

PRIORITY 1

(ACCELERATED RIDS PROCESSING)

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9510120233 DOC.DATE: 95/10/09 NOTARIZED: NO DOCKET #
FACIL:50-316 Donald C. Cook Nuclear Power Plant, Unit 2, Indiana M 05000316
AUTH.NAME AUTHOR AFFILIATION
NICHOLS,W. Indiana Michigan Power Co. (formerly Indiana & Michigan Ele
BLIND,A.A. Indiana Michigan Power Co. (formerly Indiana & Michigan Ele
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 95-006-00:on 950908,Unit 2 reactor thermal power trip
occurred.Caused by cognitive error by operations personnel.
Surveillance procedure revised to add caution on operation
of reactor trip breaker control switch.W/951009 ltr.

DISTRIBUTION CODE: IE22T COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 4
TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

NOTES:

RECIPIENT ID CODE/NAME	COPIES LTTR ENCL	RECIPIENT ID CODE/NAME	COPIES LTTR ENCL
PD3-1 PD	1 1	HICKMAN,J	1 1
INTERNAL: AEOD/SPD/RAB	2 2	AEOD/SPD/RRAB	1 1
FILE CENTER	1 1	NRR/DE/ECGB	1 1
NRR/DE/EELB	1 1	NRR/DE/EMEB	1 1
NRR/DISP/PIPB	1 1	NRR/DRCH/HHFB	1 1
NRR/DRCH/HICB	1 1	NRR/DRCH/HOLB	1 1
NRR/DRPM/PECB	1 1	NRR/DSSA/SPLB	1 1
NRR/DSSA/SPSB/B	1 1	NRR/DSSA/SRXB	1 1
RES/DSIR/EIB	1 1	RGN3 FILE 01	1 1
EXTERNAL: L ST LOBBY WARD	1 1	LITCO. BRYCE,J H	2 2
NOAC MURPHY,G.A	1 1	NOAC POORE,W.	1 1
NRC PDR	1 1	NUDOCS FULL TXT	1 1

NOTE TO ALL "RIDS" RECIPIENTS:

PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL
DESK, ROOM OWFN 5D8 (415-2083) TO ELIMINATE YOUR NAME FROM
DISTRIBUTION LISTS FOR DOCUMENTS YOU DON'T NEED!

FULL TEXT CONVERSION REQUIRED
TOTAL NUMBER OF COPIES REQUIRED: LTTR 26 ENCL 26

Indiana Michigan
Power Company
Cook Nuclear Plant
One Cook Place
Bridgman, MI 49106
616 465 5901



October 9, 1995

United States Nuclear Regulatory Commission
Document Control Desk
Rockville, Maryland 20852

Operating Licenses DPR-74
Docket No. 50-316

Document Control Manager:

In accordance with the criteria established by
10 CFR 50.73 entitled Licensee Event Report System, the
following report is being submitted:

95-006-00

Sincerely,

A. Alan Blind

A. A. Blind
Plant Manager

/clc

Attachment

c: H. J. Miller, Region III
E. E. Fitzpatrick
P. A. Barrett
R. F. Kroeger
M. A. Bailey - Ft. Wayne
S. J. Brewer
M. R. Padgett
G. Charnoff, Esq.
D. Hahn
Records Center, INPO
NRC Resident Inspector

120610

9510120233 951009
PDR ADDECK 05000316
S PDR

IEP
11

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS
INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD
COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION
AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR
REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO
THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF
MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Donald C. Cook Nuclear Plant - Unit 2

DOCKET NUMBER (2)

05000 316

PAGE (3)

1 OF 3

TITLE (4)

Reactor Trip From Reactor Trip Breaker Control Switch Mispositioning Resulting From a Cognitive Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT NUMBER (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
09	08	95	95	006	00	10	09	95	FACILITY NAME	DOCKET NUMBER
										05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING
MODE (9)

1

POWER
LEVEL (10)

100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

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

20.405(a)(1)(iii)

50.73(a)(2)(i)

50.73(a)(2)(viii)(A)

(Specify in Abstract
below and in Text, NRC
Form 366A)

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

W. Nichols, Operations Superintendent

TELEPHONE NUMBER (Include Area Code)

616/465-5901 x2536

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES

(If yes, complete EXPECTED SUBMISSION DATE)

X

NO

EXPECTED
SUBMISSION
DATE (15)

MONTH

DAY

YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 8, 1995 at 2125 hours, while Unit 2 was at 100 percent Reactor Thermal Power, a reactor trip occurred on a manual reactor trip signal. The reactor trip signal resulted from a cognitive error by Operations personnel while supporting a surveillance test on the Solid State Protection System (SSPS). The Reactor Operator improperly placed a reactor trip breaker control switch in the trip position while intending to close the breaker.

Operations personnel implemented plant procedures to verify proper response of the automatic protection systems and to assess plant conditions for initiating recovery actions. All safety systems operated normally in response to the trip signal, and the unit was stabilized in Mode 3, Hot Standby.

Administrative actions have been taken to lessen the possibility of a recurrence, and the Operations Department has developed an action plan to minimize the number of events caused by personnel errors.

It was determined that the health and safety of the public were not jeopardized by this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Donald C. Cook Nuclear Plant - Unit 2	0 5 0 0 0 3 1 6	9 5	— 0 0 6	— 0 0	0 2	OF	0 3

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

Conditions Prior To Event

Unit 2 was in Mode 1, Power Operation, at 100 percent Reactor Thermal Power

Description of Event

On September 8, 1995 at 2125 hours, a reactor trip occurred when the Train A reactor trip breaker (EIIS/AA) control switch was inappropriately placed in the trip position by Operations personnel.

Unit 2 had been in power operation for less than 48 hours. Due to the recent power ascension, the reactor was undergoing a significant xenon transient. To offset the effects of increasing xenon concentration, the Reactor Operator was frequently injecting primary water into the Reactor Coolant System (RCS) (EIIS/AB). In order to start the primary water injection flow, the blender control switch (EIIS/CB) must be momentarily placed in the stop position before it is placed in the start position.

The same individual who was performing the primary water injection was also assigned to support Instrument and Control (I&C) personnel for a surveillance test of Train A Solid State Protection System (SSPS) (EIIS/JG). As a part of the surveillance test, the Train A reactor trip bypass breaker (EIIS/AA) was closed. The Train A reactor trip breaker (EIIS/AA) was then opened, per procedure, at the local panel. The Operations person in the control room was then asked by I&C to close the Train A reactor trip breaker (EIIS/AA) in accordance with the surveillance procedure.

The Reactor Operator, who was in the routine of resetting the blender control switch (EIIS/CB) before starting primary water injection, operated the reactor trip breaker (EIIS/AA) in the same manner, placing the reactor trip breaker control switch in the trip position before it was placed in the closed position. When the control switch was placed in "trip", a manual reactor trip signal was generated which opened both the Train B reactor trip breaker and the Train A reactor trip bypass breaker.

Cause of the Event

The cause of the event was a cognitive error by Operations personnel. The error was a result of preconditioning from working with a system which operated in a different manner.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Donald C. Cook Nuclear Plant - Unit 2	0 5 0 0 0 3 1 6	9 5	— 0 0 6	— 0 0	0 3	OF	0 3

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

Analysis of Event

This event is being reported per the requirements of 10CFR50.73 (a)(2)(iv), as an event that resulted in automatic actuation of the Reactor Protection System. During this event, all Reactor Protection System and Engineering Safety Features responded as designed to mitigate the consequence of the transient. The health and safety of the public were not jeopardized.

Following the reactor trip, all equipment functioned normally. Two of the feedwater isolation valves did not automatically close due to the fact that the automatic closure functions were bypassed per the surveillance procedure in progress. Both feedwater isolation valves were manually closed by the control room personnel upon the reactor trip. Since all four feedwater regulating valves automatically closed upon the reactor trip, this is not a safety concern.

Corrective Actions

The surveillance procedure was revised to add a caution on the operation of the reactor trip breaker control switch. The procedure was also revised to be an "in-hand" procedure.

A placard with the instructions on reactor trip breaker control switch operation has been prepared to aid Operations personnel during Solid State Protection System testing.

Disciplinary actions have been completed for the involved individuals. Training material has been prepared on the lessons learned from the event for continuous training for Operations personnel.

The Operations Department management developed an action plan to minimize events caused by personnel errors. This plan includes long term provisions to improve the quality of operating procedures, enhance the structure of pre-job briefings, and promote a continuously self-checking culture among the operations personnel. The action plan also focuses on establishing and maintaining an environment among the operations personnel in which all personnel, regardless of their experience level, are encouraged to ask questions whenever a doubt exists about plant conditions or system operation. All Operations shift personnel were briefed on the action plan.

Previous Similar Events

LER 315/90-004-00