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C. K. McCoy
Vice President, Nuclear
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Georgia Power
the Southern electric system

January 30, 1992

ELV-03398
001097

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
CONTAINMENT VENTILATION ISOLATION DUE TO
RADIATION MONITOR FAILURE

In accordance with 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed report related to an event which occurred on January 10, 1992. Please note that in Licensee Event Report 50-425/1991-011, dated November 21, 1991, GPC committed to perform an engineering evaluation of the failures of containment area radiation monitor 2RE-0003. This evaluation was to be completed by February 10, 1992. As a result of this latest failure of radiation monitor 2RE-0003, GPC has rescheduled the target date for completing this evaluation to May 15, 1992, so that this event can be included in the evaluation.

Sincerely,

C. K. McCoy

CKM/NJS/gmb

Enclosure: LER 50-425/1992-001

xc: Georgia Power Company
Mr. W. B. Shipman
Mr. M. Sheibani
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

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

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

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
VOGTLE ELECTRIC GENERATING PLANT - UNIT 2	0 5 0 0 0 4 2 5	1 of 3

TITLE (4)
CONTAINMENT VENTILATION ISOLATION DUE TO RADIATION MONITOR FAILURE

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQ NUM	REV	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
										0 5 0 0 0
0 1	1 0	9 2	9 2	0 0 1	0 0	0 1	3 0	9 2		0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)											
POWER LEVEL	1 0 0		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)				
			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	
	AREA CODE	
MEHDI SHEIBANI, NUCLEAR SAFETY AND COMPLIANCE	404	826-3209

COMPLETE ONE LINE FOR EACH FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORT TO NPRDS	
X	I L	D E T	W 1 2 0	Y							

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES(If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (16)

On January 10, 1992 at 0259 EST, a containment ventilation isolation (CVI) occurred. Control room personnel observed valves and dampers actuate to their proper positions and a high radiation indicator light for containment area radiation monitor 2RE-0003 on the safety related display console (SRDC). Personnel verified that no abnormal radiation condition existed by observing other monitors, and 2RE-0003 was placed in block to prevent further actuations from this monitor. The CVI signal was reset at 0317 EST.

An investigation ensued which tested various system components but found no discrepancies. Although troubleshooting was unable to determine the root cause of the CVI, several previous CVIs have been attributed to intermittent failure of the 2RE-0003 detector tube assembly, and this is suspected to be the cause of this event. The detector tube assembly was replaced as a precautionary measure. Due to this and previous similar events, an engineering evaluation of this monitor is being conducted in an attempt to identify a common cause of the events. This evaluation will be complete with the appropriate action plan developed by May 15, 1992.

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 this event, Unit 2 was operating in Mode 1 (Power Operation) at 100 percent 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 January 10, 1992 at 0259 EST, a containment ventilation isolation (CVI) occurred. Control room personnel observed valves and dampers actuate to their proper positions and a high radiation indicator light for containment area radiation monitor 2RE-0003 on the safety related display console (SRDC). Personnel verified that no abnormal radiation condition existed by observing other monitors, and 2RE-0003 was placed in block to prevent further accuations from this monitor. The CVI signal was reset at 0317 EST.

D. CAUSE OF EVENT

An investigation ensued which tested various system components but no discrepancies were found. Also, recorders were attached to 2RE-0003 to detect intermittent failures, and a spike in monitor output was seen on January 12, 1992, but its cause was indeterminate. Although troubleshooting was unable to determine the root cause of the CVI, several previous CVIs have been attributed to intermittent failure of the 2RE-0003 detector tube assembly. Due to this past history and the spike in monitor output that was seen, intermittent failure of the detector tube assembly is suspected to be the cause of this event.

E. ANALYSIS OF EVENT

Containment valves and dampers actuated to their proper positions upon receipt of the CVI signal. Additionally, no abnormal radiation condition existed. Based on these considerations, there was no adverse impact on plant safety or the health and safety of the public.

F. CORRECTIVE ACTIONS

As a precautionary measure, the 2RE-0003 detector tube assembly was replaced. Due to this and previous similar events, an engineering evaluation of this monitor is being conducted in an attempt to identify a common cause of the events. This evaluation will be complete with the appropriate action plan developed by May 15, 1992.

G. ADDITIONAL INFORMATION

1. Previous Similar Events:

LER 50-424/1989-009, dated April 10, 1989.
LER 50-425/1991-002, dated January 31, 1991.
LER 50-425/1991-011, dated November 21, 1991.

A corrective action from LER 50-425/1991-011 to review previous events and make recommendations for improvements was not complete at the time of the January 10, 1992, event.

2. Failed Components:

Detector tube assembly manufactured by LND, Inc.
Part No. 71430
Supplied by Westinghouse Electric Corporation as Part No. 8459A08H01.

3. Energy Industry Identification System Code:

Radiation Monitoring System - IL
Containment Isolation Control System - JM