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Georgia Power

the southern electric system

May 11, 1992

ELV-03732
001689

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
PARTIAL SAFETY INJECTION ACTUATION WHILE TESTING
DUE TO PROCEDURE INADEQUACY AND PERSONNEL ERROR

In accordance with 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed report related to an event which occurred on April 23, 1992.

Sincerely,

C.K.M. '9
C. K. McCoy

CKM/NJS/gmb

Enclosure: LER 50-425/1992-004

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

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

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **VOGTLE ELECTRIC GENERATING PLANT - UNIT 2** DOCKET NUMBER (2) **05000425** PAGE (3) **1 OF 3**

TITLE (4) **PARTIAL SAFETY INJECTION ACTUATION WHILE TESTING, DUE TO PROCEDURE INADEQUACY AND PERSONNEL ERROR**

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)
04	23	92	92	004	00	05	11	92			05000
											05000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)

OPERATING MODE (9)	20.402(b)	20.405(c)	X	50.73(a)(2)(iv)	73.71(b)
5	20.405(a)(1)(i)	50.36(c)(1)		50.73(a)(2)(v)	73.71(c)
POWER LEVEL	20.405(a)(1)(ii)	50.36(c)(2)		50.73(a)(2)(vii)	OTHER (Specify in Abstract below)
0	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
MEHDI SHEIBANI, NUCLEAR SAFETY AND COMPLIANCE	706 926-3209

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NRPDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (16)

On April 25, 1992, with the unit in cold shutdown for a refueling outage, personnel were performing Technical Specification (TS) surveillance testing. At the completion of this testing, the reactor operator (RO) was resetting engineered safety feature (ESF) actuation signals following the "as required" procedural guidance. This included resetting the handswitch for "Low Stm Press SI/SLI Block/Reset Trn-A 2-HS-40068." This handswitch resets/removes a block which prevents the initiation of a safety injection (SI) signal upon sensing low pressure in the main steamline. At 0105 EDT, the RO moved the mode selector switch on the Train A solid state protection system (SSPS) logic test panel to "operate." This enabled a Train A SI actuation signal since the low steamline pressure signal was present. Control room personnel observed annunciators indicating that a SI, containment isolation, containment ventilation isolation, and a control room isolation had occurred. Control room personnel verified that no valid SI condition existed and restored the systems to their normal configurations.

The causes of this event were an inadequate procedure and a personnel error. Resetting the block handswitch allowed the SI actuation signal on low steamline pressure to complete the actuation logic when the SSPS mode selector switch was taken to "operate." Although the procedure directed that a series of steps be performed "as required," it did not specifically direct the operator when these steps would be required. Additionally, the RO failed to question the applicability of the "as required" statement. The procedure has been revised to correct the deficiency, and operator training will emphasize proper application of "as required" statements.

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		YEAR	SEQ NUM	REV			
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TEXT

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 the safety injection (SI) signal actuated.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was in Mode 5 (cold shutdown) for a refueling outage, at 0 percent of rated thermal power. The reactor coolant system (RCS) was at 188 degrees-F and 337 psig with the Train A residual heat removal system in service and with a pressurizer steam bubble established. The SI pumps were tagged out of service as required by the Technical Specifications. Other than that described herein, there was no inoperable equipment which contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On April 23, 1992, personnel were performing Technical Specification surveillance testing per Procedure 14703-2, "Reactor Trip Bypass Breaker Undervoltage Trip TADOT." Upon completion of this testing, the affected equipment was being restored to service. The reactor operator (RO) was resetting ESF actuation signals following the "as required" procedural guidance. This included resetting the handswitch for "Low Stm Press SI/SLI Block/Reset Trn-A 2-HS-40068." This handswitch resets/removes a block which prevents the initiation of a SI signal upon sensing low pressure in the main steamline. At 0105 EDT, the RO moved the mode selector switch on the Train A solid state protection system (SSPS) logic test panel to "operate." This enabled a Train A SI actuation signal because the low steamline pressure signal was present. Control room personnel observed annunciators indicating that a SI, containment isolation, containment ventilation isolation, and a control room isolation had occurred. Several Train A components actuated as expected to implement the various ESF actuations. Control room personnel verified that no valid SI condition existed and began restoring the systems to their normal configurations. This was completed by 0145 EDT.

D. CAUSE OF EVENT

The causes of this event were an inadequate procedure and a personnel error as described below.

Resetting the block handswitch allowed the SI actuation signal on low steamline pressure to complete the actuation logic when the SSPS mode selector switch was taken to "operate." In the past, operators had not reset the block handswitch at this step of the procedure because they did not believe it was "required." However, the procedure was deficient because it did not specifically direct the operator as to when this step was required. Resetting this block should not be performed below the reactor coolant system (RCS) P-11 setpoint.

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TEXT

An additional factor contributing to the occurrence of this event was that the RO had just satisfactorily completed a similar procedure that did not include this step of resetting the block handswitch.

Another cause of this event was the failure of the RO to question the applicability of the "as required" procedure statement. There were no unusual characteristics of the work location which contributed to the occurrence of this cognitive personnel error.

E. ANALYSIS OF EVENT

During this event, the Train A charging pump injected approximately 805 gallons of 2460-ppm boron solution. This charging pump was running prior to the SI signal, providing normal makeup service. Also, since the unit was in cold shutdown, the injection did not result in a thermal cycle on the reactor vessel and associated piping. 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 procedure step to reset the 2-HS-40068 block handswitch has been deleted.
2. Other SSPS test procedures will be reviewed by June 15, 1992, to ensure proper application of the block handswitch.
3. Onshift licensed and nonlicensed operators will be briefed on this event, and lessons learned from it, by June 1, 1992.

G. ADDITIONAL INFORMATION

1. Failed Components:
None
2. Previous Similar Events:
None
3. Energy Industry Identification System Code:
 Safety Injection System - BQ
 Reactor Coolant System - AB
 Reactor Protection System - AA
 Solid State Protection System - JG
 Containment Isolation Control System - JM
 Control Room Essential HVAC - VI