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December 26, 1990

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

ELV-02382
0768

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
PERSONNEL ERROR LEADS TO CONTAINMENT VENTILATION ISOLATION

In accordance with 10 CFR 50.73, Georgia Power Company hereby submits the enclosed revised report relating to an event which occurred on November 26, 1989. This revision is necessary to update the status of the corrective actions.

Sincerely,

W. G. Hairston, III

WGH,III/NJS/gm

Enclosure: LER 50-425/1989-030, 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 2

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

PAGE (3): 1 OF 0 4

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 1	2 6	8 9	8 9	0 3 0	0 1	1 2	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 11-26-89, an Instrument & Controls (I&C) technician was performing the 18-month Analog Channel Operational Test (ACOT) on Containment low range area radiation monitor 2RE-0003. The monitor's Remote/Bypass switch was in the "Bypass" position as the technician introduced a test signal to simulate a high radiation reading. The monitor's processing unit took approximately four minutes to process the signal. However, the technician did not understand the delay and proceeded to check the gain and background signal to ensure they were correct. At 1510 CST, he moved the Remote/Bypass switch to the "Remote" position which allowed the test signal to initiate a Containment Ventilation Isolation (CVI).

The root cause of this event was cognitive personnel error on the part of the technician. The procedure which was being employed to conduct the test did not address movement of the Remote/Bypass switch at the time when the technician moved it to the Remote position. The technician has been counseled regarding the importance of compliance with procedures and seeking guidance when expected test results are not achieved.

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 on 11-26-89, Unit 2 was operating in Mode 1 (Power Operation) at 100% 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 11-26-89, an Instrument & Controls (I&C) technician was performing the 18-month Analog Channel Operational Test (ACOT) on Containment low range area radiation monitor 2RE-0003. The monitor's Remote/Bypass switch was in the "Bypass" position as the technician introduced a test signal to simulate a high radiation reading. The monitor's processing unit took approximately 4 minutes to process the signal. However, the technician did not understand the delay and proceeded to check the gain and background signal to ensure they were correct. At 1510 CST, he moved the Remote/Bypass switch to the "Remote" position which allowed the test signal to initiate a Containment Ventilation Isolation (CVI). The appropriate valves and dampers actuated and control room operators verified that no abnormal radiation condition existed. The CVI signal was reset at 1547 CST.

D. CAUSE OF EVENT

The root cause of this event was personnel error on the part of the Georgia Power Company technician. Procedure 24623-2, "Containment Low Range Area Radiation Monitor Analog Channel Operational Test," which was being employed to conduct the test, did not address movement of the Remote/Bypass switch at the time when the technician moved it out of bypass.

The following are contributing causes of this event:

1. The test procedure indicates that testing should cease if expected results are not being obtained. When the technician did not understand the lengthy processing time, he failed to stop and notify his foreman as indicated by the procedure.

2. The test procedure did not indicate that a lengthy processing time may be required (depending on the test signal frequency used). This lack of information misled the technician into believing that the signal was not being processed.

3. Although the technician performing the ACOT testing was trained and qualified to do surveillance testing, this was only the second time he had performed testing on 2RE-0003. This lack of specific experience contributed to his personnel error.

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

The above cognitive personnel errors were not the result of any unusual characteristics of the work location.

E. ANALYSIS OF EVENTS

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 this event.

F. CORRECTIVE ACTIONS

1. The technician involved has been counseled regarding the importance of compliance with procedure and seeking guidance when expected test results are not achieved. Personnel responsible for performing maintenance or surveillance activities on Process Effluent Radiation Monitoring System (PERMS) monitors have been reminded of the necessity to stop testing and seek guidance whenever expected test results are not being achieved.

2. Procedures 24623-1 and 2 have been changed to advise personnel of the potential for a lengthy test signal processing time.

3. An additional instructional unit has been developed for this specific ACOT testing. Additional PERMS hands-on training will be instituted upon receipt and installation of the PERMS training simulator.

4. 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 50-424/1989-001, dated 02-01-89.
Corrective action addressed means to prevent inadvertent actuation of 1RE-0003's reset button. However, it did not address movement of the Remote/Bypass switch.

3. Energy Industry Identification System Code

Containment Isolation Control System - JM

Radiation Monitoring System - IL