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NRC Form 366A (9-63)	LICI	ENSEE EV	ENT REPO	ORT (LER) TEXT CONTINUATION APPROVED OMB NO. 31 EXPIRES: 8-31/96																	
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A. REPORTABLE OCCURRENCE

TEXT Iff more space is required, use additional NRC Form 3664's) (17)

On December 8, 1987 at 0340 during restoration steps of a surveillance test procedure, procedural actions were performed out of sequence due to personnel error. These actions caused an inadvertent Division II Loss of Coolant Accident (LOCA) signal which actuated the Combustible Gas Control System. This incident is reportable pursuant to 10CFR50.73(a)(2)(iv).

B. INITIAL CONDITION

At the time of the event, the plant was shutdown for a scheduled refueling outage with Division II inoperable for maintenance work and surveillance testing. Reactor Water Cleanup System (RWCU) pumps were in operation with the reactor vessel head removed and upper cavity flooded.

C. DESCRIPTION OF OCCURRENCE

On December 8, 1987 during restoration from surveillance procedure "RHR Containment Spray Initiation Logic System Functional Test," a licensed reactor operator instructed an Instrumentation and Control (I&C) technician to remove a temporary Emergency Core Cooling System (ECCS) test switch per step 5.2.33 prior to resetting the Residual Heat Removal (RHR) "B"/RHR "C" initiation logic per step 5.2.32.i. This sequence was not the correct sequence of steps for restoration and resulted in an inadvertent Division II LOCA signal and an ESF actuation of the Combustible Gas Control System "B" train. No ECCS injected into the vessel during the event.

Upon actuation, automatic actions were verified by the operators. When the operators determined the cause of the actuation, each of the affected systems was returned to its normal standby lineup. Plant systems were restored to normal lineup at 0400 on December 8, 1987.

D. APPARENT CAUSE

The cause of this event is personnel error due to performance of an action out of sequence as specified by the approved procedure. The surveillance had been successfully run and was in the final steps of restoration when the operator sent I&C technicians to remove the test switch prior to ensuring step 5.2.32.i had been completed. The operator was aware of the need to reset the RHR "B"/RHR "C" initiation logic, but forgot to caution the I&C technician before giving the instruction resulting in the inadvertent actuation.

NRC Form 366A (9-63)		LIC	· · · · · · · · · · · · · · · · · · ·													FULATORY COMMISSION IMB NO. 2150-0104 /86									
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E. SUPPLEMENTAL CORRECTIVE ACTION

The licensed operator was disciplined and counseled on his failure to follow approved procedures verbatim.

F. SAFETY ASSESSMENT

No sefety consequence: resulted from the actuation since all systems functioned as required and Division II was not being relied upon for any of its safety functions. The event resulted in an unnecessary challenge to plant safety systems.



OLIVER D. KINGSLEY, JR. Vice President Nuclear Operations

January 7, 1988

U. S. Nuclear Regulatory Commission Washington, D. C. 20555

Attention: Document Control Desk

Gentlemen:

SUBJECT: Grand Gulf Nuclear Station

Unit 1

Docket No. 50-416 License No. NPF-29

Inadvertent Division II LOCA Signal During Restoration from Surveillance Procedure

LER 87-023-00 AECM-88/0005

Attached is Licensee Event Report (LER) 87-023-00 which is a final report.

Yours Aruly.

ODK: bms Attachment

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Mr. N. S. Reynolds (w/a)

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