William S. Orser
Senior Vice President

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6400 North Dixie Highway
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(313) 586-5201

10CFR50.73

November 20, 1992
NRC-92-0130

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

Reference: Fermi 2
NRC Docket No. 50-341
NRC License No. NPF-43

Subject: Licensee Event Report (LER) No. 92-011

Please find enclosed LER No. 92-011, dated November 20, 1992, for a reportable event that occurred on October 24, 1992. A copy of this LER is also being sent to the Regional Administrator, USNRC Region III.

If you have any questions, please contact Jospeh Pendergast, Compliance Engineer, at (313) 586-1682.

Sincerely,

Enclosure: NRC Forms 366, 366A

cc: T. G. Colburn
A. B. Davis
M. P. Phillips
W. J. Kropp
P. L. Torpey

Wayne County Emergency
Management Division

IE22
1/1

NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Fermi 2	0 5 0 0 0 3 4 1	1 OF 0 3

TITLE (4) Reactor Pressure Vessel Low Level Trips During Vessel Pressure Test Due to Bumping an Instrument Rack

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)
1 0	2 4	9 2	9 2	0 1 1	0 0	1 1	2 4	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): 4

POWER LEVEL (10): 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (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 (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	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
Joseph M. Pendergast, Compliance Engineer	AREA CODE 3 1 3 5 8 6 - 1 6 8 2

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)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On October 24, 1992, plant personnel were performing the Reactor Pressure Vessel leakage test at hydraulic pressure (water solid) of 1045 psig. The plant was in Cold Shutdown and the Control Rods were fully inserted. At 1916 hours invalid Reactor water level (level 3, level 2, level 1) signals were received. The following Engineered Safety Feature actuations occurred: Nuclear Steam Supply Shut-off System isolated, Division 1 Drywell pnuematics and the Torus Water Management system isolated, Division 1 Core Spray started automatically and the Emergency Diesel Generators automatically started. The Division 1 Anticipated Transient Without Scram [ATWS]/Alternate Rod Insertion [ARI] logic tripped causing the Reactor Protection System to insert a full scram signal due to high water level in the scram discharge volume. There was no control rod movement. Reactor pressure was stabilized at 850 to 900 psig and the Reactor scram signal was reset at 1930 hours.

Instrument Rack H21-P004 had been bumped by a Radiation Protection technician while moving a rolling bucket. A mop within the rolling bucket was being moved out of the way of a step off pad. The bumping of the instrumentation by the mop handle caused a vibration in the sensing lines. As corrective action, during refueling outages a barrier will be installed around the instrument rack to preclude bumping of the rack.

Initial Plant Conditions:

Operational Condition: 4 (Cold Shutdown)
Reactor Power: 0 Percent
Reactor Pressure: 1045 psig
Reactor Temperature: 189 degrees Fahrenheit

Description of the Event:

On October 24, 1992, plant personnel were performing the Reactor Pressure Vessel [RPV] leakage test at hydraulic pressure (water solid) of 1045 psig. The plant was in Cold Shutdown and the Control Rods [AA] were fully inserted. At 1916 hours invalid Reactor water level (level 3, level 2, level 1) signals were received. The following Engineered Safety Feature [(ESF)(JE)] actuations occurred: Nuclear Steam Supply Shut-off System [JC] isolated, Division 1 Drywell [NH] pnuematics and the Torus Water Management [CG] system isolated, Division 1 Core Spray [BM] started automatically and the Emergency Diesel Generators [EK] automatically started.

Reactor pressure momentarily decreased to 550 PSIG as the Scram Discharge Volume [CF] filled. The Division 1 Anticipated Transient Without Scram [ATWS]/Alternate Rod Insertion [ARI] logic tripped causing the Reactor Protection System [JC] to insert a full scram signal due to high water level in the scram discharge volume. There was no control rod movement. The Core Spray system did not inject since Reactor pressure remained above the Core Spray discharge head. There was no automatic loading of the EDGs onto the safety related buses.

Reactor pressure was stabilized at 850 to 900 psig and the Reactor scram signal was reset at 1930 hours.

A review of the safety systems which did and did not actuate was conducted. The conclusion was that all safety systems responded appropriately. Subsequently, the RPV leakage test resumed and was satisfactorily completed.

Cause of the Event:

Instrument Rack H21-P004 had been bumped by a Radiation Protection technician (contract non-licensed) while moving a rolling bucket. A mop within the rolling bucket was being moved out of the way of a step off pad. The bumping of the instrumentation by the mop handle caused a vibration in the sensing lines. The mop handle had struck a level transmitter or associated tubing. The striking of the instrumentation caused a vibration in the sensing lines. The rolling bucket and mop had been placed there by decontamination personnel (contract non-licensed), staged for decontamination activities.

The root cause of this event was personnel error in that plant personnel did not avoid inadvertent contact with instrumentation on rack H21-P004.

Analysis of the Event:

The instrument rack level transient actuated ESF systems, which functioned as designed. Had the actual Reactor vessel water level required the operation of the ESF systems involved, their actuation and performance would have already been initiated and performed their designed safety functions. If this event would have occurred during reactor operation an unexpected plant shutdown would have been the result. However, the ESF systems involved would have functioned properly.

Corrective Actions:

During refueling outages a barrier will be installed around the instrument rack H21-P004.

Previous Similar Events:

None.