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At 1520 on February 10, 1994, Train A of the Control Room Toxic Gas Isolation System (TGIS) [VI] was manually actuated as required by Technical Specification 3.3.2, "Engineered Safety Features Actuation System Instrumentation," Action Statement B when both trains of TGIS instrumentation became inoperable. Train A was inoperable due to sample pump replacement. Train B became inoperable at approximately 1430 when the discharge fire damper of Control Room Cabinet Area Emergency Unit E426 became inoperable during surveillance testing. Train A TGIS components operated correctly. E426 was restored to operability at 1640 and TGIS Train A was reset at 1730.

The cause of E426 inoperability was the inadvertent dropping into the ventilation duct, during an 18-month surveillance test, of the fusible link that holds the discharge fire damper of E426 open. Corrective action was to retrieve and reinstall the fusible link, thereby restoring the fire damper to operability, and to reset TGIS Train A. No further corrective action is required for this event; however, the timing of the surveillance of the fire damper associated with E426 with respect to potential cross-train impact is being reviewed separately for lessons learned.

Because TGIS Train A was manually actuated and operated as designed, this event had no safety significance. Additionally, there was no toxic gas present.

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