

LICENSEE EVENT REPORT (LER)

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

TITLE (4)
RELAY FAILURE CAUSES A CONTAINMENT VENTILATION ISOLATION

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)
04	10	88	88	010	00	05	06	88			0 5 0 0 0
											0 5 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

OPERATING MODE (9) <u>1</u>	20.402(b)	20.406(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73
POWER LEVEL (10) <u>01913</u>	20.406(a)(1)(i)	50.36(c)(1)		50.73(a)(2)(v)	73.7
	20.406(a)(1)(ii)	50.36(c)(2)		50.73(a)(2)(vii)	OTHER: Below # 366A
	20.406(a)(1)(iii)	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)	Abstract NRC Form
	20.406(a)(1)(iv)	50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)	
	20.406(a)(1)(v)	50.73(a)(2)(iii)		50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
<u>W. E. Burns, Nuclear Licensing Manager - Vogtle</u>	<u>4 0 1 4 5 2 1 6 1 - 1 7 1 0 1 1 4</u>
AREA CODE	

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS
B	I	R	L	Y	P	2	1	9	7
				N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

At 1116 hours CDT, on April 10, 1988, plant personnel were completing maintenance on channel A of radiation monitor IRE-2565 when a high radiation signal was received in the control room from channel C of IRE-2565 due to a relay malfunction. The high radiation signal initiated a Containment Ventilation Isolation (CVI) signal which actuated associated valves to their proper positions. Control room personnel verified that an actual high radiation condition did not exist, and the CVI signal was reset at 1230 CDT. A prompt investigation showed that operation of the mode keyswitch while returning the monitor to service had resulted in a high radiation signal from channel C of IRE-2565. The monitor was left in a bypass condition pending further investigation.

The cause of this event was the malfunction of a relay associated with the mode keyswitch. The relay was replaced. A contributing cause of this event was the conservatively low value for the loss-of-power default setpoints of the radiation monitor. These setpoints will be reviewed.

IE22 1/1

8805110285 880506
PDR ADOCK 05000424
S DCD

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
PLANT VOGTLE - UNIT 1	0 5 0 0 0 4 2 4	8 8	- 0 1 0	- 0 0	0 2	OF 0 4	

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)(iv) because of an unplanned actuation of an Engineered Safety Feature (ESF) system.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was in Mode 1 (power operations) at 93 percent of rated thermal power. Other than the equipment failure described herein, there was no inoperable equipment that contributed to this event.

C. DESCRIPTION OF EVENT

At 1116 hours CDT, on April 10, 1988, plant personnel were completing maintenance on channel A of radiation monitor 1RE-2565 when a high radiation signal was received in the control room from channel C of 1RE-2565 due to a relay malfunction. The high radiation signal initiated a Containment Ventilation Isolation (CVI) signal (1 out of 3 logic) which actuated associated valves to their proper positions. Control room personnel verified that an actual high radiation condition did not exist, and the CVI signal was reset at 1230 CDT. A prompt investigation showed that operation of the mode keyswitch while returning the monitor to service had resulted in a high radiation signal from channel C of 1RE-2565. The monitor was left in bypass condition pending further investigation.

D. CAUSE OF EVENT

The event was caused by the malfunction of a relay when operating the mode keyswitch. The relay malfunction simulated a loss-of-power condition to channel C of the data processing module of radiation monitor 1RE-2565. After a loss-of-power and the subsequent automatic power reset, a pre-programmed sequence occurs to re-input values to the monitor. During this power reset sequence, a set of default values or parameters, which are permanently stored in Programmable Read Only Memory (PROM), are loaded into the monitor registers. These default values are preselected conservative values used as an interim measure to return the monitor on-line until the actual current monitor

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) PLANT VOGTLE - UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 4 2 4	LER NUMBER (6)			PAGE (3)	
		YEAR 8 8	SEQUENTIAL NUMBER 0 1 0	REVISION NUMBER 0 0	0 3	OF 0 4

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

parameters can be reentered. Because these default values are significantly lower than the normal background radiation level, a high radiation alarm occurred after the power reset sequence was completed.

A contributing cause of this event was the conservatively low values of the inserted default parameters for channel C.

E. ANALYSIS OF EVENT

No actual high radiation condition existed at the time of the event as shown by the redundant radiation monitors. The valves receiving the CVI signal actuated to their correct positions. Based on these considerations, it is concluded that there was no adverse effect on plant safety or public health and safety as a result of this event.

F. CORRECTIVE ACTIONS

1. The malfunctioning relay was replaced.
2. Plant engineering personnel are evaluating the application of this relay in the radiation monitor. The evaluation is expected to be complete by May 25, 1988.
3. Plant personnel are evaluating the acceptability of the permanently inserted default parameters, both in safety related and non-safety related radiation monitors. The evaluation is expected to be complete by May 25, 1988.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) PLANT VOCTLE - UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 4 2 4	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 8	0 1 0	0 0	0 4	0 4

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

G. ADDITIONAL INFORMATION

1. Failed Components

Relay manufactured by Potter and Brumfield
Model #K10P11A3524

2. Previous Similar Events

None

Several previous Licensee Event Reports addressed events relating to this radiation monitor; however, none of these events were caused by the failure of a relay.

3. Energy Industry Identification System

Radiation Monitoring System - IL
Containment Isolation Control System - JM

Georgia Power Company
333 Piedmont Avenue
Atlanta, Georgia 30308
Telephone 404 526 6526

Mailing Address:
Post Office Box 4545
Atlanta, Georgia 30302

Executive Department



Georgia Power

the southern electric system

SL-4638
0919m
X7GJ17-V310

May 6, 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
RELAY FAILURES CAUSES A
CONTAINMENT VENTILATION ISOLATION

Gentlemen:

Georgia Power Company is submitting a Licensee Event Report (LER) concerning an unplanned actuation of an Engineered Safety Feature (ESF) system.

Sincerely,

R. P. McDonald
Executive Vice President,
Nuclear Operations

PAH/lm

Enclosure: LER 50-424/1988-010

c: (see next page)

IE22
"11

U. S. Nuclear Regulatory Commission
May 6, 1988
Page Two

c: Georgia Power Company
Mr. P. D. Rice
Mr. G. Bockhold, Jr.
GO-NORMS

U. S. Nuclear Regulatory Commission
Dr. J. N. Grace, Regional Administrator
Mr. J. B. Hopkins, Licensing Project Manager, NRR (2 copies)
Mr. J. F. Rogge, Senior Resident Inspector-Operations, Vogtle

0919m