

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) PLANT VOGTLE - UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 4 2 4	PAGE (3) 1 OF 0 4
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TITLE (4)
PERSONNEL ERROR CAUSES LOSS OF MONITOR OPERABILITY RESULTING IN TECHNICAL SPEC. VIOLATION

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)
11	27	87	87	076	00	01	26	88		0 5 0 0 0
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OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)				
POWER LEVEL (10) 0 9 8	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)	
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)	
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)	
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)		
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)		
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)		

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER
NAME W. E. Burns, Nuclear Licensing Manager - Vogtle		AREA CODE 4 0 4
		5 2 6 - 7 0 1 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS		

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On November 26, 1987, while in Mode 1 (power operations) at 98 percent rated thermal power, plant personnel were performing Technical Specification (TS) surveillance testing on the Train A containment hydrogen monitor. Instrument panel 1-1513-P5-HMA had been unbolted in order to reach test points behind the panel. Upon completion of the testing, the panel was shut and only 1 of the 4 panel bolts was reinstalled. It remained inoperable for longer than the 7 day period allowed by the TS Limiting Condition for Operation (LCO). On December 27, 1987, plant personnel were again performing surveillance testing when they discovered that the 3 panel bolts were not installed. Upon completion of the testing, they replaced the missing bolts and informed the control room of the situation.

The cause of this event is personnel error. Corrective action includes briefing appropriate personnel on control and temporary storage of materials during in-process work.

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TEXT (if more space is required, use additional NRC Form 366A's) (17)

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a)(2)(i)(b) because an instrument panel was not declared inoperable and plant operations exceeded the time limit as stated by the Technical Specifications (TS) Limiting Condition for Operation (LCO).

B. UNIT STATUS AT TIME OF EVENT

At the time of the event on November 26, 1987, Unit 1 was in Mode 1 (power operations) at 98 percent rated thermal power. There was no inoperable equipment that contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On November 26, 1987, Georgia Power Company (GPC) plant personnel were performing TS surveillance testing on the Train A containment hydrogen monitor. Instrument panel 1-1513-P5-HMA had been unbolted and swung open on its hinges in order to reach test points behind the panel. Upon completion of the testing, the panel was swung shut and only 1 of the 4 panel bolts was reinstalled. Since the panel was originally seismically qualified with all 4 bolts in place, the seismic qualification with only one bolt securing the panel was questionable. Therefore, the monitor should have been declared inoperable per the applicable TS for the accident monitoring instrumentation channels for containment hydrogen concentration. Technical Specification Table 3.3-8, Action 31a. LCO reads as follows:

"With the number of OPERABLE channels one less than the Total Number of Channels requirements, restore one inoperable channel to OPERABLE status within 7 days, or be in at least HOT SHUTDOWN within the next 12 hours."

It remained inoperable for longer than the 7 day period allowed by the above stated LCO. On December 27, 1987, plant personnel were again performing surveillance testing when they discovered that the 3 panel bolts were not installed. Upon completion of the testing, they replaced the missing bolts and informed the control room of the situation.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

During this time period, the Train B monitor was removed from service from December 7-10, 1987, for approximately three days. Technical Specification Table 3.3-8, Action 31b. reads as follows:

"With the number of Operable channels less than the Minimum Channels Operable requirements, restore at least one inoperable channel to Operable status within 48 hours, or be in HOT SHUTDOWN within the next 12 hours."

The plant staff believed themselves to be within the action statement of TS Table 3.3-8, Action 31a. since, at the time the Train B monitor was removed from service, the Train A monitor was believed to be operable.

D. CAUSE OF EVENT

The cause of this event is personnel error. Procedure 00352-C, "Control of In-Process Material", was not adequately adhered to during the November 26, 1987, surveillance testing.

E. ANALYSIS OF EVENT

During the period from November 26, 1987, to December 27, 1987, there were no incidents which necessitated the use of the Containment Hydrogen Monitoring System. Also, the hydrogen monitor would have continued to properly function for any anticipated plant transient or postulated accident which did not directly challenge the operability of the monitor in its potentially non-seismic configuration (without bolts). Therefore, unless an earthquake had occurred, the hydrogen monitor would have functioned properly for any postulated plant event. Additionally, the Train B channel was operable for all but 3 days of this period.

Five mechanisms exist for monitoring and controlling hydrogen inside the containment. These are the hydrogen recombiners, the post-LOCA containment hydrogen purge system, post-LOCA cavity hydrogen purge, containment hydrogen monitoring, and containment hydrogen mixing. Additionally, the post-accident sampling system (PASS) has the capability to obtain a hydrogen sample. The Final Safety Analysis Report (FSAR) Section 6.2.5.3.1.6 indicates that without recombiners, the hydrogen concentration would reach 4 volume percent within 12 days. The starting of a single recombiner on the second day or when the bulk containment concentration reaches 3.5 volume percent, quickly reduces the hydrogen concentration, thus demonstrating an ample margin for the hydrogen control system.

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TEXT (If more space is required, use additional NRC Form 306A's) (17)

The plant operators could have easily restored the Train B hydrogen monitor to an operable status, sampled the containment hydrogen concentration utilizing the PASS system, or conservatively turned on one recombiner. 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

Plant Administrative Procedure 00352-C, "Control of In-Process Material", was approved for use on September 29, 1987. The procedure addresses the control and temporary storage of the material, parts, and equipment (including nuts, bolts, etc.) during in-process work. Engineering reviewed the procedure and considers it adequate to prevent recurrence of the event for future work on the hydrogen monitors and other plant equipment. In addition, Maintenance personnel will be required to review or will be briefed on the procedure (00352-C). This action is scheduled to be completed by February 1, 1988.

G. ADDITIONAL INFORMATION

1. Failed Components
None
2. Previous Similar Events
There are no previous similar events where plant equipment was made inoperable; e.g., lost its seismic qualification, as a result of the performance of a TS surveillance test.
3. Energy Industry Identification System Code:
Hydrogen Recombiner and Monitoring System - BB

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L. T. Guwa
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Georgia Power

the southern electric system

SL-4053
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X7GJ17-V310

January 26, 1988

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

PLANT VOGTLE - UNIT 1
NRC DOCKET 50-424
OPERATING LICENSE NPF-68
LICENSEE EVENT REPORT
PERSONNEL ERROR CAUSES LOSS OF MONITOR
OPERABILITY RESULTING IN TECHNICAL SPECIFICATION VIOLATION

Gentlemen:

In accordance with the requirements of 10 CFR 50.73(a)(2)(i), Georgia Power Company hereby submits a Licensee Event Report (LER) concerning a deviation from the plant's Technical Specification.

Sincerely,

J. D. Hecht
per
L. T. Guwa

PAH/lm

Enclosure: LER 50-424/1987-076

c: (see next page)

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U. S. Nuclear Regulatory Commission
January 26, 1988
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