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C. K. McCoy
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Georgia Power
the southern electric system

June 4, 1992

ELV-03765
001743

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
SAFETY INJECTION PUMP START
DURING SURVEILLANCE TESTING

In accordance with 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed revised report related to an event which occurred on August 13, 1991. This revision is necessary since the original report stated that a malfunctioning reset switch would be replaced during the Spring 1992 refueling outage. A replacement switch was not delivered in time for installation during this outage and the installation has been rescheduled for the Fall 1993 refueling outage.

Sincerely,

C. K. McCoy

CKM/NJS/gmb

Enclosure: LER 50-425/1991-009, Revision 1

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

IE22
1/1

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)
SAFETY INJECTION PUMP START DURING SURVEILLANCE TESTING

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
0 8	1 3	9 1	9 1	0 0 9	0 1	0 6	0 4	9 2		0 5 0 0 0

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

OPERATING MODE (9)	1								
POWER LEVEL	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)
			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	
MEHDI SHEIKANI, NUCLEAR SAFETY AND COMPLIANCE	706	826-3209

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	
X	J C	H S	W 1 2 0	Y							

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES(If yes complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (16)

On 8-13-91, personnel were performing Technical Specification (TS) surveillance testing of slave relay K610 from the solid state protection system (SSPS) test cabinet in the control room. The appropriate leads had been lifted to prevent equipment actuation while relay K610 was energized. Following testing, reset switch S-921 was taken to the "Reset" position to deenergize relay K610, and at 0124 CDT, the previously disconnected leads were reconnected. At that moment, personnel in the control room observed the starting of a group of Train B equipment, including safety injection pump (SIP) B. The SIP did not inject water into the reactor coolant system (RCS) because the normal RCS pressure, which existed at the time, was higher than the shutoff head of the SIP. Operators again took switch S-921 to the reset position and visually verified that the K610 relay deenergized. The equipment which had actuated was returned to standby status at approximately 0200 CDT.

The cause of this event was the intermittent failure of reset switch S-921 which will be replaced during the Fall 1993 refueling outage.

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.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was operating in Mode 1 (Power Operations) at 100% 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 8-13-91, personnel were performing Technical Specification (TS) surveillance testing of slave relay K610 per procedure 14619-2, "SSPS Slave Relay K610 Train B Test Safety Injection," from the solid state protection system (SSPS) test cabinet in the control room. The appropriate leads had been lifted to prevent equipment actuation while relay K610 was actuated. Following testing, reset switch S-921 was taken to the "Reset" position to deenergize relay K610, and at 0124 CDT, the previously disconnected leads were reconnected. At that moment, personnel in the control room observed the starting of a group of Train B equipment that included safety injection pump (SIP) B, the ESF actuation system sequencer, diesel generator (DG) 2B, and the SIP B room cooler. The SIP did not inject water into the reactor coolant system (RCS) because the normal RCS pressure, which existed at the time, was higher than the shutoff head of the SIP. The operators again took switch S-921 to the reset position and visually verified that the K610 relay deenergized. The equipment which had actuated was returned to standby status at approximately 0200 CDT.

D. CAUSE OF EVENT

The cause of this event was the intermittent failure of reset switch S-921. Troubleshooting determined that the switch may not make adequate contact each time the switch is actuated. Although a panel light indicates a reset has occurred, S-921 is a 6-deck switch which makes it possible for some contacts to be completed while other contacts are not.

E. ANALYSIS OF EVENT

The reset switch is only relied on to reset relays following testing and does not prevent ESF components from actuating. Furthermore, during the 8-13-91 event, ESF components actuated as expected, providing assurance that the appropriate response would have occurred had an actual emergency condition existed. Finally, no safety injection water entered into the RCS, avoiding thermal shock and any abnormal changes in reactor chemistry or reactivity. Based on these considerations, there was no adverse impact on plant safety or the health and safety of the public as a result of this event.

F. CORRECTIVE ACTION

1. Shift briefings were held during which control room personnel were advised of the switch malfunction and the need to verify proper switch operation when it is used.

2. The malfunctioning reset switch will be replaced during the Fall 1993 refueling outage. The original report stated that the reset switch would be replaced during the Spring 1992 refueling outage. However, the replacement switch was not delivered in time to facilitate installation during the Spring 1992 outage.

3. Procedures which govern the testing of slave relays that actuate ESF components were reviewed and changed by 1-1-92 to require additional confirmation that reset has occurred prior to reconnecting ESF actuation system leads.

G. ADDITIONAL INFORMATION

1. Failed Components:

   Reset switch manufactured by Westinghouse Electric Corporation.

   Model #2384A36H01

2. Previous Similar Events:

   None.

3. Energy Industry Identification System Code:

   Solid State Protection System - JC

   Emergency Diesel Generator System - EK

   Safety Injection System - BQ

   Engineered Safety Features Actuation System - JE

   ESF Room Cooler Systems - VF

   Component Cooling Water System - CC

   Nuclear Service Cooling Water System - BS

   Reactor Coolant System - AB