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)
INADEQUATE TRAINING CAUSES A SURVEILLANCE TO BE IMPROPERLY PERFORMED

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
1 1	2 1	8 7	8 7	0 7 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)	1 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
W. E. Burns, Nuclear Licensing Manager - Vogtle	AREA CODE 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 December 9, 1987, a Technical Specification (TS) Surveillance for Unit 1 was identified as being inadequately performed on November 21, 1987. The auxiliary plant operator (APO) taking the readings from the Plant Safety Monitoring System (PSMS) data displays failed to obtain the correct readings for the Reactor Vessel Level Indication System (RVLIS) and the Reactor Coolant System (RCS) Subcooling channels. A review of the surveillance data by the Unit 1 Shift Supervisor (SS) did not identify these readings as being incorrect.

This event was caused by an APO who failed to obtain the correct readings from the display screen. The APO had not received adequate "hands-on" training for the PSMS console and was unaware of the proper operation of the console and the expected values of these instrument channels. Also, there are no PSMS console and display screens on the plant simulator.

Corrective actions include a training discussion and counseling of the individuals involved. A PSMS console and display screen will be procured for the plant simulator.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
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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)(i) because there was a deviation from the plant's Technical Specifications (TS).

B. UNIT STATUS AT TIME OF EVENT

The Unit was in Mode 1 (power operation) at approximately 100% of rated thermal power (RTP) with reactor coolant temperature and pressure at approximately 588 degrees Fahrenheit and 2240 psig respectively.

C. DESCRIPTION OF EVENT

Technical Specification 4.3.3.6.a, requires that each accident monitoring instrumentation channel shall be demonstrated operable every 31 days by performance of a Channel Check. Included among these instruments are the Reactor Coolant System (RCS) Subcooling and the Reactor Vessel Level Instrumentation System (RVLIS). This TS Surveillance requirement is addressed in Procedure 14228-1, "Operations Monthly Surveillance Logs".

On November 21, 1987, the monthly surveillances for procedure 14228-1 were performed and were indicated as satisfactory. On December 9, 1987, at approximately 1330 CST, an off-shift Shift Supervisor (SS) was reviewing the monthly surveillance logs and observed the readings taken on November 21, 1987 for the RCS subcooling and the RVLIS instruments appeared to be incorrect, based upon past experience. A monthly surveillance was performed for the two instruments and the surveillance was completed at 1355 CST on December 9, 1987.

The readings were taken from the Plant Safety Monitoring System (PSMS) data displays and had been misread by an auxiliary plant operator (APO) on November 21, 1987. The logs were also reviewed and accepted by the Unit 1 SS. As a result of the erroneous data taken, the TS surveillance was not adequately performed on November 21, 1987 for the instruments discussed.

D. CAUSE OF EVENT

There were several contributing factors involved with this event:

1. The APO who obtained the readings was not familiar with PSMS. He had never operated the console and was not familiar with the details of the data displays. There are three (3) indications per channel (Full range, narrow range, and dynamic range). When in Mode 1, the dynamic range provides the proper indication which should be logged. This was not known by the APO.

2. The SS who performed the review of the completed surveillance failed to identify the incorrect readings.

3. There was no required training for plant equipment operators (PEO's) and APO'S to provide "hands-on" experience for the surveillances for the PSMS console and the data displays or where specific readings are located on the display. This is attributed to the absence of the PSMS console and display screen on the plant simulator.

E. ANALYSIS OF EVENT

The surveillances conducted prior to the event (on October 28, 1987) and immediately after the event (on December 9, 1987), were satisfactory. These surveillances provide reasonable assurance that the channels would have functioned properly. Based on this consideration, it is concluded that this event had no adverse effect upon plant safety and/or the health and safety of the public.

F. CORRECTIVE ACTIONS

As soon as the event was discovered, surveillance procedure 14228-1 was immediately performed and satisfactorily completed for the RVLIS and RCS subcooling channels.

A detailed discussion of this event was conducted with the APO and SS who performed the review of the surveillance on November 21, 1987. A training discussion was also conducted with the APO on the PSMS operation. Detailed data displays were called up on the screen and the readings discussed. Also discussed was the importance of expected readings, and not just verifying that all channels read the same approximate value.

The SS who performed the review of the surveillance of November 21, 1987, was counseled on the importance of performing thorough reviews. Additionally, this LER will be placed in the required reading file for licensed personnel (reactor operators, senior reactor operators, shift supervisors and shift technical advisors).

Additional training material has been provided on RVLIS and PSMS in the annual operating performance portion of the requalification program for licensed operators.

A PSMS console and display are being procured for the plant specific simulator. This equipment is scheduled to be incorporated into the simulator within the next six (6) months.

A review of previous RCS and RVLIS surveillances will be performed to determine if any may have been performed incorrectly. This action is scheduled to be completed by January 15, 1988. A review of previous RCS and RVLIS surveillances has been completed and an additional event has been identified. On March 19, 1987 RCS and RVLIS chart A was identified as inoperable on the monthly surveillance data sheet (procedure 14228-1) and was not demonstrated operable until March 28, 1987. This exceeded the TS allowed time period for system restoration.

G. ADDITIONAL INFORMATION

1. Failed Components
   None

2. Previous Similar Events
   None

3. Energy Industry Identification Code
   Post-Accident Monitoring System - IP

Georgia Power Company
333 Piedmont Avenue
Atlanta, Georgia 30308
Telephone 404 526-6526

Mailing Address:
Post Office Box 4545
Atlanta, Georgia 30302

L. T. Gucwa
Manager Nuclear Safety
and Licensing

Georgia Power
the southern electric system

SL-4326
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X7GJ17-V310

March 11, 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
INADEQUATE TRAINING CAUSES A SURVEILLANCE
TO BE IMPROPERLY PERFORMED

Gentlemen:

Georgia Power Company hereby submits a supplemental Licensee Event Report (LER) concerning a deviation from the plant's Technical Specifications.

Sincerely,

L. T. Gucwa

PAH/lm

Enclosure: LER 50-424/1987-072-01

c: (see next page)

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Georgia Power

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

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

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