

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 3
---	---	-----------------------------

TITLE (4)
INADEQUATE INSTALLATION LEADS TO CONTAINMENT VENTILATION ISOLATIONS

EVENT DATE (5)			LJR 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	6	10	8	8	8	8	8	8	0	1	9	0	0	0	7	0	5	8	8	0	5	0	0	0

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) 1 0 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.38(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"/> 50.38(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input 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)	
NAME J. E. Swartzwelder, Nuclear Safety and Compliance Manager	TELEPHONE NUMBER AREA CODE: 4 0 4 NUMBER: 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 NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

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 6-10-88, at 0016 CDT, a Containment Ventilation Isolation (CVI) occurred due to an apparent power supply failure in radiation monitor 1RE-2565C. The appropriate dampers and valves actuated as designed. Control room personnel verified that no abnormal radiation condition existed. At 0206 CDT, 1RE-2565C was bypassed and the CVI signal was reset.

At 0212 CDT another CVI occurred, when plant personnel removed 1RE-2565C from bypass in order to reenter monitor setpoints. Again the proper dampers and valves actuated and control room personnel verified that no abnormal radiation condition existed. By 0218 CDT, 1RE-2565C was again placed in bypass and the CVI signal was reset.

An investigation demonstrated that the cause of the CVI's was an inadequate installation which left a flow transmitter shield wire exposed that electrically grounded, simulating a loss of power. Corrective action includes insulating the shield wire.

IE22
1/1

8807150136 880705
PDR ADOCK 05000424
S PDC

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) PLANT VOGTLE - UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 4 2 4 8 8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 8	0 1 9	0 0	0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 388A's) (17)

A. REQUIREMENT FOR REPORT

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

B. UNIT STATUS AT TIME OF EVENTS

At the time of these events Unit 1 was in Mode 1 (power operations) at 100% rated thermal power. There was no inoperable equipment which contributed to the occurrence of these events.

C. DESCRIPTION OF EVENTS

On 6-10-88, at 0016 CDT, a Containment Ventilation Isolation (CVI) occurred due to an apparent power supply failure in radiation monitor 1RE-2565C. The appropriate dampers and valves actuated as designed. Control room personnel verified that no abnormal radiation condition existed by observing redundant monitors. Because personnel were troubleshooting the monitor, the CVI signal was not quickly reset. At 0206 CDT, 1RE-2565C was placed in bypass and the CVI signal was reset. At 0212 CDT, 1RE-2565C was taken out of bypass to re-enter monitor setpoints when another CVI occurred. Again, the proper dampers and valves actuated and control room personnel verified that no abnormal radiation condition existed. By 0218 CDT, 1RE-2565C was again placed in bypass and the CVI signal was reset.

D. CAUSE OF EVENT

An investigation showed that the root cause of the CVI's is an inadequate installation which left a flow transmitter shield wire partially exposed. Vibration of the underlying equipment skid eventually caused a slight movement of the wire until it contacted a metal enclosure and electrically grounded, simulating a loss of power. The data processing module of the radiation monitor sensed a loss of power and automatically inserted default parameters. These default parameters are abnormally low values. Subsequently, the normal background radiation level was sufficient to trigger high radiation alarms and CVI signals were generated.

E. ANALYSIS OF EVENTS

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.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) PLANT VOGTLE - UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 4 2 4 8 8	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 8	- 0 1 9	- 0 0	0 3	OF	0 3

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

F. CORRECTIVE ACTIONS

1. The exposed transmitter shield wire was insulated from further grounding and radiation monitor flow transmitters with similar wiring are being inspected. These inspections and any necessary repairs are scheduled to be completed by 9-1-88.
2. New default parameters which incorporate the higher, actual background values are forecast to be in place by 9-2-88.

G. ADDITIONAL INFORMATION

1. Failed Components
None
2. Previous Similar Events
Several previous License Events Reports addressed events where abnormally low default parameters led to high radiation alarms and CVI actuation:

LER 50-424/1988-010, 5-6-88
LER 50-424/1987-065, 12-9-87
LER 50-424/1987-022-01, 3-10-88
3. Energy Industry Identification System Code
Radiation Monitoring System - IL
Confinement 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

Nuclear Operations Department



Georgia Power

the southern electric system

NON-00181

July 5, 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
INADEQUATE INSTALLATION LEADS TO
CONTAINMENT VENTILATION ISOLATIONS

Gentlemen:

In accordance with the requirements of 10 CFR 50.73, Georgia Power Company hereby submits a Licensee Event Report (LER) concerning Containment Ventilation Isolations which represent actuations of an Engineered Safety Feature.

Sincerely,

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

TEW:st1

Enclosure: LER 50-424/1988-019

c: (see next page)

TEW
11

U. S. Nuclear Regulatory Commission
July 5, 1988
Page 2

c: Georgia Power Company
Mr. P. D. Rice
Mr. G. Bockhold, Jr.
Mr. M. Sheibani
Mr. L. T. Gucwa
GO-NORMS
VOGTLE-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