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Georgia Power

the southern electric system

C. K. McCoy  
Vice President, Nuclear  
Vogtle Project

August 13, 1992

ELV-03936  
002071

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  
IMPROPER CALIBRATION OF INSTRUMENT LOOP  
RESULTS IN CONDITION PROHIBITED BY TECHNICAL SPECIFICATIONS

In accordance with 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed report related to an event which occurred on July 16, 1992.

Sincerely,

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

CKM/HJM/gmb

Enclosure: LER 50-425/1992-008

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
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TITLE (4)  
IMPROPER CALIBRATION OF INSTRUMENT LOOP RESULTS IN CONDITION PROHIBITED BY TECH. SPECS.

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)
07	16	92	92	008	00	07	13	92			05000
05000											

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

OPERATING MODE (9) 1	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL 100	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)	X 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 MEHDI SHEIBANI, NUCLEAR SAFETY AND COMPLIANCE	TELEPHONE NUMBER AREA CODE: 706, 826-3209
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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

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (if yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (16)

On July 16, 1992, an instrument and controls (I&C) technician performed a quarterly Technical Specifications (TS) surveillance calibration on the delta-I portion of the loop 2 overtemperature delta T function of the reactor protection system (RPS). Upon completion, the Unit Shift Supervisor was notified, and the loop was returned to service at 1619 EDT.

On July 17, 1992, a review found that the "as-left" voltage calibration values were outside allowable limits. This resulted in the loop 2 overtemperature delta T function being inoperable. Consequently, the unit had operated in a condition prohibited by the TS because the inoperable loop had not been tripped within 6 hours as required by TS table 3.3-1, action statement 6. The inoperable instrument loop was removed from service at 1711 EDT on July 17, 1992, properly calibrated, and returned to service at 1736 EDT.

The causes of this event were an incorrect procedure and a cognitive personnel error by the technician. The surveillance procedure gave incorrect values for determining calibration limits, and the technician failed to realize that the as-left condition of the affected instrument loop was outside allowable limits. The appropriate procedures have been corrected, and appropriate personnel will be disciplined for failing to ensure accuracy of procedures and calibration of TS-related equipment.

**LICENSEE EVENT REPORT (LER)  
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VOGTLE ELECTRIC GENERATING PLANT - UNIT 2

05000425

92

008

00

2

OF 3

TEXT

**A. REQUIREMENT FOR REPORT**

This report is required per 10 CFR 50.73 (a)(2)(i) because the unit operated in a condition prohibited by the Technical Specifications (TS) when an improperly calibrated instrument loop was restored to service and relied on to meet TS requirements.

**B. UNIT STATUS AT TIME OF EVENT**

At the time of this event, Unit 2 was operating in Mode 1 (power operations) at 100 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 July 16, 1992, an instrument and controls (I&C) technician performed a quarterly TS surveillance calibration on the delta-I portion of the loop 2 overtemperature delta T function of the reactor protection system (RPS) per Procedure 24811-2, "Delta T/Tavg Loop 2 Protection Channel II 2T-421 Analog Channel Operational Test And Channel Calibration." Upon completion, the Unit Shift Supervisor was notified, and the loop was returned to service at 1619 EDT.

On July 17, 1992, another I&C technician performed the quarterly TS surveillance calibration on the delta-I portion of the corresponding loop 4 instrumentation using Procedure 24813-2, "Delta T/Tavg Loop 4 Protection Channel IV 2T-441 Analog Channel Operational Test And Channel Calibration." During the process, he discovered a procedure discrepancy which prohibited proper loop calibration. The procedure was corrected, and the loop was properly calibrated and restored to service at 1637 EDT.

A review of Procedure 24811-2 and the surveillance task sheet completed for loop 2 on July 16, 1992 found the same procedure discrepancy. Also, the review found another problem in that the "as-left" voltage calibration values were outside allowable limits. This resulted in loop 2 of the overtemperature delta T function being inoperable. Consequently, the unit had operated in a condition prohibited by the TS because the loop had not been tripped within 6 hours as required by TS table 3.3-1, action statement 6. The inoperable instrument loop was removed from service at 1711 EDT on July 17, 1992, properly calibrated, and returned to service at 1736 EDT. The corresponding instrument loops on Unit 1 and loops 1 and 3 on Unit 2 were not affected by these discrepancies because they had not been calibrated with the incorrect values.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

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TEXT

D. CAUSE OF EVENT

The causes of this event were an incorrect procedure and a cognitive personnel error by the technician. The surveillance procedure gave incorrect values for determining calibration limits due to an error in the typing process whereby a change was inserted into a section of the procedure that was not required and, consequently, was not reviewed for correctness. The personnel error occurred when the Georgia Power Company technician failed to realize that the as-left condition of the affected instrument loop was outside allowable limits. There were no unusual circumstances of the work location which contributed to the occurrence of this event.

E. ANALYSIS OF EVENT

The result of the improper calibration was that, for 24 hours and 52 minutes, only three instrument loops were available to initiate a RPS actuation rather than the four loops that were assumed to be available. However, no event occurred during this period which required RPS actuation, and there is no reason to suspect that the operable instrument loops would not have performed an actuation if one had been required. 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 ACTION

1. The personnel responsible for the procedural and calibration inaccuracies have been disciplined. By August 17, 1992, meetings will be held with appropriate personnel to emphasize the importance of accuracy of procedures and the calibration of TS-related equipment.
2. Procedure 24811-2 and similar loop calibration procedures have been corrected to prevent the possibility of future improper calibrations.

G. ADDITIONAL INFORMATION

1. Failed Components:  
None
2. Previous Similar Events:  
None
3. Energy Industry Identification System Code:  
Reactor Protection System - AC