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Georgia Power
the southern electric system

C. K. McCoy
Vice President, Nuclear
Vogtle Project

April 15, 1993

ELV-05387

Docket No. 50-425

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

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
LICENSEE EVENT REPORT
CONTAINMENT PERSONNEL AIRLOCK FOUND
INOPERABLE WHEN INTERLOCK FOUND DEFEATED

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company submits the enclosed report related to an event which was discovered on March 19, 1993.

Sincerely,

C. K. McCoy

CKM/NJS

Enclosure: LER 50-425/1993-002

xc: Georgia Power Company
Mr. W. B. Shipman
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

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NRC Form 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
VOGTLE ELECTRIC GENERATING PLANT - UNIT 2	0 5 0 0 0 4 2 5	1 OF 3

TITLE (4)
CONTAINMENT PERSONNEL AIRLOCK FOUND INOPERABLE WHEN INTERLOCK FOUND DEFEATED

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)
0 3	1 9	9 3	9 3	0 0 2	0 0					0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)			
POWER LEVEL	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)
		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	
	AREA CODE	
MEHDI SHEIBANI, NUCLEAR SAFETY AND COMPLIANCE	706	826-3209

COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORT TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES(If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (16)

On March 19, 1993, personnel discovered that one of the interlocks for the containment building personnel airlock door was defeated. The consequence of this condition was that the outer door of the airlock could have been opened while the inner door was open. This represented operation of the unit in a condition prohibited by the Technical Specifications (TS) because the appropriate TS action statement had not been complied with.

The cause of this event was a personnel error by the individual responsible for reinstating the interlock following the period when the interlocks were defeated for personnel access (during Modes 5 and 6 when containment airlocks are not required to be operable by the TS). The individual has been disciplined regarding the importance of self-checking. Maintenance personnel responsible for performing this activity will be briefed regarding this event and the significance of the failure to ensure the activity was complete.

TEXT

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 the containment personnel airlock was apparently inoperable for a period of time greater than that allowed by the TS action statement.

B. UNIT STATUS AT TIME OF EVENT

At the time of the discovery of this event, Unit 2 was operating in Mode 1 (power operation) at 100 percent of rated thermal power. Other than that described herein, there was no inoperable equipment which contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On March 19, 1993, personnel were performing a 6-month surveillance test on the containment personnel airlock per Procedure 24905-C, "Modes 1 - 4 Containment Leakage Totalization." At 1815 EST, personnel tested the interlock which keeps the outer door locked when the inner door is open and found that the outer door handwheel could rotate while the inner door was open. The unit shift supervisor was notified and a limiting condition for operation (LCO) was entered. On inspection of the airlock's interior drive box, an interlock key stock was found installed under a latching pawl. (Key stocks are used to defeat the interlocks to allow personnel access when the airlocks are not required to be operable by the TS.) The key stock was removed, the interlock tested satisfactorily, and the LCO was exited at 2256 EST.

Defeating the interlock will render the airlock inoperable per TS 3.6.1.3. This TS LCO action statement requires the airlock to be restored to operable status within 24 hours, or the unit must be in hot standby within the next 6 hours and cold shutdown within the following 30 hours. However, a review of work orders found no entries into the drive box since maintenance was performed in December 1992; therefore, the unit apparently operated in a condition prohibited by the TS since December 1992.

D. CAUSE OF EVENT

The cause of this event was a cognitive personnel error by the individual responsible for reinstating the interlock following the period when the interlocks were defeated for personnel access (during Modes 5 and 6 when containment airlocks are not required by the TS). There were no unusual characteristics of the work location which contributed to the occurrence of this error by the Georgia Power Company employee involved.

E. ANALYSIS OF EVENT

Although the interlock, which prevents simultaneous opening of both airlock doors, was found to be inoperable, personnel are administratively restricted from opening both airlock doors simultaneously. Furthermore, the outer door is normally locked and containment entries are monitored by security, operations, and health physics personnel, making a violation of this restriction unlikely. 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.

F. CORRECTIVE ACTIONS

1. The maintenance individual responsible for leaving the interlock defeated has been disciplined regarding the importance of self-checking.

2. Other maintenance personnel responsible for performing this activity will be briefed by July 30, 1993, regarding the event and the significance of the failure to ensure the activity was complete.

3. By July 1, 199[illegible], Procedure 25236-C, "Airlock Maintenance," will be enhanced to include a section for defeating and restoring the interlocks.

G. ADDITIONAL INFORMATION

1. Failed Components

None

2. Previous Similar Events

None

3. Energy Industry Identification System Code

Containment Building. - NH