

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **ST. LUCIE, UNIT 2** DOCKET NUMBER (2) **0 5 0 0 0 3 8 9** PAGE (3) **1 OF 2**

TITLE (4)
Inadvertent Containment Isolation Signal Actuation

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)												
1	0	2	4	8	4	0	0	7	1	1	2	3	8	4	St. Lucie 1	0	5	0	0	0	3	3	5
												0	5	0	0	0							

OPERATING MODE (9) **6** THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

20.402(b)	<input type="checkbox"/>	20.408(a)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	<input type="checkbox"/>	72.71(b)	<input type="checkbox"/>
20.408(a)(1)(i)	<input type="checkbox"/>	50.73(a)(1)	<input type="checkbox"/>	50.73(a)(2)(v)	<input type="checkbox"/>	72.71(c)	<input type="checkbox"/>
20.408(a)(1)(ii)	<input type="checkbox"/>	50.73(a)(2)	<input type="checkbox"/>	50.73(a)(2)(vi)	<input type="checkbox"/>	OTHER (Specify in Abstract below and in Text, NRC Form 305A)	
20.408(a)(1)(iii)	<input type="checkbox"/>	50.73(a)(2)(i)	<input type="checkbox"/>	50.73(a)(2)(vii)(A)	<input type="checkbox"/>		
20.408(a)(1)(iv)	<input type="checkbox"/>	50.73(a)(2)(ii)	<input type="checkbox"/>	50.73(a)(2)(vii)(B)	<input type="checkbox"/>		
20.408(a)(1)(v)	<input type="checkbox"/>	50.73(a)(2)(iii)	<input type="checkbox"/>	50.73(a)(2)(viii)	<input type="checkbox"/>		

LICENSEE CONTACT FOR THIS LER (12)

NAME: **S. A. Valdes, Shift Technical Advisor.** TELEPHONE NUMBER: **3 10 5 4 6 5 - 3 5 5 10**

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS										
A	J	K	M	O	N	G	0	6	3	N									

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, specify EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 17 lines single-space typewritten final) (16)

During a refueling outage, St. Lucie Unit 2 received a Containment Isolation Signal (CIS) Actuation. The source of the signal was 2 of 4 Containment High Radiation Monitors. All immediate actions pursuant to a CIS Actuation were carried out. Control Room ventilation on Unit 1 shifted to filtered recirculation mode, as specified by a Unit 2 CIS Actuation. This Actuation was caused by improper calibration of one Containment Radiation Monitor, shortly followed by maintenance of a second Radiation Monitor. A phone notification, as required by 10 CFR 50.72 (b) (2) (ii), was made over ENS notification system to the Nuclear Regulatory Commission at 0010 on 10/25/84.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) ST. LUCIE UNIT 2	DOCKET NUMBER (2) 0 5 0 0 0 3 8 9 8 4 - 0 0 7 -	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
					2	OF 2

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

On 10/24/84, at approximately 2255, Unit 2 received an Inadvertent Containment Isolation Signal (CIS) Actuation. The source of the Actuation was a 2 of 4 logic from the Containment CIS High Radiation Monitors. All automatic and manual immediate actions of a CIS Actuation were carried out. Subsequently, it was discovered that all areas of containment were at normal radiation levels for the condition the Plant was in. Upon investigation of the Actuation, it was discovered that one High Radiation Monitor (Channel "C") was in alarm at a normal radiation reading. At the time of Actuation, maintenance on a second monitor (Channel "B") was in progress. It was determined that, earlier in the day, personnel had incorrectly entered an abnormally low alarm setpoint in Channel "C" monitor as part of scheduled calibration. A procedure was being used, however, it was not properly followed. Since all CIS Radiation Monitors are tied together by a system computer, due to the erroneous calibration, the wrong setpoint had been entered into the computer, and the erroneous calibration had gone unnoticed. Subsequently, trouble-shooting on the "B" Channel Monitor commenced. As part of the approved trouble-shooting procedure, the central computer had to be reset or "rebooted". This reset causes the computer to discard all previous setpoint inputs and respond to setpoints entered at the monitor. Channel "B" was out of service at this time and in a "Trip" condition. Upon rebooting, the new, erroneous setpoint from Channel "C" was entered in the computer, processed, and sent to the Engineering Safety Features (EFS) Actuation Logic Cabinets, where, coupled with the existing "Trip" condition from Channel "B", the 2 of 4 Actuation Logic was met, thereby causing the Actuation. Following the required immediate actions, and investigation, Channel "C" was promptly and correctly calibrated. Personnel involved in the calibration process were reminded of the importance of procedural compliance.



November 23, 1984

L-84-348

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

Gentlemen:

Re: Reportable Event 84-007
St. Lucie Unit 2
Date of Event: 10-24-84
Inadvertant CIS

The attached Licensee Event Report is being submitted pursuant to the requirements of 10 CFR to provide notification of the subject event.

Very truly yours,

J.W. Williams, Jr.
J.W. Williams, Jr.
Group Vice President
Nuclear Energy

JWW/PLP:mvt

Attachment

cc: J.P. O'Reilly, Region II, USNRC
Harold F. Reis, Esquire
File 933.1

IE22
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