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C. K. McCoy Vice President, Nucle Voote Project



May 18, 1992

ELV-03764 000409

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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 FUEL HANDLING BUILDING ISOLATION DUE TO RADIATION MONIT, 3 FAILURE

In accordance with 10 CFR 50.73, Georgia Power Company (GPC) hereby submits the enclosed report related to an event which occurred on May 2, 1992.

Sincerely,

C. K. McCov

CKM/NJS

Enclosure: LER 50 424/1992-003

xc: <u>Georgia Power Company</u> 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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On May 2, 1992 at 1340 EDT, a high level radiation alarm annunciated for fuel handling building (FHB) area radiation monitors ARE-2532 A & B, and a FHB isolation occurred. The normal ventilation system isolated, and the post-accident filter system actuated as designed. Control room personnel verified that no valid radiation condition existed to cause the isolation and placed monitors ARE-2532 A & B in block. Radiation monitors ARE-2533 A & B were placed in service to perform the FHB area monitoring function. At 1416 EDT, the post-accident filter units were shut down, and at 1419 EDT the normal ventilation system was returned to service.

Although the direct cause of the event was a power reset of the monitors' data processing module (DPM), troubleshooting has been unable to identify the root cause. Performance monitoring will continue until May 18, 1992. If no further problems are found, the monitors will be returned to service.

U.S. ROCLEAR REGULATORY COMPLETION LICENSEE EVENT REPORT (LER) TEXT CONTINUATION					
DOCKET NUMBER (2)	LER	PAGE (3)			
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## 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 when the fuel handling building (FHB) normal ventilation isolated and the post-accident filter system actuated.

## B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was in Mode 1 (power operation) at 100 percent of rated thermal power (RTP). Unit 2 was in Mode 5 (cold shutdown) at 0 percent RTP with the reactor coolant system (RCS) at 128 degrees F and 0 psig. Other than that described herein, there was no inoperable equipment which contributed to the occurrence of this event.

#### C. DESCRIPTION OF EVENT

On May 2, 1992 at 1340 EDT, a high level radiation alarm annunciated for FHB area radiation monitors ARE-2532 A & B, and a FHB isolation occurred. The normal ventilation system isolated, and the post-accident filter system actuated as designed. Control room personnel verified that no valid radiation condition existed to cause the isolation and placed monitors ARE-2532 A & B in block. Radiation monitors ARE-2533 A & B were placed in service to perform the FHB area monitoring function. At 1416 EDT, the post-accident filter units were shut down, and at 1419 EDT the normal ventilation system was returned to service.

D. CAUSE OF EVENT

Although the direct cause of the event was a power reset of the monitors' data processing module (DPM), troubleshooting was unable to identify any problems with the DPM and the root cause of this event is unknown at this time.

## E. ANALYSIS OF EVENT

The FHB normal ventilation system isolated and the post-accident filter system actuated as designed to seal the FHB from the outside environment. This provides assurance that plant systems would have responded as required had an abnormal radiation condition actually existed. Based on this consideration, there was no adverse effect on plant safety or on the health and safety of the public as a result of this event.

NAC Form 366A (6-89)	LICENSEE EVENT REPO TEXT CONTINUATI	DRT (LER)	N APPROVED OMB NO 3150-0104 EXPIRES: 4/30/92					
FACILITY NAME (1)		DOCKET NUMBER (2)	LER NUMBER (5)	PAGE (3)				
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VOGTLE ELECTRIC	GENERATING PLANT - UNIT 1	05000424	92 003 00 3	OF 3				

## F. CORRECTIVE ACTIONS

- Troubleshooting was performed to determine the root cause for the power reset of the radiation monitor's DPM. No specific problem has been found, and the monitor has been operating correctly since the failure on May 2, 1992.
- 2. Performance monitoring will continue through May 18, 1992. If no further problems are found, the monitor will be returned to service.
- G. ADDITIONAL INFORMATION
  - 1. Failed Components

Not known at this time.

2. Previous Similar Events

LER 50-424/1991-014, dated December 20, 1991. Corrective actions from this LER were not applicable to the prevention of the May 2, 1992, event.

3. Energy Industry Identification System Code

Radiation Monitoring System - IL Fuel Handling Building HVAC System - VG