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the southern electric system

W. G. Hairston, III Senior Vice President Nuclear Operations

May 11, 1990

ELV-01636 0381

Docket No. 50-424

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

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT
LICENSEE EVENT REPORT
IMPROPER RECORDING OF DATA LEADS TO INADEQUATE
TECHNICAL SPECIFICATION SURVEILLANCE

In accordance with 10 CFR 50.73, Georgia Power Company hereby submits the enclosed report related to an event which was discovered on April 18, 1990.

Sincerely,

W. G. Hairston, III

WGH, III/NJS/gm

Enclosure: LER 50-424/1990-010

xc: Georgia Power Company

Mr. C. K. McCoy Mr. G. Bockhold, Jr. Mr. P. D. Rushton Mr. R. M. Odom

NORMS

U. S. Nuclear Regulatory Commission

Mr. S. D. Ebneter, Regional Administrator

Mr. T. A. Reed, Licensing Project Manager, NRR

Mr. R. F. Aiello, Senior Resident Inspector, Vogtle

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ABSTRACT (Limit to 1400 spaces, (a. approximately fifteen single space typewritten lines) (16)

MANUFAC TURER TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

On 4-18-90, during his review of completed procedure 14000-1, "Operations Shift and Daily Surveillance Logs", the oncoming Unit Shift Supervisor (USS) found that on 4-17-90 and 4-18-90, containment level C temperature had been recorded from Emergency Response Facility (ERF) computer point T7502 which had been reading erroneously low since 4-11-90. This low reading caused the overall containment average temperature, comprised of the average of level 2, level B and level C readings per Technical specification 4.6.1.5, to be erroneously low. A review of surveillances performed on 4-12-90 through 4-16-90 determined that alternate indication had been utilized and the results were satisfactory. The surveillance on 4-11-90 was performed prior to the failure of computer point T7502.

MANUFAC

COMPONENT

CAUSE SYSTEM

REPORTABLE TO NPROS

MONTH

DAY

YEAR

The cause of this event was a cognitive personnel error by the on-duty Reactor Operator (RO) and Unit Shift Supervisor (USS) in that they recorded and reviewed data from a malfunctioning indication. In addition, the USS on duty on 4-12-90 failed to ensure adequate turnover of information to prevent use of the malfunctioning computer point. The USS and RO responsible for the inadequate surveillances were counseled regarding the importance of attention to detail in the performance and review of surveillance procedures. The USS on duty on 4-12-90 was counseled regarding the need to ensure adequate turnover of information to the oncoming shift.

CAUSE

SYSTEM

COMPONENT

YES III yes complete EXPECTED SUBMISSION DATE!

# NRC FORM 366A

#### US NUCLEAR REGULATORY COMMISSION

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

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20565. AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)		LER NUMBER (6)							PAGE (3)			
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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 a surveillance required by the Technical Specifications (TS) was not performed adequately within the specified time interval. A containment air temperature reading required by TS 4.6.1.5 was obtained from a computer indication that was not functioning properly.

## B. UNIT STATUS AT TIME OF EVENT

At the time of discovery of this event on 4-18-90, Unit 1 was in Mode 1 (power operation) at approximately 11% 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 4-18-90, during his review of completed Procedure 14000-1, "Operations Shift and Daily Surveillance Logs", the oncoming Unit Shift Supervisor (USS) found that on 4-17-90 and 4-18-90, containment level C temperature had been recorded from Emergency Response Facility (ERF) computer point T7502 which is specified by Procedure 14000-1. This computer point had been reading erroneously low (.027 degrees fahrenheit) since 4-11-90. This low reading caused the overall containment average temperature, comprised of level 2, level B and level C readings, to be erroneously low. Upon noting this, the USS had ERF computer point T7502 removed from trending so that erroneous readings would not be taken. An investigation of surveillances performed on 4-12-90 through 4-16-90 determined that alternate indication was used and the results were satisfactory. The surveillance on 4-11-90 was performed prior to the failure of computer point T7502.

The cause of this event was cognitive personnel error. The Reactor Operator (RO) recorded data from an indication which was not functioning properly and failed to realize it was an unrealistic value. This data was also reviewed by a USS other than the one that discovered the discrepancy. In addition, the USS on duty on 4-12-90 failed to ensure adequate turnover of information to prevent use of the malfunctioning computer point. There were no unusual characteristics of the work location which contributed to the occurrence of this event.

## NAC FORM 386A

#### U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3160-0104 EXPIRES 4/30/92

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 50.0 HRS. FORWARD COMMENTS RECARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH IP-530, U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20655, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20603.

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### E. ANALYSIS OF EVENT

A review of recorded data for containment levels 2 and B from properly functioning indication showed that, for surveillances performed on 4-17-90 and 4-18-90, containment temperatures were well below the TS limit of 120 degrees fahrenheit. Surveillances performed between 4-12-90 and 4-16-90, using alternate indication, showed that containment level C readings were consistent with level 2 and level B readings and that all readings were well below the TS limit. The surveillance on 4-11-90 was performed prior to the failure of computer point T7502. Therefore, it is concluded that there was no adverse effect on plant safety or public health and safety as a result of this event.

## F. CORRECTIVE ACTIONS

- The USS and RO responsible for the inadequate surveillances were counseled regarding the importance of attention to detail in performance and review of surveillance procedures.
- The USS on duty on 4-12-90 has been counseled regarding the need to ensure adequate turnover of information in order to prevent a recurrence of this type of event.
- A copy of this LER will be placed in the Operations Reading Book for reading by licensed operators.
- Procedural controls are being evaluated for addressing malfunctioning computer points. This evaluation will be completed by 9-15-90.

### G. ADDITIONAL INFORMATION

1. Failed Components

None

2. Previous Similar Events

LER 50-424/1990-001, dated 3-27-90, described a previous event for Unit 2 involving an inadequately performed Technical Specification surveillance. LERs 50-425/1989-026, dated 10-2-89, and 50-424/1988-012, dated 5-12-88, involved improperly completed surveillances. The causes of these events were different than this event.

Energy Industry Identification System Code:

Containment Environmental Monitoring System - IK