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December 26, 1990

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

ELV-02381
0767

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
PERSONNEL ERROR LEADS TO CONTAINMENT VENTILATION ISOLATION

In accordance with 10 CFR 50.73, Georgia Power Company hereby submits the enclosed revised report related to an event which occurred on December 11, 1989. This revision is necessary to update the status of the corrective actions.

Sincerely,

W. G. Hairston, III

WGH,III/NJS/gm

Enclosure: LER 50-424/1989-020, Revision 1

xc: Georgia Power Company
Mr. C. K. McCoy
Mr. W. B. Shipman
Mr. P. D. Rushton
Mr. R. M. Odom
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

IE22
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NRC FORM 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104
EXPIRES 4/30/92
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH 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 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1): VOGTLE ELECTRIC GENERATING PLANT - UNIT 1

DOCKET NUMBER (2): 0 5 0 0 0 4 2 4

PAGE (3): 1 OF 0 3

TITLE (4): PERSONNEL ERROR LEADS TO CONTAINMENT VENTILATION ISOLATION

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)
1 2	1 1	8 9	8 9	- 0 2 0	- 0 1	1 2	6 9	0		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): 1

POWER LEVEL (10): 1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

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
R. M. ODOM, NUCLEAR SAFETY AND COMPLIANCE	AREA CODE 4 0 4 — 8 2 6 - 3 2 0 1

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)

[ ] YES (If yes, complete EXPECTED SUBMISSION DATE)

[X] NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

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

On 12-11-89, an Instrument and Controls (I&C) technician was preparing to check the fuses in Containment low range area radiation monitor 1RE-0003. At 1034 CST, he removed power from the monitor prior to lifting the leads to the Engineered Safety Features (ESF) actuation circuits. The loss of power caused the monitor to revert to its failed, or safe, condition which sent a high alarm signal to ESF actuation circuits, initiating a Containment Ventilation Isolation.

The root cause of this event was a cognitive personnel error on the part of the technician in not adequately following procedure. The technician was disciplined and provisions for blocking the ESF actuation signal during maintenance and testing are currently planned for installation in 1991.

A. REQUIREMENT FOR REPORT

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

B. UNIT STATUS AT TIME OF EVENT

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

C. DESCRIPTION OF EVENT

On 12-11-89, an Instrument and Controls (I&C) technician was preparing to check the fuses in Containment low range area radiation monitor 1RE-0003. At 1034 CST, he removed power from the monitor prior to lifting the leads to the Engineered Safety Features (ESF) actuation circuits. The loss of power caused the monitor to revert to its failed, or safe, condition and this safe condition sent a high alarm signal to ESF actuation circuits. A Containment Ventilation Isolation (CVI) occurred and the appropriate valves and dampers actuated to their proper positions. Control room personnel responded to verify that no abnormal radiation condition existed and the CVI signal was reset at 1153 CST.

D. CAUSE OF EVENT

The root cause of this event was personnel error on the part of the Georgia Power Company technician. Procedure 2462° 1, "Containment Low Range Area Radiation Monitor Analog Channel Operational Test," which is used for general maintenance activities as well as Technical Specification surveillances, was attached to and referenced on the work order for checking the fuses. The procedure requires the ESF actuation circuit leads to be lifted prior to removing power from the monitor. However, the technician neglected to consult the procedure. This cognitive personnel error was not the result of any unusual characteristics of the work location.

The following are contributing causes for this event:

1. Department policy did not require use of procedure check-off blocks when performing non-routine activities of this type. The procedure is used for performing Technical Specification surveillances as well as for general maintenance activities but does not detail all possible activities which may need to be performed. However, the procedure provides a means for self-checking which should be employed when possible.

2. No caution label exists on the monitor to advise personnel of the potential for initiating an ESF actuation by removing power.

3. Operational needs for blocking the ESF actuation signal during maintenance and testing were not addressed in the original design.

E. ANALYSIS OF EVENT

During this event, the CVI signal actuated the proper valves and dampers and control room operators responded correctly in verifying that no abnormal radiation condition existed. Therefore, plant safety would have been maintained if an abnormal radiation condition had, in fact, existed. Based on these considerations, there was no adverse effect on plant safety or public health and safety as a result of these events.

F. CORRECTIVE ACTIONS

The Positive Discipline Program was enacted for the technician involved in this event.

The following are contributing factor corrective actions:

1. An I & C policy statement was issued stressing the need for using self-checking blocks when appropriate. Also, all appropriate personnel were coached on the importance of using procedures.

2. Permanent caution labels were placed on the exterior of the radiation monitor data processing modules (DPM's) advising of the potential for initiating ESF actuations.

3. A blocking capability has been designed with installation currently planned for completion by June 1991.

G. ADDITIONAL INFORMATION

1. Failed Components
None

2. Previous Similar Events:
LER 50-424/1988-027, dated 10-26-88.
Corrective action addressed lack of a switch to block the CVI actuation signal. Installation of these switches is scheduled to occur during 1991.

3. Energy Industry Identification System Code
Containment Isolation Control System - JM
Radiation Monitoring System - IL