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)
PLANT VOGTLE - UNIT 1	0 5 0 0 0 4 2 4	1 OF 0 4

TITLE (4)
CONTAINMENT VENTILATION ISOLATION CAUSED BY RADIATION MONITOR LOSS OF POWER

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)
										0 5 0 0 0
0 5	0 3	8 7	8 7	0 2 2	0 1	0 3	1 0	8 8		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 7 4	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
	AREA CODE
W. E. Burns, Nuclear Licensing Manager - Vogtle	4 0 4 5 2 6 - 7 0 1 4

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 May 3, 1987, at 0752 CDT, Unit 1 was in Mode 1 at 74% rated thermal power when an unplanned, automatic Containment Ventilation Isolation (CVI) occurred. The cause of the CVI was a high radiation signal from the containment ventilation effluent radiation monitor (1RE-2565C).

The root cause of the CVI was due to an operator error. A trouble annunciator was received for 120 volt AC Instrument Panel 1NYS and a Plant Equipment Operator (PEO) was dispatched to the 480 volt motor control centers to verify that the panel feeder breakers were closed. The PEO assumed that feeder breaker 1NBS21 was tripped and subsequently opened the breaker to reset it. Since the radiation monitor receives its power from the 1NYS panel, there was a temporary loss of power to the monitor (1RE-2565). When the monitor was re-energized, a high radiation alarm was received and initiated the CVI.

Corrective action included reprimanding and counseling the PEO about the performance of his duties.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(iv), because there was an unplanned, automatic Engineered Safety Feature (ESF) actuation.

B. UNIT STATUS AT TIME OF EVENT

Unit 1 was in Mode 1 at 74 percent of rated thermal power.

C. DESCRIPTION OF EVENT

On May 3, 1987, a trouble light was indicated on the Electrical Auxiliary Board for 120V AC Instrument Panel, 1NYS. A Plant Equipment Operator (PEO) was dispatched to the 480 volt motor control centers (MCC) 1NBS and 1NBR to determine if the feeder breakers (1NBS21 and 1NBR21) were opened or closed. The PEO assumed feeder breaker 1NBS21 was tripped (when actually it was closed to supply power to the 1NYS panel) and, he subsequently opened the breaker to reset it and then immediately reclosed it. This resulted in a temporary loss of power to the 1NYS panel. A high radiation alarm was received on the containment ventilation Effluent Radiation Monitor (1RE-2565C) which initiated a Containment Ventilation Isolation (CVI) actuation at 0752 CDT. Upon receiving the CVI, some train "A" components did not function properly. The train "A" containment minipurge supply valve (HV-2626B) and exhaust valve (HV-2628B) did not close; however redundant train "B" isolation valves did close as designed to achieve the isolation of this line. The train "A" inlet and outlet isolation valves (HV-12975, HV-12978) for radiation monitor 1RE-2562 did not close; however the redundant train "B" valves did close as required. The electrical penetration filter unit fan (1-1562-N7-001-000) did not start. As a result of the train "A" components that did not operate, two (2) Limiting Conditions of Operation (LCO's) were entered for Technical Specification paragraphs 3.6.1.7 and 3.6.3. Investigative trouble-shooting was begun to resolve the identified problems. At approximately 0934 CDT, May 3, 1987, the CVI was reset.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

D. CAUSE OF EVENT

The cause of the containment ventilation effluent radiation monitor (1RE-2565A) high radiation alarm was a result of the temporary loss of power to panel 1NYS which supplies power to the radiation monitor. A permanent alarm setpoint and a gain factor (called default values) are built into the data processing module (DPM). A calculated alarm setpoint and gain factor are established and manually set into the DPM. The manual setpoints override the default values. Therefore, for normal operation, the actual reading of the monitor is obtained by the actual count rate minus an established background count rate times an established gain factor. When power is lost to the DPM, the induced values are lost and the default values are established. When the power was restored to the DPM, the background reading was higher than the default value and a high radiation alarm was received.

The immediate cause of the Containment Ventilation Isolation (CVI) was the high radiation signal from the radiation monitor 1RE-2565C.

The root cause of the event was operator error. The Plant Equipment Operator (PEO) assumed the 1NYS feeder breaker was tripped. Without verifying that the breaker was in a tripped position, the PEO cycled the breaker to reset and close it. This caused the temporary loss of power to the radiation monitor 1RE-2565C.

E. ANALYSIS OF EVENT

Containment purge gases were monitored by the Plant Vent Radiation Monitor (1RE-12442A,B, and C) and did not indicate any increase of radioactivity. It was determined that the reason for the high radiation alarm on monitor 1RE-2565C was due to background activity being higher than the default values to which the system reverted on the temporary loss of power. Therefore, no valid radioactive condition existed.

All of train "B" CVI components functioned as designed. Portions of train "A" did not function correctly. However, the effectiveness of the isolation remained because all train "B" components actuated.

Since a valid radiation signal did not exist, no safety hazard was created and the health and safety of the public was not affected. Since this ESF (CVI) functions independently of reactor power, this event would also have had no adverse effect on plant safety or the health and safety of the public, even at higher power levels.

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F. CORRECTIVE ACTIONS

Further investigation revealed the train "A" items which did not operate were associated with train "A" master relay K528 in the "SSPS" cabinet. No specific problem was located and surveillance procedure 14600-1 "ESFAS Slave Relay and Final Device Test" was performed and all components functioned properly.

Subsequent to this event, procedure 14600-1 "ESFAS Slave Relay and Final Device Test" was performed 3 times, with acceptable test results from each functional test. The random failure that occurred was not repeated. Subsequently, containment ventilation isolations occurred on August 9, 1987 and November 9, 1987 in which this equipment properly performed its intended safety function. The train "A" event of May 3, 1987 has now been attributed to a random failure.

The plant equipment operator (PEO), although considered to have received adequate training, was not attentive in the performance of his duties. The PEO was counselled for his actions and a letter of reprimand was entered in his record.

G. ADDITIONAL INFORMATION

1. Previous LER's on similar events
   None

2. Energy Industry Identification System
   Radiation Monitoring System - IL

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Manager Nuclear Safety
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Georgia Power
the southern electric system

SL-4112
0767m
X7GJ17-V310

March 10, 1988

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

PLANT VOGTLE - UNIT 1
NRC DOCKET 50-424
OPERATING LICENSE NPF-68
LICENSEE EVENT REPORT
CONTAINMENT VENTILATION ISOLATION
CAUSED BY RADIATION MONITOR LOSS OF POWER

Gentlemen:

In accordance with the requirements of 10 CFR 50.73(a)(2)(iv), Georgia Power Company is submitting a supplemental Licensee Event Report (LER) concerning an event where a containment ventilation isolation was caused by loss of power to a radiation monitor.

Sincerely,

L. T. Gucwa

PAH/1m

Enclosure: LER 50-424/1987-022-01

c: Georgia Power Company
Mr. P. D. Rice
Mr. G. Bockhold, Jr.
GO-NORMS

U. S. Nuclear Regulatory Commission
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Mr. J. B. Hopkins, Licensing Project Manager, NRR (2 copies)
Mr. J. F. Rogge, Senior Resident Inspector-Operations, Vogtle

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