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C. K. McCoy
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Georgia Power
the southern electric system

May 14, 1992

ELV-03757
000386

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
COMMUNICATIONS PROBLEMS RESULT IN MISSED
TECHNICAL SPECIFICATION SURVEILLANCE

In accordance with 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed report related to an event which was discovered on April 22, 1992.

Sincerely,

C. K. McCoy

CKM/NJS

Enclosure: LER 50-425/1992-005

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

IE22
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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)
COMMUNICATIONS PROBLEMS RESULT IN MISSED TECH. SPEC. SURVEILLANCE

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 4	2 2	9 2	9 2	0 0 5	0 0	0 5	1 4	9 2		0 5 0 0 0

OPERATING MODE (9)	5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR (11)			
POWER LEVEL	0	20.402(b)	20.405(c)	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)	X 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	706	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	

SUPPLEMENTAL REPORT EXPECTED (14)

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

ABSTRACT (16)

On April 21, 1992 at 1352 EDT, plant vent radiation monitor 2RE-12444 was deenergized (along with other components) when engineered safety feature actuation system (ESFAS) testing was initiated. Because plant vent monitor 2RE-12442 had previously been removed from service and auxiliary equipment was monitoring for iodine and particulate levels only, there was no plant vent monitoring taking place for noble gases. The Technical Specifications (TS) require that a plant vent monitor remain operable or appropriate action statements must be implemented. On April 22, 1992 at approximately 0200 EDT, the reactor operator advised the chemistry foreman to restore 2RE-12444 to service. Following a channel check and a source check, 2RE-12444 was restored to service at approximately 0400 EDT. Because over 12 hours had elapsed with no plant vent monitoring for noble gases, and without grab samples being taken as required by the Limiting Condition for Operation action statement, this incident represented unit operation in a condition prohibited by the TS.

Cognitive personnel errors and poor communications were responsible for causing this event. The appropriate personnel are being counseled.

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(i) because the unit was operated in a condition prohibited by the Technical Specifications (TS) when the requirements of a Limiting Condition for Operation (LCO) action statement were not met.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 2 was operating in Mode 5 (cold shutdown) at 0 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 April 21, 1992 at 1352 EDT, plant vent radiation monitor 2RE-12444 was deenergized (along with other components) when engineered safety feature actuation system (ESFAS) testing was initiated. Because plant vent monitor 2RE-12442 had previously been removed from service and auxiliary sampling equipment was monitoring for iodine and particulates only, there was no plant vent monitoring taking place for noble gases. Technical Specification table 3.3-10 requires, in part, that a plant vent monitor remain operable. Since no containment purging was taking place, the required action would have been to obtain grab samples at least every 12 hours. At approximately 2100 EDT, ESFAS testing was completed and equipment restoration was initiated. On April 22, 1992 at approximately 0200 EDT, the reactor operator advised the night shift chemistry foreman to restore 2RE-12444 to service. Following a channel check and a source check, 2RE-12444 was placed in service at approximately 0400 EDT. Because over 12 hours had elapsed with no plant vent monitoring for noble gases, and without grab samples being taken as required by the LCO action statement, this incident represented unit operation in a condition prohibited by the TS.

D. CAUSES OF EVENT

Poor communications and personnel knowledge were responsible for causing this event as discussed below:

1. The day shift unit shift supervisor (USS) failed to properly communicate the required TS actions to be taken by Chemistry personnel. The USS believed that the auxiliary equipment was performing all plant vent monitoring functions. He did not understand that it does not monitor for noble gases.

2. After learning of the deenergization of monitor 2RE-12444, the day shift chemistry foreman failed to consult with the USS, as required by procedure, regarding the initiation of TS action statement requirements. From a prior meeting, he had learned of the need to maintain plant vent monitoring during the ESFAS testing, but he had not ensured that the TS requirements would be maintained.

3. The day shift chemistry foreman failed to advise the night shift chemistry foreman that plant vent monitoring was inadequate and that grab samples would be required if monitoring was not restored within 12 hours of test initiation.

There were no unusual characteristics of the work locations which contributed to the occurrence of these cognitive personnel errors by the Georgia Power Company individuals involved.

E. ANALYSIS OF EVENT

Although noble gases were not monitored during the period of time involved, there were no abnormal levels of either iodine or particulates measured. Furthermore, there was no evolution occurring in the unit which would be expected to increase the level of noble gases while maintaining iodine and particulate levels at normal values. Based on this consideration, there was no adverse effect on either plant safety or public health and safety as a result of this event.

F. CORRECTIVE ACTIONS

1. By June 8, 1992, control room personnel will be instructed in the proper communications to be used for implementing TS action statements involving other departments.

2. The day shift chemistry foreman will be counseled by May 15, 1992, regarding the necessity of compliance with procedures and making adequate shift turnovers.

3. Personnel from the Chemistry and Operations departments will be trained by July 19, 1992, regarding the capabilities of the auxiliary monitoring equipment.

G. ADDITIONAL INFORMATION

1. Failed Components:
   None

2. Previous Similar Events:
   LER 50-424/1991-008, dated November 21, 1991.
   Corrective actions for this LER were not applicable to the prevention of the April 23, 1992, event.

3. Energy Industry Identification Code System:
   Plant Effluent Radiation Monitoring System - IL
   Engineered Safety Features Actuation System - JE
   Plant Vent Monitoring System - VL