NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

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

TITLE (4)

PROCEDURE INADEQUACY LEADS TO 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)
										0 5 0 0 0
1 0	0 4	8 8	8 8	- 0 2 7	- 0 0	1 0	2 6	8 8		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
1		20.402(b)	20.405(c)	X 50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0 8 2	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 and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	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
J. E. Swartzwelder, Nuclear Safety and Compliance Manager	4 0 4 8 2 6 - 3 6 1 8

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On October 4, 1988, a technician was in the process of changing out a circuit component in the Containment Low Range Radiation Monitor, 1RE-0003. The monitor was placed in bypass and, at 0938 CDT, was powered down, initiating a Containment Ventilation Isolation (CVI).

Control room personnel observed a 1RE-0003 high radiation alarm and CVI indicators. They verified that no high radiation condition existed by observing redundant monitors. Control room personnel were aware of the 1RE-0003 work in progress and immediately contacted the technician to determine the cause of the CVI. The CVI signal was reset at 1215 CDT.

The cause of this event is an inadequate procedure that did not call for the lifting of leads to the CVI actuation circuits before powering down 1RE-0003. Corrective actions include changing the procedure.

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 2 7	— 0 0	0 2 OF 0 3

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

A. REQUIREMENT FOR REPORT

The report is required per 10 CFR 50.73 (a)(2)(iv) because an unplanned actuation of an Engineered Safety Feature occurred.

B. UNIT STATUS AT TIME OF EVENT

At the time of this event, Unit 1 was in Mode 1 (power operations) at 82% of rated thermal power. There was no inoperable equipment which contributed to the occurrence of this event.

C. DESCRIPTION OF EVENT

On October 4, 1988, a technician was in the process of changing out a circuit component in the Containment Low Range Radiation Monitor, 1RE-0003. The monitor was placed in bypass and, at 0938 CDT, was powered down, initiating a Containment Ventilation Isolation (CVI).

The appropriate valves and dampers actuated. Control room personnel observed a 1RE-0003 high radiation alarm and CVI indicators. They verified that no high radiation condition existed by observing redundant monitors. Control room personnel were aware of the 1RE-0003 work in progress and immediately contacted the technician to determine the cause of the CVI. The CVI signal was reset at 1215 CDT.

D. CAUSE OF EVENT

The cause of this event is an inadequate procedure. The procedure in use at the time, 24623-1 ("Containment Low Range (1RE-0003) Area Monitor 1RX-0003 Channel Operational Test And Channel Calibration"), allows unscheduled maintenance to be performed. However, it did not call for the lifting of leads to the CVI actuation circuits before powering down 1RE-0003.

Contributing to this event was the lack of blocking capability to block a spurious CVI actuation from 1RE-0003 while work was in progress.

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 and dampers 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. Procedure 24623-1 and a procedure used with a similar monitor (1RE-0002) are scheduled to be changed by 11/15/88 to incorporate steps to prevent CVI actuations.

2. An evaluation to implement CVI actuation blocking capabilities for 1RE-0002 and 1RE-0003 is estimated to be complete by 3/1/89.

3. Following this event, a broadness review was instituted to study corrective actions from this and previous similar events. Recommendations as a result of this review, if any, are expected to be made by 3/1/89.

G. ADDITIONAL INFORMATION

1. Component Failures

None

2. Previous Similar Events

LER 50-424/1988-026

LER 50-424/1987-060

LER 50-424/1987-040

Although the specific corrective actions from these LERs did not effect this 10/4/88 event because the events were not duplicates, a study will determine if more, general types of corrective actions are needed.

3. Energy Industry Identification System Code:

Containment Isolation Containment Isolation Control System - JM

Radiation monitoring System - IL

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W. G. Hairston, III
Senior Vice President
Nuclear Operations

the southern electric system

NON-00387

October 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
PROCEDURE INADEQUACY LEADS TO
CONTAINMENT VENTILATION ISOLATION

Gentlemen:

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company hereby submits a Licensee Event Report (LER) concerning a Containment Ventilation Isolation due to procedure inadequacy.

Sincerely,

W. G. Hairston, III

TEW:ca

Enclosure: LER 50-424/1988-027

c: Georgia Power Company
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GO-NORMS
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