

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Prairie Island Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 3 0 6 1 OF 0 12										PAGE (3) 1 OF 0 12																																							
TITLE (4) Reactor Trip Resulting From Inadvertent Safety Injection During Safeguards Logic Testing																																																											
EVENT DATE (5)									LER NUMBER (6)									REPORT DATE (7)									OTHER FACILITIES INVOLVED (8)																																
MONTH			DAY			YEAR			YEAR			SEQUENTIAL NUMBER			REVISION NUMBER			MONTH			DAY			YEAR			FACILITY NAMES													DOCKET NUMBER(S)																			
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OPERATING MODE (9) N									THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																																																		
POWER LEVEL (10) 1 1 0 1 0									20.402(b)									20.406(c)									X 50.73(a)(2)(v)									73.71(b)																							
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									20.406(a)(1)(ii)									50.36(e)(2)									50.73(a)(2)(vii)									OTHER (Specify in Abstract below and in Text, NRC Form 366A)																							
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LICENSEE CONTACT FOR THIS LER (12)																																																											
NAME Arne A Hunstad, Staff Engineer																				TELEPHONE NUMBER AREA CODE 6 1 2 3 8 8 1 - 1 1 2 1																																							
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																																											
CAUSE					SYSTEM					COMPONENT					MANUFACTURER					REPORTABLE TO NRC					CAUSE					SYSTEM					COMPONENT					MANUFACTURER					REPORTABLE TO NRC														
SUPPLEMENTAL REPORT EXPECTED (14)																				EXPECTED SUBMISSION DATE (15)										MONTH DAY YEAR																													
YES (If yes, complete EXPECTED SUBMISSION DATE)																				Y NO																																							

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On July 28, 1986, Unit 2 was operating at 100% power. The monthly safeguards logic test was in progress. The Train A safeguards relay rack was placed in test and a simulated Safety Injection signal was generated. While checking the test lights on the safeguards test panel, one lamp was found burned out and had to be replaced. At 0801, while the test light was being replaced, due to miscommunication the control room operator mistakenly reset Train A Safety Injection; this released Train A from test and initiated a safety injection signal. Unit 2 tripped and all Train A safeguards equipment was actuated.

Primary cause of the event was miscommunication between the personnel performing the test in the Relay Room and the Control Room.

Operators instituted normal trip recovery procedures. The event was discussed with the involved personnel. The test procedure has been reviewed and found to be correct; however, a revision is being considered that would clarify the criteria for resetting a safety injection train.

Safeguards logic testing has resulted in several reactor trips and safety injection actuations on both units, but only one such event has occurred since reporting of these events has been required. That event is described in Unit 2 LER 86-001.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1) Prairie Island Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 0 6 8 6 - 0 0 3 - 0 0 0 2 OF 0 2	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

TEXT (If more space is required, use additional NRC Form 366A's) (17)

EVENT DESCRIPTION

On July 28, 1986, Unit 2 was operating at 100% power. The monthly safeguards logic test was in progress and communications were established between the control room and the safeguards relay racks (RK). The rack was placed in "test" and the test condition was verified by the control room annunciator (ANN) and by the test lights on the safeguards rack. A Safety Injection (SI) signal was then generated by simulating low steam line pressure from two of three channels to satisfy the logic and to verify continuity of the slave relays. During the slave relay continuity verification, one of the test lights on the safeguards test panel was found burned out and had to be replaced.

At 0801, while the personnel at the safeguards test panel were replacing the burned out test light, the control room operator mistakenly thought he heard a request to reset the Safety Injection train. The control room operator then reset Train A Safety Injection, which released Train A from test and initiated a safety injection signal. Unit 2 tripped and all Train A safeguards equipment was actuated.

CAUSE

The primary cause of the event was miscommunication between the test personnel in the Relay Room and the Control Room. Contributing factors to the miscommunication were confusion resulting from the delay in the test while the test light was replaced and the poor quality of the phone line being used. The sound-powered phone line used in the test had a poor signal-to-noise ratio at the time of the event; the personnel involved had planned to find a better line after the evolution they were performing was completed.

SAFETY CONSIDERATIONS

This event is reportable under 10CFR50.73(a)(2)(iv). There was no effect on public health and safety since all systems operated as required. The unit was restarted at 0021 the next day; the delay in restart was due to the need to replace one source range/intermediate range detector assembly and because of end-of-cycle reactivity considerations.

CORRECTIVE ACTIONS

Operators instituted normal trip recovery procedures. The event was discussed with the involved personnel. The test procedure has been reviewed and found to be correct; however, a revision is being considered that would clarify the criteria for resetting a safety injection train.

SIMILAR PREVIOUS EVENTS

Safeguards logic testing has resulted in several reactor trips and safety injection actuations on both units, but only one such event has occurred since reporting of these events has been required. That event is described in Unit 2 LER 86-001.



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August 27, 1986

U S Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

PRAIRIE ISLAND NUCLEAR GENERATING PLANT
Docket Nos. 50-282 License Nos. DPR-42
50-306 DPR-60

Reactor Trip Resulting From Inadvertent Safety
Injection During Safeguards Logic Testing

The Licensee Event Report for this occurrence is attached.

This event was reported via Emergency Notification System per 10 CFR Part 72
on July 28, 1986.

Eugene Eckholt

for David Musolf
Manager - Nuclear Support Services

DMM/EFE/efe

c: Regional Administrator-III, NRC
NRR Project Manager, NRC
Resident Inspector, NRC
MPCA
Attn: F W Ferman

Attachment

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