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J. D. Woodard
Senior Vice President

August 18, 1995

LCV-0654

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 - UNIT 1
AUTOMATIC CONTAINMENT VENTILATION ISOLATION (CVI)
ACTUATION FUNCTION INACTIVATED

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company (GPC) submits the enclosed report associated with a condition which was discovered on July 25, 1995.

Sincerely,

J. D. Woodard

JDW/TEW/AFS

Enclosure: LER 1-95-03

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. L. L. Wheeler, Licensing Project Manager, NRR
Mr. C. R. Ogle, Senior Resident Inspector, Vogtle

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): Vogtle Electric Generating Plant - Unit 1

DOCKET NUMBER (2): 05000424

PAGE (3): 1 OF 4

TITLE (4): AUTOMATIC CONTAINMENT VENTILATION ISOLATION ACTUATION FUNCTION INACTIVATED

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR
07	24	95	95	003	00	08	18	95

OTHER FACILITIES INVOLVED (8)	
FACILITY NAME	DOCKET NUMBER(S) 05000
FACILITY NAME	DOCKET NUMBER(S) 05000

OPERATING MODE (9)	3
POWER LEVEL (10)	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)		50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)		50.36(c)(1)	X	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 706 826-3209

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 July 24, 1995, personnel were preparing to perform maintenance on intermediate range neutron detector NI-36. This detector is highly radioactive and technicians requested that containment radiation monitors be placed in block to prevent an inadvertent containment ventilation isolation (CVI) when NI-36 was lifted and removed from the containment building. The unit shift supervisor (USS) authorized and had the monitors placed in block for approximately 3 and 1/2 hours. On July 25, 1995, the event was discovered when technicians requested that the radiation monitors be placed in block for further work on NI-36. Another USS explained that this could not be done due to Technical Specification (TS) requirements.

The TS allows unit operation to continue with one radiation monitor operable provided the containment purge supply and exhaust valves are closed within 24 hours. The USS on duty on July 24, 1995, had closed the purge valves but misread the TS requirement and erroneously concluded that no monitors were required to be operable provided the purge valves were closed. The time the monitors were in block represents a TS 3.0.3 entry and a condition that alone could have prevented fulfillment of a safety function needed to control the release of radioactive material. The USS has been counseled regarding the importance of attention to detail when addressing plant configuration changes that affect a safety related system's operability.

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 TS 3.0.3 was inadvertently entered. It is also required per 10 CFR 50.73 (a)(2)(v) because a condition existed that alone could have prevented fulfillment of a safety function needed to control the release of radioactive material.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was operating in Mode 3 (Hot Standby) 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 July 24, 1995, personnel were preparing to perform maintenance on intermediate range neutron detector NI-36. This detector is highly radioactive and technicians requested that containment radiation monitors be placed in block to prevent an inadvertent containment ventilation isolation (CVI) when NI-36 was lifted and removed from the containment building. TS Table 3.3-2, action statement 18, allows continued unit operation with one radiation monitor operable provided the containment purge supply and exhaust valves are closed within 24 hours. After verifying that the purge supply and exhaust dampers were closed, the unit shift supervisor (USS) misread the TS action statement and erroneously concluded that the unit was in compliance with the action statement requirements. Therefore, at 0213 EDT, the USS directed personnel to ensure the containment purge supply and exhaust valves were closed and then to block the CVI actuation signal from the appropriate monitors. At 0233 EDT, this was completed. After removing NI-36, no high radiation levels were experienced and the radiation monitors were taken out of block at 0550 EDT.

On July 25, 1995, technicians again requested that the radiation monitors be placed in block for further work on NI-36. Another USS explained that this could not be done due to TS requirements and the technicians advised him that it had been done the previous day. At 1145 EDT a deficiency card was initiated and the NRC operations center was later notified because the removal of the automatic CVI actuation capability from the radiation monitors represented a condition that alone could have prevented fulfillment of a safety function needed to control the release of radioactive material.

D. CAUSE OF EVENT

The cause of this event is a cognitive personnel error on the part of the Georgia Power Company USS and his supervisor, the shift superintendent (SS), who was consulted prior to blocking the monitors on July 24, 1995. There were no unusual characteristics of the work location that contributed to the occurrence of these errors.

E. ANALYSIS OF EVENT

Because the containment purge valves were closed, there was no direct venting from the containment atmosphere to the outside atmosphere during this event. Other containment isolation valves that close on a CVI signal and remained open during this event do not provide a direct vent path to the outside atmosphere. Additionally, the indication and alarm functions for the containment radiation monitor remained functional and a CVI actuation could have been conducted manually. Furthermore, automatic CVI actuation capability was still available in the event of a safety injection, containment isolation phase A actuation, or a containment spray actuation. Finally, there was no event during the period of time involved that would have required an automatic CVI actuation to prevent the release of radioactive material. 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 and the SS have been counseled regarding the importance of attention to detail when addressing plant configuration changes that affect a safety related system's operability.

2) A copy of this LER will be placed in the Operations Reading Book and this event will be discussed in the next session of licensed operator requalification training.

G. ADDITIONAL INFORMATION

1) Failed Components:
None

2) Previous Similar Events:
LER 50-425/1990-012, dated 10-15-90.
This 1990 LER dealt with the simultaneous inoperability of both containment spray pumps due to control room personnel errors. The corrective actions were specific, addressing an isolated incident, and were generally not applicable for the prevention of the event that occurred on July 24, 1995.

3) Energy Industry Identification System Code:
Radiation Monitoring System - IL
Containment Isolation and Ventilation Systems - JM
Neutron Detection System - JD