

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Callaway Plant Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 4 8 3	PAGE (3) 1 OF 0 2
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TITLE (4)  
Inadvertent Control Room 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 1 2 5	8 5	8 5	8 5	0 0 4	0 0 0	0 2 2	5 8	5			0 5 0 0 0
											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	20.402(b)	20.405(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)					
	20.405(a)(1)(i)	50.38(c)(1)		50.73(a)(2)(v)	73.71(c)					
	20.405(a)(1)(ii)	50.38(c)(2)		50.73(a)(2)(vi)	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)(vii)(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)(v)							

LICENSEE CONTACT FOR THIS LER (12)

NAME Charles D. Naslund - Superintendent, I&C	TELEPHONE NUMBER
	AREA CODE: 3 1 4   6 7 6   - 1 8 5 1 0 1 0

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)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15): MONTH:    DAY:    YEAR:
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On 1/25/85 and 2/2/85 Containment Purge Isolations and Control Room Ventilation Isolations occurred due to incorrect high radiation signals from a containment process monitor. All equipment functioned as designed following the actuations.

In both events, the incorrect high radiation signal was caused by a high vacuum at the inlet sample line to the containment process monitor. In the first event, the high vacuum condition occurred during a Technical Specification surveillance procedure which required stroke testing the sample line isolation valves to the monitor without taking the monitor out of service. The cause of the second high vacuum condition is suspected to be a malfunction of the inlet valves on the monitor itself.

The surveillance procedure responsible for the first event is currently being revised to require taking the monitor out of service prior to stroking the sample line isolation valves. Additionally, the operating console for the containment process monitoring system has been marked indicating the possible malfunction of the sample line valves of the process monitor. A plant work request has been issued to investigate the operation of the sample line valves to the monitor. Corrective actions pertaining to these events are expected to be complete by 3/1/85.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Callaway Plant Unit 1	DOCKET NUMBER (2)  0   5   0   0   0   4   8   3   8   5   -   0   0   4   -   0   0   0   2	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		

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

On 1/25/85 and 2/2/85 Containment Purge Isolations and Control Room Ventilation Isolations (CPIS/CRVIS) were actuated due to a incorrect high radiation signal from containment process monitor GT-RE-32. All Engineered Safety Features equipment functioned as designed following the actuations.

Prior to the first event, the plant was in Mode 1 at approximately 100% power, and Technical Specification surveillance procedure OSP-GS-V0001, "Hydrogen Control System Mode 1 Valve Operability," which requires stroke testing the sample line isolation valves to GT-RE-32, was being performed. Also, monitor GT-RE-32 was operating in the "Alert Alarm" mode prior to this event.

The inlet suction valve to monitor GT-RE-32 was stroked closed per OSP-GS-V0001. This valve closure resulted in a high vacuum alarm at the monitor. The high vacuum caused the monitor to apply a large correction factor to the current radiation reading thus taking the value over the alarm setpoint, subsequently actuating a CPIS/CRVIS at 0552 CST.

To prevent recurrence of this event, surveillance procedure OSP-GS-V0001 is being revised to require taking the monitor out of service prior to stroking the sample line isolation valves. This revision is expected to be complete by 2/26/85.

Prior to the second event, the plant was in Mode 1 at approximately 60% power. At 0835 CST a monitor purge was requested for process monitor GT-RE-32. At 0837 the purge terminated and a high vacuum alarm occurred at the monitor. As before, a large correction factor was applied to the current radiation reading and the alarm setpoint was exceeded, generating a CPIS/CRVIS.

A malfunction of the purge valves on the monitor skid itself is suspected to have generated the high vacuum condition. On 2/7/85 with the actuation systems bypassed, a purge cycle was initiated on GT-RE-32 and the same high vacuum conditions occurred when the purge was terminated.

A condition tag has been attached to the operating console of the monitoring system indicating the possible malfunction of the monitor purge valves. A plant work request has been issued and is currently being scheduled to investigate/correct the monitor purge valve malfunctions. This is expected to be completed by 3/1/85.

There was no damage to plant equipment or release of radioactivity as a result of these incidents. Since the aforementioned actuations were initiated by an incorrect electrical signal and not actual radiation levels, the public health and safety was not threatened at any time during these events.

Previous occurrences: none

UNION ELECTRIC COMPANY  
CALLAWAY PLANT

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February 25, 1985

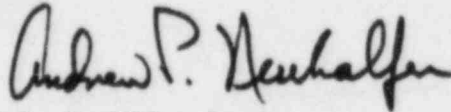
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ULNRC-1046

Gentlemen:

DOCKET NUMBER 50-483  
CALLAWAY PLANT UNIT 1  
FACILITY OPERATING LICENSE NPF-30  
LICENSEE EVENT REPORT 85-004-00  
INADVERTENT CONTROL ROOM VENTILATION ISOLATION

The enclosed Licensee Event Report is submitted pursuant to 10 CFR 50.73(a)(2)(iv) concerning an inadvertent Control Room Ventilation Isolation Signal caused by a spurious radiation monitor signal.

*for* 

S. E. Miltenberger  
Manager, Callaway Plant

CDN/JMS/drs  
Enclosure

cc: Distribution attached

*LEZZ*  
*11*

cc distribution for ULNRC-1046

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