Georgia Power Company 333 Piedmont Avenue Atlanta, Georgia 30308 Telephone 404 526 3195

Mailing Address 40 inverness Center Parkway Post Office Box 1295 Birmingham, Alabama 35201 Telephone 205 868-5581

# November 16, 1990

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ELV-02260 0701

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

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 VALVING OUT RADIATION MONITGR LEADS TO UNMONITORED LIQUID RELEASE

In accordance with 10 CFR 50.73, Georgia Power Company hereby submits the enclosed report related to an event which was discovered on October 29, 1990.

Sincerely,

W.S. Kant the

# W. G. Hairston, III

WGH, II1/NJS/gm

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Enclosure: LER 50-425/1990-014

- xc: <u>Georgia Power Company</u> Mr. C. K. McCoy
  - Mr. W. B. Shipman Mr. P. D. Rushton Mr. R. M. Odom NORMS

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<u>U. S. Nuclear Regulatory Commission</u> 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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RC Form 388 6-893	LICENSEE EVENT REPORT (LER)					STON	APPROVED ONE NO. 3150-0104 EXPIRES: 4/30/92								
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On 9-19-90, the Steam Generator Blowdown (SGBD) 3ystem was removed from service for maintenance and the SGBD effluent line radiation monitor 2RE-0021 was valved out and isolated without a Limiting Condition for Operation (LCO) tracking sheet being initiated.

On 9-27-90, a portion of the SGBD System was restored to service in order to drain Steam Generator (SG) #3. However, 2RE-0021 was not restored to service and a violation of Technical Specification (TS) Table 3.3-9, Action 38, occurred when the SG contents were released to the Savannah River (via the Waste Water Retention Basin) and no grab samples were taken. On 10-1-90, a similar release occurred when SG #4 was drained.

On 10-20-90, a monthly alignment check was being performed on the 2RE-0021 radiation monitor skid when personnel discovered that radiation monitor 2RE-0021 was isolated. The Shift Supervisor (SS) was notified and a LCO tracking sheet was initiated.

The Shift Supervisor (SS) on duty failed to adequately identify the LCO requirement for 2RE-0021 on 9-19-90. The SS was counseled regarding the proper reviews to ensure TS compliance prior to removing equipment from service. Samples taken prior to draining and after refilling the SG's indicated no primary to secondary leaks.

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(6-89) LICENSEE EVENT REPORT (LER) TEXT CONTINUATION			APPROVED ONE NO 3150-0104 EXPIRES: 4/30/92								
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VOGTLE ELECTRIC GENERATING PLANT - UNIT	2 05000425	90	014	00	2	OF	3				

#### A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(i) because a liquid waste release was not monitored in accordance with Technical Specification (TS) requirements.

#### B. UNIT STATUS AT TIME OF EVENT

At the time of the event on 9-27-90, Unit 2 was in Mode 6 (Refueling) at 0% of rated thermal power. Radiation effluent monitor 2RE-0019 was out of service at the time. Other than this and other equipment described herein, there was no inoperable equipment which contributed to the occurrence of this event.

## C. DESCRIPTION OF EVENT

On 9-19-90, the Steam Generator Blowdown (SGBD) System was removed from service for maintenance and the SGBD effluent line radiation monitor 2RE-0021 was valved out and isolated without a Limiting Condition for Operation (LCO) tracking sheet being initiated.

On 9-27-90, a portion of the SGBD System was restored to service in order to drain Steam Generator (SG) #3. However, 2RE-0021 was not restored to service and a violation of TS Table 3.3-9, Action 38, occurred when the SG contents were released to the Savannah River (via the Waste Water Retention Basin) and no grab samples were taken. Action 38 provides for liquid effluent releases in the event of an inoperable radiation monitor on the condition that grab samples are taken and appropriately analyzed for radioactivity. On 10-1-90, a similar release occurred when SG #4 was drained.

On 10-20-90, a monthly alignment check was being performed on the 2RE-0021 radiation monitor skid when personnel discovered the closed inlet valve which had isolated 2RE-0021. The Shift Supervisor (SS) was notified and a LCO tracking sheet was initiated.

#### D. CAUSE OF EVENT

The Shift Supervisor (S3) on duty made a cognitive personnel error when he failed to adequately identify the LCO requirement for 2RE-0021 on 9-19-90. There were no unusual characteristics of the work location which contributed to the occurrence of this error.

A contributing cause to this event was a lack of prerequisites in procedure 13601-2, "Steam Generator And Main Steam System Operation". When the SG's were drained on 9-27-90 and 10-1-90, there were no procedural requirements to ensure that 2RE-0021 was in the release flowpath.

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## E. ANALYSIS OF EVENT

The last samples taken from the SG's prior to draining and the first samples taken after refilling indicated that there were no primary to secondary leaks in the Vogtle Electric Generating Plant SG's. In addition, there was no primary water in the SG's during this period. As a result, there was no radioactive effluent released when the SG's were drained. Based on this consideration, there was no adverse effect on plant safety or public health and safety as result of this event.

## F. CORRECTIVE ACTIONS

- 1. The SS involved was counseled regarding the proper reviews to ensure TS compliance prior to removing equipment from service.
- Procedures 13601-1 and 13601-2 have been revised to require that personnel either ensure 2RE-0021 is in service or provide the TS required release monitoring by utilizing grab samples.
- A copy of this LER will be placed in the Operations Reading Book for review by licensed operators.
- G. ADDITIONAL INFORMATION
  - 1. Failed Components:

None

2. Previous Similar Events

None

3. Energy Industry Identification System Code:

Liquid Waste Processing System - WD

Main Steam System - SB