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This report involves two incidents of personnel inadvertently removing power from radiation monitors resulting in Engineered Safety Feature (ESF) actuations.

The first incident occurred on 8/13/84 at approximately 1640 CDT. Instrumentation and Control (I&C) technicians were in the process of performing a functional check on radiation monitor GT-RT-31. This requires that GT-RT-31 be bypassed at the ESF cabinets prior to removing power from the radiation monitor skid. Located parallel to GT-RT-31 is radiation monitor GT-RT-33. The I&C technicians had placed the channel for GT-RT-31 in bypass as required, however, they inadvertently removed power from GT-RT-33 instead. This resulted in a Control Room Ventilation Isolation Signal (CRVIS) and a Containment Purge Isolation Signal (CPIS).

The second incident occurred on 8/17/84 at approximately 1525 CDT. Maintenance support personnel were upgrading wiring in the 480 VAC NGO1B bus. While the personnel were reinstalling the panel cover to NGO1B they inadvertently hit and opened the breaker providing power to radiation monitor GG-RT-27. This loss of power to GG-RT-27 resulted in a Fuel Building Isolation Signal (FBIS) and a CRVIS.

No radiation above normal background was present and this event has in no way affected the health and safety of the public.

NRC Form 366A (9-83)		U.S. NUC
(9-63)	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION	AP
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LEAR REGULATORY COMMISSION PROVED OMB NO 3150_0104 PIRES: 8/31/85

FACILITY NAME (1)			DOCKET NUMBER (2)							LER NUMBER (6)								PAGE (3)						
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

On 8/13/84 and 8/17/84 the plant experienced inadvertent Engineered Safety Feature (ESF) actuations, due to loss of power to radiation monitors GT-RT-33 and GG-RT-27 respectively. The plant was in Mode 4, Hot Shutdown, 0% power at the time of the incidents. These inadvertent ESF actuations are classified as reportable under 10 CFR 50.73(a)(2)(iv).

The first incident occurred on 8/13/84 at approximately 1640 CDT. Instrumentation and Control (I&C) technicians were in the process of performing a functional check on radiation monitor GT-RT-31. This requires that GT-RT-31 be bypassed at the ESF cabinets prior to removing power from the radiation monitor skid. Located parallel to GT-RT-31, on the 2047' level of the Auxiliary Building, is radiation monitor GT-RT-33. The I&C technicians had placed the channel for GT-RT-31 in the bypass mode, as required to perform the functional check. However, when they were ready to remove power from GT-RT-31 they inadvertently removed power from GT-RT-33 instead. This resulted in a Control Room Ventilation Isolation Signal (CRVIS) and a Containment Purge Isolation Signal (CPIS). Power was returned to GT-RT-33 and the CRVIS and CPIS were restored, per plant operating procedures.

The second incident occurred on 8/17/84 at approximately 1525 CDT. Maintenance support personnel were upgrading wiring in the 480 VAC bus NG01B. When the personnel were reinstalling the panel cover to NB01B they inadvertently hit and opened the breaker providing power to radiation monitor GG-RT-27. This loss of power to GG-RT-27 resulted in a Fuel Building Isolation Signal (FBIS) and a CRVIS. By 1640 CDT the power to GG-RT-27 was restored and the FBIS and CRVIS were reset per plant operating procedures.

I&C and Maintenance supervisors have reviewed these incidents with departmental personnel. It was stressed that personnel must use the utmost of caution when performing tests or maintenance to avoid inadvertently de-energizing or upsetting plant equipment. In addition, the Plant Manager and/or Assistant Plant Managers have also held a series of meetings with plant staff and support personnel. The purpose of these meetings was to enhance the communication of management's philosophy to all levels of the work force, highlight the recent Callaway events, and stress the necessity for improving individual performance, group performance, and communication. These meetings were completed 9/7/84.

No radiation above normal background was present and this event has in no way affected the health or safety of the public.

Previous occurrences: LER 84-019-00

UNION ELECTRIC COMPANY CALLAWAY PLANT

P.O. BOX 620 FULTON, MO. 65251

September 11, 1984

U. S. Nuclear Regulatory Commission Document Control Desk Washington, DC 20555

ULNRC-923

DOCKET NUMBER 50-483
CALLAWAY PLANT UNIT 1
FACILITY OPERATING LICENSE NPF-25
LICENSEE EVENT REPORT 84-027-00
INADVERTENT ENGINEERED SAFETY FEATURES ACTUATION

Gentlemen:

The enclosed Licensee Event Report is submitted pursuant to 10 CFR 50.73(a)(2)(iv) concerning inadvertent Engineered Safety Features actuations.

S. E. Miltenberger / Manager, Callaway Plant

Steven & Millertings

APN/CDN/WRR/RCW/drs Enclosure

cc: Distribution attached

cc distribution for ULNRC-923

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