Georgia Power Company
40 Inverness Center Parkway
Post Office Box 1295
Birmingham, Alabama 35201
Telephone 205 877-7122

C. K. McCoy
Vice President, Nuclear
Vogtle Project

Georgia Power
the southern electric system

October 28, 1994

LCV-0493

Docket No. 50-424

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

Ladies and Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
LICENSEE EVENT REPORT - SURVEILLANCE NOT PERFORMED
PRIOR TO RESTORING RADIATION MONITOR TO SERVICE

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company (GPC) submits the enclosed report related to an event which occurred on October 3, 1994.

Sincerely,

C. K. McCoy

CKM/AFS

Enclosure: LER 1-94-7

cc: Georgia Power Company
Mr. J. B. Beasley, Jr.
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

IE22
1/1

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 5/31/95
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 (MNBB7714), 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.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Vogtle Electric Generating Plant - Unit 1	0 5 0 0 0 4 2 4	1 OF 3

TITLE (4)
SURVEILLANCE NOT PERFORMED PRIOR TO RESTORING RADIATION MONITOR TO SERVICE

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 NAME	DOCKET NUMBER(S)
1 0	0 4	9 4	9 4	– 0 0 7	– 0 0	1 0	2 8	9 4		0 5 0 0 0
									FACILITY NAME	0 5 0 0 0

OPERATING MODE (9)	6	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR ?: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 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 and in Text, NRC Form 366A)
		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 (include area code)
Mehdi Sheibani, Nuclear Safety and Compliance	AREA CODE 7 0 6 8 2 6 - 3 2 0 9

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 15 single-space typewritten lines) (16)

On October 3, 1994, containment radiation monitors 1RE-0002 and 1RE-2565 were in service to provide automatic containment ventilation isolation (CVI) capability per Technical Specification (TS) requirements to have two monitors operable during refueling. At 0228 EDT, another containment radiation monitor, 1RE-0003, was returned to service. However, a TS special condition surveillance requirement applicable during core alterations, to verify that a CVI occurs on a high radiation test signal from 1RE-0003, had not been performed. At 0236 EDT, 1RE-2565 was removed from service for a period of 3 hours and 12 minutes. As a result, 1RE-0003 and 1RE-0002 were relied upon during this period as the two required instruments to provide automatic CVI actuation capability. Although 1RE-0003 had been demonstrated to be functional, the special condition surveillance had not been performed prior to the return to service. This represented unit operation in a condition prohibited by the TS. On October 4, 1994, the Unit Shift Supervisor (USS) discovered this event during a review of logs from the previous day.

The cause of this event is a cognitive personnel error on the part of the USS who did not ensure that the special condition surveillance had been performed prior to returning 1RE-0003 to service. The USS will be counseled regarding the importance of ensuring that all applicable surveillances are satisfactorily completed prior to returning TS components to service.

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 a surveillance requirement was not properly completed prior to returning a radiation monitor to service.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was in Mode 6 (Refueling) at 0 percent of rated thermal power, as fuel was being reloaded into the core. Other than that described herein, there was no inoperable equipment that contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On October 3, 1994, containment radiation monitors 1RE-0002 and 1RE-2565 were in service to provide automatic containment ventilation isolation (CVI) capability per the TS 3.3.2 and TS 3.9.9 requirements to have two radiation monitors and the CVI system operable during refueling. At 0228 EDT, containment radiation monitor 1RE-0003 was returned to service following the reenergization of its power source and performance of a source check, channel check and parameter verification. However, the TS 4.9.9 special condition surveillance requirement, applicable during core alterations, to verify that a CVI occurs on a high radiation test signal from 1RE-0003, had not been performed. At 0236 EDT, 1RE-2565 was removed from service to transfer power sources. At 0548 EDT, 1RE-2565 was returned to service, ending a period of 3 hours and 12 minutes when only 1RE-0002 was proven operable in accordance with TS surveillance 4.9.9. During a review of the Limiting Condition for Operation (LCO) log on October 4, 1994, the Unit Shift Supervisor (USS) discovered the condition that had existed the previous day. This condition represented unit operation prohibited by the TS because 1RE-0003 had been relied on to provide automatic CVI actuation capability when it had not been fully tested prior to being returned to service.

D. CAUSE OF EVENT

The cause of this event is a cognitive personnel error on the part of the USS in overlooking an LCO and not ensuring that 1RE-0003 was tested per the special condition surveillance prior to being returned to service on October 3, 1994. 1RE-0003 had been removed from service the previous morning and a source check, channel check, and parameter verification were performed prior to

returning the monitor to service. Additionally, the three radiation monitors share a common actuation logic circuit which was proven operable during testing of 1RE-0002 and 1RE-2565. However, during core alterations, the additional surveillance testing per TS 4.9.9 must also be performed prior to returning to service any of the monitors that are relied on to maintain automatic CVI capability. There were no unusual characteristics of the work location that led to the occurrence of this error by the Georgia Power Company USS involved.

E. ANALYSIS OF EVENT

1RE-0003 was tested and calibrated prior to its return to service on October 3, 1994, and the signal flow path through the solid state protection system to the actuated components had already been shown to be operable by testing performed for radiation monitors 1RE-0002 and 1RE-2565. Additionally, no event occurred during the period of time involved which required a CVI. Based on these considerations, there was no adverse affect on plant safety or on the health and safety of the public as a result of this event.

F. CORRECTIVE ACTIONS

1) The USS involved has been counseled regarding the importance of ensuring that all applicable surveillances are satisfactorily completed prior to returning TS components to service.
2) A copy of this LER will be placed in the Operations Reading Book for review by licensed operators.

G. ADDITIONAL INFORMATION

1) Failed Components:
None

2) Previous Similar Events:
None

3) Energy Industry Identification System Code:
Containment Ventilation Isolation System - JM
Solid State Protection System - JG
Radiation Monitoring System - IL