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C. K. McCoy
Vice President, Nuclear
Vogtle Project



Georgia Power
the southern electric system

April 26, 1993

ELV-05400

Docket No. 50-424

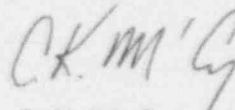
U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

VOGTLE ELECTRIC GENERATING PLANT
LICENSEE EVENT REPORT
CONTAINMENT VENTILATION ISOLATION DUE TO
IMPROPER RADIATION MONITOR ACTUATION SETPOINTS

Gentlemen:

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company submits the enclosed report related to an event which occurred on April 11, 1993.

Sincerely,


C. K. McCoy

CKM/NJS

Enclosure: LER 50-424/1993-005

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) 05000424		PAGE (3) 1 OF 3		
TITLE (4) CONTAINMENT VENTILATION ISOLATION DUE TO IMPROPER RADIATION MONITOR ACTUATION SETPOINTS.														
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)			
04	11	93	93	005	00	04	26	93			05000			
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)												
6		20.402(b)			20.405(c)			X		50.73(a)(2)(iv)		73.71(b)		
POWER LEVEL		0			20.405(a)(1)(i)					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)			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 MEHDI SHEIBANI, NUCLEAR SAFETY AND COMPLIANCE										TELEPHONE NUMBER AREA CODE 706 826-3209				
COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)														
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	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 April 11, 1993, at 1824 EDT, the reactor upper internals were raised inside of the water filled reactor cavity prior to placement of the upper internals into the reactor vessel. This evolution reduces the shielding and increases the proximity of the internals to the containment building area radiation monitors. Therefore, a subsequent rise in background radiation occurred as expected. However, the actuation setpoint for initiating a containment ventilation isolation (CVI) had not been raised as required by procedure, resulting in a high radiation alarm and a CVI. Unit operators determined that only expected levels of radioactivity were detected, and the actuation setpoints for these radiation monitors were reset by 1951 EDT.

The cause of this event was a cognitive personnel error by the unit shift supervisor (USS) in not ensuring that the actuation setpoints for the radiation monitors were raised prior to moving the reactor upper internals. The USS was disciplined regarding the importance of procedural compliance.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (5)			PAGE (3)		
		YEAR	SEQ NUM	REV			
VOGTLE ELECTRIC GENERATING PLANT - UNIT 1	0 5 0 0 0 4 2 4	9 3	0 0 5	0 0	2	OF	3

TEXT

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(iv) because an unplanned engineered safety feature (ESF) actuation occurred when a containment ventilation isolation (CVI) took place.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was operating in Mode 6 (refueling) at 0 percent of rated thermal power. Other than that described herein, there was no inoperable equipment that contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On April 11, 1993, at 1824 EDT, the reactor upper internals were raised inside of the water filled reactor cavity prior to placement of the upper internals into the reactor vessel. This evolution reduces the shielding and increases the proximity of the internals to the containment building area radiation monitors. Therefore, a subsequent rise in background radiation occurred as expected. However, the actuation setpoint for initiating a CVI had not been raised as required by procedure, resulting in a high radiation alarm and a CVI. Unit operators determined that only expected levels of radioactivity were detected, and the actuation setpoints for these radiation monitors were reset by 1951 EDT.

D. CAUSE OF EVENT

The cause of this event was a cognitive personnel error by the unit shift supervisor (USS) in not ensuring that the actuation setpoints for the radiation monitors were raised prior to moving the reactor upper internals, as required by procedure. There were no unusual characteristics of the work location which contributed to the occurrence of this error by the Georgia Power Company USS involved.

A contributing factor was that the USS was following Procedure 12007-C, "Refueling Operations," in a section titled "Post Refueling Operations." The directions for resetting the actuation setpoints are located in Procedure 12000-C, "Post Refueling Operations."

E. ANALYSIS OF EVENT

Due to the reduced shielding and increased proximity to the radiation monitors when the upper internals were raised, a subsequent rise in background radiation was detected, as expected for this evolution. When a high radiation signal was received, valves and dampers actuated to effect a CVI as designed. Plant operators responded to ensure that no unexpected radiation condition existed and took actions to ensure that the actuation setpoints for the radiation monitors were reset. Based on this consideration, there was no adverse effect on plant safety or on the health and safety of the public as a result of this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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		YEAR	SEQ NUM	REV			
VOGTLE ELECTRIC GENERATING PLANT - UNIT 1	0 5 0 0 0 4 2 4	9 3	0 0 5	0 0	3	OF	3

TEXT

F. CORRECTIVE ACTIONS

1. The actuation setpoints for the radiation monitors were raised to the proper values.
2. The USS was disciplined regarding the importance of procedural compliance.
3. By June 1, 1993, Procedure 12007-C will be modified to clarify the appropriate transition to Procedure 12000-C.

G. ADDITIONAL INFORMATION

1. Failed Components

None

2. Previous Similar Events

None

3. Energy Industry Identification System Code

Containment Isolation Control System - JM

Reactor Core System - AC