communicating the appropriate action to IAE Specialist B. IAE Specialist A misread the "NOTE" and told IAE Specialist B to place the "Input Error Inhibit" switch into the "Normal" position. He did this prior to reading the "CAUTION" which required performing steps 12.9.7, 12.9.8, and 12.9.9.

This monthly functional test has been a continuing source of problems and has contributed to several reactor trips. The procedure has been improved and even rewritten in an effort to reduce the inadvertent reactor trips. The Human Engineering Deficiency (HED) group has been reviewing this procedure since May, 1984. On July 3, a member of HED met with IAE personnel to present their recommendations concerning improvements to this procedure. One of the areas of improvement concerned the "NOTES" and "CAUTIONS" in the procedure, such as in section 12.7. A total of thirty-six recommendations were made by HED to improve this procedure, thirty of which have now been incorporated. The other six recommendations involved changes which could not be incorporated and were deemed unnecessary after discussion with the HED evaluator. IAE personnel have reviewed the event. This event had no impact on the health and safety of the public.

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August 7, 1984

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

Subject: McGuire Nuclear Station, Unit 1
Docket No. 50-369
LER 369/84-20

Gentlemen:

Pursuant to 10 CFR 50.73 Sections (a) (1) and (d), attached is Licensee Event Report 369/84-21 concerning an inadvertent actuation of a reactor trip breaker which is submitted in accordance with §50.73.(a)(2) (iv). Initial notification of this event was made (pursuant to §50.72 Section (b) (2)(ii) with the NRC Operations Center via the ENS on July 2, 1984. This event was considered to be of no significance with respect to the health and safety of the public.

It should be noted that this report was due August 1, 1984. However, due to an administrative error, which was largely caused by the fact that responsibility for preparing these reports changed hands the day before this event occurred, this report is submitted late.

Very truly yours,

Hal B. Tucker

SAG/mjf

Attachment

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