

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **BYRON, UNIT 1** DOCKET NUMBER (2) **0 5 0 0 0 4 5 4 1** OF **0 1 2**

TITLE (4) **AUTO START OF CONTROL ROOM FAN**

EVENT DATE (6)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)													
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)											
1	2	2	5	8	4	8	4	0	3	9	0	0	0	1	2	4	5	0	5	0	0	0

OPERATING MODE (9) **5**

POWER LEVEL (10) **0 0 0**

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

<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.402(a)	<input checked="" type="checkbox"/> 20.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
<input type="checkbox"/> 20.402(a)(1)(B)	<input type="checkbox"/> 20.30(a)(1)	<input type="checkbox"/> 20.73(a)(2)(v)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.402(a)(1)(B)	<input type="checkbox"/> 20.30(a)(2)	<input type="checkbox"/> 20.73(a)(2)(vi)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 305A)
<input type="checkbox"/> 20.402(a)(1)(B)	<input type="checkbox"/> 20.73(a)(2)(i)	<input type="checkbox"/> 20.73(a)(2)(vii)(A)	
<input type="checkbox"/> 20.402(a)(1)(B)	<input type="checkbox"/> 20.73(a)(2)(ii)	<input type="checkbox"/> 20.73(a)(2)(vii)(B)	
<input type="checkbox"/> 20.402(a)(1)(B)	<input type="checkbox"/> 20.73(a)(2)(iii)	<input type="checkbox"/> 20.73(a)(2)(viii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **Rich Hildebrand, System Test Engineer, Ext. 250** TELEPHONE NUMBER **8 1 5 2 3 4 - 5 4 4 1**

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
A	I	L	G 0 6 3	N					

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-spaced typewritten lines) (16)

A monitor "loss-of-sample-flow" alarm on the OPR33J (Main Control Room Outside Air Intake 'B') radiation monitor automatically caused the Control Room Ventilation System to switch to its make up mode of operation. The alarm resulted when the operator manually stopped the ventilation purge prematurely during a filter change operation. Training was provided to the appropriate personnel in regards to this event.

8502040052 850124  
PDR ADOCK 05000454  
S PDR

IE22  
1/1

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  BYRON, UNIT 1	DOCKET NUMBER (2)  0 5 0 0 0 4 5 4	LER NUMBER (8)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 5	0 3 9	0 0	0 2	OF 0 2

TEXT (If more space is required, use additional NRC Form 386A's) (17)

On December 25, 1984 at 0755 with the plant operating in Mode 5, the gas monitor channels of radiation monitor OPR33J (Main Control Room Outside Air Intake 'B') underwent a "loss-of-sample-flow" during a filter change operation. Due to the interlock alarm, the ventilation system for the Main Control Room automatically switched to the ESF make-up mode of operation.

The monitor "loss-of-sample-flow" alarm was caused by a personnel error. The filter change procedure is structured so that the radiation monitor is placed in the purge mode prior to a filter change. This blocks various interlocks which during the changing of a filter can cause the ventilation to shift to the makeup mode. The purge lasts for 30 minutes then the monitor returns to normal operation automatically. While the filter is being removed from the monitor, the automatic flow control feature attempts to compensate for excessive flow. In this case, after the filter was replaced, the NSO took the monitor out of the purge mode manually before the automatic flow control feature could return sample flow to normal. As the automatic control feature was restricting flow due to the filter change, the "loss-of-sample-flow" alarm actuated causing the ventilation to shift to the makeup mode.

Plant and public safety were not affected since the result of the event was to switch the Control Room HVAC to a safer mode of operation.

The operator was instructed on proper procedure use, and this event was discussed with all appropriate licensed personnel through training.

There have been similar occurrences of ventilation makeup mode shifts during filter changes, (LER 84-018-00, LER 84-027-00). The earlier occurrences were due to an improper procedure which has been corrected.



**Commonwealth Edison**  
Byron Nuclear Station  
4450 North German Church Road  
Byron, Illinois 61010

January 24, 1985

LTR: BYRON 85-0118

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

Dear Sir:

The enclosed Licensee Event Report from Byron Generating Station is being transmitted to you in accordance with the requirements of 10CFR50.73(a)(2)(iv) which requires a 30 day written report.

This report is number 84-039-00, Docket No. 50-454.

Very truly yours,

R. E. Querio  
Station Superintendent  
Byron Nuclear Power Station

REQ/vda

Enclosure: Licensee Event Report No. 84-039-00

cc: J. G. Keppler, NRC Region III Administrator  
J. Hinds, NRC Resident Inspector  
INPO Record Center  
CECO Distribution List

IFX2  
1/1