

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>VOGTLE - UNIT 1</b>	DOCKET NUMBER (2) <b>0 5 0 0 0 4 2 4</b>	PAGE (3) <b>1 OF 0 4</b>
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TITLE (4)  
**USE OF IMPROPER TOOL 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)																																											
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<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">OPERATING MODE (9) <b>1</b></td> <td colspan="11">THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)</td> </tr> <tr> <td rowspan="5">POWER LEVEL (10) <b>1 0 0</b></td> <td>20.402(b)</td> <td><input checked="" type="checkbox"/></td> <td>50.73(a)(2)(iv)</td> <td><input type="checkbox"/></td> <td>73.71(b)</td> </tr> <tr> <td>20.405(a)(1)(i)</td> <td><input type="checkbox"/></td> <td>50.73(a)(2)(v)</td> <td><input type="checkbox"/></td> <td>73.71(e)</td> </tr> <tr> <td>20.405(a)(1)(ii)</td> <td><input type="checkbox"/></td> <td>50.73(a)(2)(vi)</td> <td><input type="checkbox"/></td> <td>OTHER (Specify in Abstract below and in Text, NRC Form 366A)</td> </tr> <tr> <td>20.405(a)(1)(iii)</td> <td><input type="checkbox"/></td> <td>50.73(a)(2)(vii)(A)</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>20.405(a)(1)(iv)</td> <td><input type="checkbox"/></td> <td>50.73(a)(2)(vii)(B)</td> <td><input type="checkbox"/></td> <td></td> </tr> <tr> <td>20.405(a)(1)(v)</td> <td><input type="checkbox"/></td> <td>50.73(a)(2)(ix)</td> <td><input type="checkbox"/></td> <td></td> </tr> </table>												OPERATING MODE (9) <b>1</b>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)											POWER LEVEL (10) <b>1 0 0</b>	20.402(b)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	<input type="checkbox"/>	73.71(b)	20.405(a)(1)(i)	<input type="checkbox"/>	50.73(a)(2)(v)	<input type="checkbox"/>	73.71(e)	20.405(a)(1)(ii)	<input type="checkbox"/>	50.73(a)(2)(vi)	<input type="checkbox"/>	OTHER (Specify in Abstract below and in Text, NRC Form 366A)	20.405(a)(1)(iii)	<input type="checkbox"/>	50.73(a)(2)(vii)(A)	<input type="checkbox"/>		20.405(a)(1)(iv)	<input type="checkbox"/>	50.73(a)(2)(vii)(B)	<input type="checkbox"/>		20.405(a)(1)(v)	<input type="checkbox"/>	50.73(a)(2)(ix)	<input type="checkbox"/>	
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LICENSEE CONTACT FOR THIS LER (12)

NAME <b>J. E. Swartzwelder, Nuclear Safety and Compliance Manager</b>	TELEPHONE NUMBER <b>4 0 4 8 2 6 - 3 6 1 8</b>
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

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)

On 9/7/88, an electrician was in the process of reinstalling shorting bars into fuse holders following the completion of an electrical switch replacement. At 1257 CDT, the electrician unintentionally created a short between two 120 volt AC circuits. Various alarms and indicators actuated, including those for a Containment Ventilation Isolation (CVI). The appropriate CVI valves and dampers actuated. Control room personnel verified that no abnormal radiation condition existed by observing redundant monitors. The control room personnel and the electrician immediately notified each other and confirmed that the electrical short had initiated the CVI.

The cause of this event is the use of an improper tool by the electrician. Fuse pullers provided to the electrician would not fit between the inserted shorting bars, so he used needle-nose pliers to perform the insertions. These pliers made the electrical short by simultaneously contacting two shorting bars following one shorting bar's insertion. Appropriate personnel will be advised to avoid the use of needle-nose pliers or makeshift tools for installation of fuses or shorting bars. Also, the proper size fuse-pullers will be made available.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (if more space is required, use additional NRC Form 385A's) (17)

## A. REQUIREMENT FOR REPORT

This 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 100% rated thermal power. There was no inoperable equipment which contributed to the occurrence of this event.

## C. DESCRIPTION OF EVENT

On 9/7/88, an electrician was in the process of reinstalling shorting bars into fuse holders following the completion of an electrical switch replacement. The fuse holders are located in the Balance of Plant (BOP) Safety Actuation Cabinet in the main control room. At 1257 CDT, the electrician unintentionally created a short between two 120 volt AC circuits.

This initiated various alarms:

- (1) 480 Volt Non-1E switchgear alarm
- (2) 120 volt AC panel trouble alarm
- (3) Inverter trouble alarm
- (4) 4160 Volt 1E switchgear trouble alarm
- (5) Sequencer trouble alarm
- (6) Pressurizer level alarm
- (7) Radiation monitor trouble alarm
- (8) 1RE-0003 area radiation monitor high alarm
- (9) Containment Ventilation Isolation (CVI) indicating lights

The appropriate CVI valves and dampers actuated. Control room personnel verified that no abnormal radiation condition existed by observing redundant monitors. The control room personnel and electrician had previously discussed the possibility of problems created by the electrician's cramped working conditions and immediately notified each other confirming that the electrical short had initiated the CVI. Recovery from the CVI was complete at 1330 CDT. The various other indications and alarms, which were also found to be caused by the electrical short, were reset.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		— 0 2	6	— 0 1	0	0 3 OF 0 4

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

D. CAUSE OF EVENT

The direct cause of this event is the electrical short which led to a momentary loss of power to 1RE-0003, resulting in a high radiation alarm and a CVI.

The root cause of this event is the use of an improper tool by the electrician. Fuse pullers provided to the electrician would not fit between the inserted shorting bars, so he used needle-nose pliers to perform the insertions. These pliers made the electrical short by simultaneously contacting two shorting bars following one shorting bar's insertion.

Contributing to this event were the cramped conditions surrounding the fuse holders. Although the electrician had successfully inserted three shorting bars without incident, the tight quarters which he encountered were a hindrance to the completion of his task.

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. Appropriate personnel will be advised to avoid the use of needle-nose pliers or makeshift tools for installation of fuses or shorting bars and to contact their foreman if the occasion arises. They will also be instructed to exercise extreme care when working in cramped conditions. These guidance sessions are expected to be complete by 10/31/88.
2. Proper-size fuse pullers will be obtained and are scheduled to be available for use by 12/1/88.

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TEXT (if more space is required, use additional NRC Form 285A's) (17)

G. ADDITIONAL INFORMATION

1. Failed Components

None

2. Previous Similar Events

No previous ESF actuations have occurred as a result of the use of improper tools.

3. Energy Industry Identification System Code:

Containment Isolation Control System - JM

Radiation Monitoring System - IL

Reactor Coolant System - AB

4160 Volt IE Switchgear System - EB

480 Volt Non-IE Switchgear System - EC

120 volt AC power supply system - EF

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

Mailing Address:  
Post Office Box 4545  
Atlanta, Georgia 30302

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

the southern electric system

NON-00344

October 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  
USE OF IMPROPER TOOL 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.

Sincerely,

  
W. G. Hairston, III

TEW:dmh

Enclosure: LER 50-424/1988-026

c: Georgia Power Company  
Mr. P. D. Rice  
Mr. G. Bockhold, Jr  
Mr. M. Sheibani  
Mr. J. P. Kane  
GC-NORMS  
Vogtle/NCRMS

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

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