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

YES IT yes complete EXPECTED SUBMISSION DATE

SUPPLEMENTAL REPORT EXPECTED (14)

On April 25, 1988, at approximately 1048 CDT, it was discovered that a Technical Specification (TS) surveillance test had not been performed within the required time interval. In accordance with T.S. 4.0.5, the surveillance for the containment air radioactivity monitor inlet valves, HV-12975 and HV-12976, and outlet valves, HV-12977 and HV-12978 was required to be performed no later than April 25, 1988, at 0902 CDT. As soon as the Unit Shift Supervisor (USS) was informed it had been missed, the surveillance was performed immediately and satisfactory.

On May 13, 1988, at approximately 1400 CDT, it was realized that the plant should have entered T.S. 3.0.3 on April 25, 1988, since both isolation valves for the two (2) penetration were inoperable and a 1 hour report was made to the NRC.

This event occurred because the USS failed to utilize the scheduling document (i.e., Overdue Report). Also the On Shift Operations Supervisor (OSOS) was aware of the surveillance and when it was due, but failed to inform the USS. The T.S. 3.0.3 entry was not performed because the USS and the OSOS failed to perform an adequate technical review of the system condition.

Corrective actions include counseling of the USS and the OSOS concerning the use of the surveillance overdue report and performing an adequate technical review.

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EXPECTED SUBMISSION DATE 1151 DAY

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

		EXPIRES 8/7	
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EXT If more apoce is required, use additional NRC Form 366.4 (17)

A. REQUIREMENT FOR REPORT

This report is required per 10 CFR 50.73 (a) (2) (i) because a Technical Specification Surveillance was not performed within the required time interval and the plant operated for approximately seven (7) minutes in a condition prohibited by Technical Specification (TS).

B. UNIT STATUS AT TIME OF EVENT

Unit 1 was in Mode 3 (Hot Standby) with the reactor coolant system temperature and pressure at approximately 557 degrees fahrenheit and 2240 psig, respectively.

C. DESCRIPTION OF EVENT

On April 25, 1988, at approximately 1048 CDT it was discovered that a Technical Specification Surveillance Test had not been performed, within the required time interval, for four(4) Containment Ventilation Isolation (CVI) valves.

T. S. Section 4.0.5 requires, inservice inspection and testing of ASME Code Class 1, 2, and 3 components shall be as required by Section XI of the ASME Code. The containment air radioactivity monitor inlet valves, HV-12975 and HV-12976, and outlet valves, HV-12977 and HV-12978 stroke time surveillance test was required to be performed no later than April 25, 1988 at 0902 CDT. At approximately 1048 CDT on April 25, 1988, the Surveillance Tracking Coordinator (STC) informed the Unit Shift Supervisor (USS) that it appeared the surveillance had not been performed. The USS entered the Limited Condition of Operation (LCO) action statement, LCO #1-88-239, for TS Section 3.6.3. The surveillances were commenced immediately, completed satisfactorily, and the LCO 1-88-239 was exited at 10:55 CDT on April 25, 1988.

At approximately 1400 CDT on May 13, 1988, it was realized that the plant should have entered Section 3.0.3 (The "Motherhood Statement") and a one (1) hour report was made to the NRC. TS Section 3.6.3 action was not applicable since both isolation valves of the two (2) affected penerations were considered inoperable. Therefore the plant was operating in a condition prohibited by TS and the plant should have entered Section 3.0.3. Although a 3.0.3 entry was not documented at that time, the 3.0.3 action requirements were satisfied when the surveillance was completed at approximately 10:55 CDT on April 25, 1988.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104

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D. CAUSE OF EVENT

This event occurred because the USS did not review and utilize the surveillance scheduling documents (i.e. the Overdue Report). The overdue report is a listing, updated and issued on a daily basis, that identifies the surveillances which are past the normal scheduled date of the surveillance. This surveillance had been on the Overdue Report since April 17, 1988. A Surveillance Task Sheet (STS) is used to document the surveillance status, after it is performed in accordance with the surveillance procedure for the activity. The Operation's Surveillance Task Sheets are maintained in a Daily Activity Log Binder in the Control Room. Therefore when the STS for this surveillance was not in the Daily Activity Log Binder, the USS was not aware it was due, and it was not performed.

A contributing cause to this event was inadequate communication between the OSOS and the USS. The OSOS attended the morning management meeting on Friday, April 22, 1988. An extended overdue report was prepared for the weekend and this surveillance was brought to the attention of the OSOS at the meeting. However, the OSOS failed to bring this to the attention of the USS.

The 3.0.3 entry was not performed, because the USS and the OSOS failed to perform an adequate technical review of the system condition for this event.

E. ANALYSIS OF EVENT

The surveillance tasks, which were performed just prior to and after the missed surveillance task, were both satisfactory. Based on this consideration, it is concluded this event had no impact on plant safety or the health and safety of the public.

F. CORRECTIVE ACTION

- Appropriate personnel will be instructed on the use of the surveillance scheduling documents. These documents will be used during shift relief to improve communication and awareness. This action is scheduled to be completed by July 1, 1988.
- A letter was issued by the Operations Superintendent to ensure all licensed supervisors are aware of this event.
- The OSOS involved was counseled concerning this event, and the need to improve attention to detail in scheduling surveillances, and communication with the shift supervisor.
- 4. The USS and the OSOS were counseled concerning the lack of an indepth technical review of the system conditions due to the missed surveillance.

NRC Ferm 206A (9-63)	LICENSEE EVEN	REPORT (LER) TEXT CONTINU	JATIO	N	U	AP	PROVED O	MB NO			BION
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G. ADDITIONAL INFORMATION

1. Failed Component Identification

None

2. Previous Similar Events

None

Energy Industry identification Systems Codes
 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

R. P. McDonald Executive Vice President Nuclear Operations the southern electric system

NON-00108

May 24, 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

MISSED SURVEILLANCE DUE TO

PERSONNEL ERROR AND INADEQUATE COMMUNICATIONS

Gentlemen:

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company hereby submits a Licensee Event Report (LER) concerning a Technical Specification surveillance which was not performed within the required time interval.

Sincerely,

R. P. McDonald

HC/st1

Enclosure: LER 50-424/1988-014

c: (see next page)

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U. S. Nuclear Regulatory Commission May 24, 1988 Page Two

c: Georgia Power Company Mr. P. D. Rice

Mr. G. Bockhold, Jr.

Mr. M. Sheibani Mr. L. T. Gucwa 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