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C. K. McCoy
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Georgia Power
the southern electric system

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. McCoy

CKM/HWM/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. Ebneter, Regional Administrator
Mr. D. S. Hood, Licensing Project Manager, NRR
Mr. B. R. Bonser, Senior Resident Inspector, Vogtle

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NRC Form 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
VOGTLE ELECTRIC GENERATING PLANT - UNIT 2	0 5 0 0 0 4 2 5	1 of 3

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)
										0 5 0 0 0
0 7	1 6	9 2	9 2	0 0 8	0 0	0	13	92		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)			
POWER LEVEL	1 0 0	20.402(b)	20.405(c)	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 (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	TELEPHONE NUMBER	
	AREA CODE	
MEHDI SHEIBANI, NUCLEAR SAFFTY AND COMPLIANCE	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
☐ YES(If yes, complete EXPECTED SUBMISSION DATE)	☒ NO				

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.

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.

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