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C. K. McCoy Vice President, Nuclea Vogtle Project



March 27, 1992

ELV-03589 001367

Docket No. 50-425

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

Gentlemen:

# VOGTLE ELECTRIC GENERATING PLANT !ICENSEE EVENT REPORT REACTOR TRIP DUE TO PERSONNEL ERROR WHILE INVESTIGATING TROUBLE ALARMS

In accordance with 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed report related to an event which occurred on March 9, 1992.

Sincerely,

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CKM/NJS/gmb

Enclosure: LER 50-425/1992-002

xc: Georgia Power Company Mr. W. B. Shipman Mr. M. Sheibani NORMS

> <u>U. S. Nuclear Regulatory Conmission</u> Mr. S. D. Ebneter, Regional Administrator Mr. D. S. Hood, Licensing Project Manager, NRR Mr. B. R. Bonser, Senior Resident Irspector, Vogtle

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On March 9, 1992, 125 volt dc switchgear trouble alarms began to intermittently annunciate in the control room. The control building operator (CBO) was dispatched to investigate. In the the switchgear room, the CBO looked for trouble indications but found none. While scanning the breakers, the CBO noticed that two of the circuit breakers had a yellow dot that he had not seen before. Suspecting that the dots were either stick-on tabs used for labeling or indication flags, the CBO depressed the yellow dot on breaker No. 8. The dot recessed, and the breaker switch went to the tripped position.

When breaker No. 8 tripped, 125 volt DC control power was lost to the electrical Train A main steam isolation valves (MSIVs), main feedwater isolation valves (MFIVs), and bypass feedwater isolation valves (BFIVs). These valves failed closed, as designed, isolating feedwater flow to and steam flow from the steam generators (SGs). Within seconds, the reactor coolant system (RCS) pressurizer pressure rose to its trip setpoint, due to the loss of a heat sink, and a reactor trip occurred.

The cause of this event was a cognitive personnel error by the CBO. Although the CBO had not been taught that the yellow dot was a trip test pushbutton, operator training advises personnel to request direction from supervision when unsure of how to proceed. The CBO was counseled.

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#### A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(iv) because an unplanned reactor protection system (RPS) actuation occurred.

### B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was operating in Mode 1 (Power Operation) at 80 percent of rated thermal power. Other than that described herein, there was no inoperable equipment which contributed to the occurrence of this event.

## C. DESCRIPTION OF EVENT

On March 9, 1992, at approximately 2015 EST, Train A 125 volt dc switchgear trouble alarms began to intermittently annunciate in the control room. The control building operator (CBO) was dispatched to investigate. Upon entering the switchgear .oom, the CBO opened the cabinet door to panel 2AD12, and looked for trouble indications but found none. While scanning the breakers, the CBO noticed that two of the breakers had a yellow dot that he had not seen before. Suspecting that the dots were either stick-on tabs used for labeling or indication flags, the CBO depressed the yellow dot on breaker No. 8. The dot recessed and the breaker switch went to the tripped position.

When breaker No. 8 tripped, 125 volt dc control power was lost to the electrical Train A main steam isolation valves (MSIVs), main feedwater isolation valves (MFIVs), and bypass feedwater isolation valves (BFIVs). These valves failed closed as designed, isolating feedwater flow to and steam flow from the steam generators (SGs). Within seconds, the reactor coolant system (RCS) pressurizer pressure rose to its trip setpoint of 2385 psig due to the loss of a heat sink, and a reactor trip occurred at 2025 EST.

A pressurizer power operated relief valve (PORV) opened to relieve RCS pressure. Also, atmospheric relief valves and several safety valves opened to relieve SG pressure. When SG water levels decreased to their low-low setpoint, the auxiliary feedwater (AFW) system actuated to provide feed to the SGs. A normal reactor trip recovery ensued.

#### D. CAUSE OF EVENT

The cause of this event was a cognitive personnel error by the Georgia Power Company CBO. Although the CBO had not been taught that the yellow dot was a trip test pushbutton, operator training advises personnel to request direction from supervision when unsure of how to proceed. There were no unusual characteristics of the work location which contributed to the occurrence of this event.

The cause of the switchgear trouble alarms is suspected to be an intermittent ground condition. Troubleshooting will be conducted during the ongoing refueling outage and post-outage period, as necessary.

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## E. ANALYSIS OF EVENT

The reactor trip occurred as designed when pressurizer pressure reached its high pressure setpoint. A PORV opened to relieve RCS pressure and both atmospheric relief valves and safety valves opened to relieve SG pressure. A normal reactor trip ensued and recovery from the trip was appropriately handled by control room personnel. 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

The CBO was counseled and reminded of the importance of requesting assistance when confronted with unfamilar conditions. Furthermore, shift briefings have been conducted to inform the operations staff of this event and the proper course of action to pursue under similar circumstances.

Operator training will be enhanced to include the operation of the trip test pushbutton for this type breaker. This information will be included in lesson plans for the next training cycles.

#### G. ADDITIONAL INFORMATION

- Failed Components: None
- 2. Previous Similar Events: None
- 3. Energy Industry Identification System Code: Reactor Goolant System - AB Main Steam System - SB 125 volt dc Class 1E Power System - EJ Auxiliary Feedwater System - BA