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C. K. McCoy  
Vice President, Nuclear  
Vogtle Project



Georgia Power

*the southern electric system*

March 24, 1993

ELV-05349

Docket No. 50-424

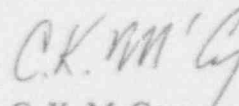
U. S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, D. C. 20555

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT  
LICENSEE EVENT REPORT  
VALVE MISPOSITIONING RESULTS IN  
INOPERABILITY OF BOTH ECCS SUBSYSTEMS

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company submits the enclosed report related to an event which occurred on March 3, 1993.

Sincerely,

  
C. K. McCoy

CKM/NJS

Enclosure: LER 50-424/1993-001

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 1										DOCKET NUMBER (2) 0 5 0 0 4 2 4				PAGE (3) 1 OF 3		
TITLE (4) VALVE MISPOSITIONING RESULTS IN INOPERABILITY OF BOTH ECCS SUBSYSTEMS																
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 3	0 3	9 3	9 3	0 0 1	0 0	0 3	2 4	9 3					0 5 0 0 0			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)														
1		20.402(b)				20.405(c)				50.73(e)(2)(iv)				73.71(b)		
POWER LEVEL		9 0				20.405(a)(1)(i)				X 50.73(e)(2)(v)				73.71(c)		
		20.405(a)(1)(ii)				50.36(c)(2)				50.73(e)(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)				X 50.73(a)(2)(ii)				50.73(e)(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						
MEHDI SHEIBANI, NUCLEAR SAFETY AND COMPLIANCE										AREA CODE		706 826-3209				
COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORT TO NPRDS						
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO				
ABSTRACT (16)																

On March 3, 1993, while removing one train of the residual heat removal system from service for testing, a valving error caused the opposite train to be inadvertently removed from service. As a result, both subsystems of emergency core cooling were inoperable for a period of approximately 4 minutes. During this time, the unit was operated in a condition prohibited by the Technical Specifications (TS), a condition outside of its design basis, and a condition that alone could have prevented the emergency core cooling system from mitigating the consequences of an accident.

The causes of this event were personnel errors by the operators responsible for closing the valve and verifying that the correct valve was closed. Corrective actions include personnel discipline and conducting shift briefings to advise other personnel of the event.

LICENSEE EVENT REPORT (LER)  
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		YEAR	SEQ NUM	REV			
VOGTLE ELECTRIC GENERATING PLANT - UNIT 1	05000424	93	001	00	2	OF	3

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## A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(i), because the unit was operated per Technical Specification (TS) 3.0.3, that is, in a condition outside of and prohibited by the TS. It is also required per 10 CFR 50.73 (a)(2)(ii) because the unit operated in a condition outside of its design basis when both subsystems of the emergency core cooling system (ECCS) were inoperable. Furthermore, this report is required per 10 CFR 50.73 (a)(2)(v) because the inoperability of both ECCS subsystems represented a condition that alone could have prevented the fulfillment of a safety function needed to mitigate the consequences of an accident.

## B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was operating in Mode 1 (power operation) at 90 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 March 3, 1993, personnel were preparing to perform TS surveillance testing on Train B of the residual heat removal (RHR) system per Procedure 14805-1, "Residual Heat Removal Pump And Check Valve IST And Response Time Tests." The procedure requires closure of the hot leg crosstie isolation valve 1HV-8716A to maintain the Train A RHR pump discharge routing to the reactor coolant system (RCS) piping when the crosstie piping is opened to the refueling water storage tank (RWST). However, at approximately 2130 EST, the reactor operator (RO) inadvertently closed valve 1HV-8716B, rather than 1HV-8716A, and the balance of plant (BOP) operator improperly verified this action. The crosstie piping path to the RWST was subsequently opened to provide a pump discharge path for testing of Train B RHR. Nevertheless, because the 1HV-8716B valve was closed, it was actually the Train A RHR pump discharge that had been opened to the RWST, effectively leaving Train A RHR unable to provide rated flow and, therefore, inoperable. Because Train B RHR was removed from service when the heat exchanger outlet valve was closed at 2134 EST, both ECCS subsystems were now inoperable per TS 3.5.2. Since there is no TS action statement for both ECCS subsystems being inoperable, the unit was operating in a condition prohibited by the TS. The test was started at approximately 2135 EST, but no flow was observed from the Train B RHR pump. The unit shift supervisor (USS) was advised and, at approximately 2136 EST, he noticed that the wrong crosstie isolation valve was closed. At approximately 2138 EST, valve 1HV-8716B was opened and valve 1HV-8716A was closed, effectively restoring Train A RHR to service.

During a control room followup critique of the mispositioning, personnel realized that both ECCS subsystems had been made inoperable during this event and that the unit had operated in a condition prohibited by the TS. At 0250 EST on March 4, 1993, further discussion with plant management resulted in

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VOGTLE ELECTRIC GENERATING PLANT - UNIT 1	0 5 0 0 0 4 2 4	9 3	0 0 1	0 0	3	OF	3

TEXT

the conclusion that this event resulted in the unit being in a condition outside of its design basis and in a condition that alone could have prevented the fulfillment of a safety function needed to mitigate the consequences of an accident. The NRC Operations Center was notified per the appropriate criteria of 10 CFR 50.72.

## D. CAUSE OF EVENT

The causes of this event were cognitive personnel errors by the RO, in closing the wrong valve, and by the BOP operator, in incorrectly verifying that the proper valve was closed. There were no unusual characteristics of the work location which contributed to the occurrence of these errors by the Georgia Power Company operators involved.

## E. ANALYSIS OF EVENT

During this event, the centrifugal charging pumps and safety injection pumps remained available to provide high pressure and medium pressure emergency core cooling water from the RWST had it been needed. Also, Train B RHR would have been available to perform its safety function had operators opened the RHR heat exchanger outlet valve. Furthermore, the risk of core damage imposed on the unit as a result of this event was small due to the short period of time involved (approximately 4 minutes). Finally, no event occurred during this time which necessitated ECCS actuation. Based on these considerations, there was no adverse effect on plant safety or on the health and safety of the public as a result of this event.

## F. CORRECTIVE ACTIONS

1. The RO and the BOP operator have been disciplined.
2. Shift briefings were held to discuss this event and the importance of self-checking and independent verifications.

## G. ADDITIONAL INFORMATION

1. Failed Components:

None

2. Previous Similar Events:

None

3. Energy Industry Identification System:

Residual Heat Removal System - BP

Reactor Coolant System - AB