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December 26, 1990

W. G. Hainston, HI Service Visa President Nuclear Operations

ELV-02379 0766

Docket No. 50-424

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

Gentlemen:

VOGTLE ELECTRIC GENERATING PLANT LICENSEE EVENT REPORT PERSONNEL ERRORS LEAD TO MISSED SPECIAL CONDITION SURVEILLANCE

In accordance with 10 CFR 50.73, Georgia Power Company hereby submits the enclosed report related to an event which occurred on December 2, 1990.

Sincerely,

W. S. Hunt

W. G. Hairston, III

WGH, III/NJS/gm

Enclosure: LER 50-424/1990-021

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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During the period between 1718 CST on 12-2-90 and 0602 CST on 12-3-90, Georgia Power Company failed to comply with a Technical Specification 4.1.3.2 special condition surveillance which is applicable when the rod position deviation monitor is inoperable. This surveillance requires that the Demand Position Indication System and the Digital Rod Position Indication System be compared at least once per 4 hours. Control room personnel had inadvertently made the rod position deviation monitor inoperable when attempting to reinsert control rod position indicator values into the Proteus (plant status) computer.

The cause of this event was the failure of the Unit Shift Supervisor (USS) to follow procedure when reentering the rod position values into the Proteus computer. Additionally, the Shift Superintendent failed to ensure that the USS complied with the procedure. These personnel have undergone Positive Discipline regarding the importance of procedural compliance.

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A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(i) because the Technical Specifications (TS) were violated when p surveillance task was not performed.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was in Mode 1 (Power Operation) at 100% 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 12-2-90, the Proteus (plant status) computer, which displays the status of various plant systems, became inoperable. When the computer was reinitialized, the "Rod Deviation/Radial Tilt" annunciator alarmed for control rods H10, B08 and P08. Proteus was checked and the alarm was found to be invalid. Rod position indication for the three affected rods was changed and then reset to the original settings. This process cleared the invalid alarms at 1718 CST.

On 12-3-90 at approximately 0545 GST, the system engineer was reviewing the computer status when he found that the position indication foc rods H10, B08 and P08 had not been updated by the scanni g function of Proteus. This meant that the values being displayed were the ones last entered the previous day at 1718 GST, when the rod position indication for these three rods was reset to clear the alarm. At 0602 GST, the control rod monitoring points were restored to the scanning function and normal monitoring of their positions resumed.

During the period between 1718 CST on 12-2-90 and 0602 CST on 12-3-90, the rod position deviation monitor was inoperable for rods H10, B08 and P08. During this time, Georgia Power Company failed to comply with the TS 4.1.3.2 special condition surveillance which is applicable when the rod position deviation monitor is inoperable. This surveillance requires that the Demand Position Indication System and the Digital Rod Position Indication System be compared at least once per 4 hours.

D. CAUSE OF EVENT

The cause of this event was the failure of the Unit Shift Supervisor (USS) to follow procedure 13504-C, "Proteus Computer," when resetting the rod position values into the Proteus computer. The USS should have entered a "1" into the entry scan field after entering the rod position values as required by the procedure. The effect of this omission was that the scan function for the three control rods involved was not put back into service. Additionally, the Shift Superintendent failed to ensure that the USS complied with the procedure. There were no unusual characteristics of the work location which contributed to the occurrence of these cognitive personnel errors.

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Contributing to this event was the temporary shutdown of the Proteus computer, the cause of which was not determined prior to its being reinitialized. Additionally, there was a lack of detailed understanding of the Proteus computer operation on the part of all the above mentioned control room personnel. Emphasis on Proteus operation in their prior training had been inadequate.

E. ANALYSIS OF EVENT

A review of the Reactor Engineering Houriy Log printout indicated that rods in control bank D were positioned at 226 steps during the period of time involved. Since this falls within the normal range of 222-228 steps, it provides a degree of confidence that no abnormal rod position deviation occurred within other control rod banks as well. Based on this consideration, there was no adverse impact on plant safety or public health and safety as a result of this event.

F. CORRECTIVE ACTIONS

- 1. The USS and Shift Superintendent have undergone Positive Discipline regarding the importance of procedural compliance.
- Future training will include more detail related to the operation of the Proteus computer.
- 3. In en effort to enhance reliability of the Proteus computer, a System Stop log is scheduled to be installed by 4-1-91. Following a computer shutdowr, this will print out computer software information which can be utilized to uncover hardware problems.

G. ADDITIONAL INFORMATION

1. Failed Components:

Proteus computer manufactured by Westinghouse Electric Corp. Model #W2500

2. Previous Similar Events:

None.

3. Energy Industry Identification System Code:

Control Rod Drive System - AA

Computer System - ID