NRC F: 1 (9-83)	LICENSEE EVENT REPORT (LER)									AF	.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/86							
FACILITY	Y NAME (1)		_		_						1	DOCKET N			PAGE (3)		
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								CENSEE	CONTAC	T FOR THIS	LER (12)							
NAME	Merli	n G.	Will	iam		Ac	dmini	strat	ive S	Service	es	Quality	31	A CODE	3 6 4 -	18 18 13 1		
CAUSE	SYSTEM	COMP	PONENT	MANUFAC P		REPORTABLE TO NPROS					SYSTEM	COMPONENT	MAN	UFAC- RER	REPORTABLE TO NPRDS			

ABSTRACT (Limit to 1400 speces, i.e., approximately fifteen single-space typewritten lines) (16)

SUPPLEMENTAL REPORT EXPECTED (14)

IIL MIOIN GO 613 N

YES (If yes, complete EXPECTED SUBMISSION DATE)

On seven different occasions between July 2 and July 12, 1985, an Engineered Safety Features actuation was initiated by a Control Room intake radiation monitor spurious alarm causing a Control Room Ventilation Isolation. In each instance, all required Engineered Safety Features equipment responded properly.

NO

The plant was in Mode 3, Hot Standby, prior to two of these events, and in Mode 1, Power Operation, with Reactor power levels ranging between 36 percent and 50 percent prior to the five other events. Each incident occurred with the Reactor Coolant System at normal operating pressure and temperature.

On each occasion, no radiation above normal background was present, as determined by a redundant radiation monitor, and at no time was the public health or safety threatened.

The cause of the radiation monitor spurious alarms has been attributed to a mismatch between the software and hardware in the microprocessing unit for the radiation monitor. A modification to the microprocessing unit has been installed to resolve the mismatch problem.

Previous actuations due to spurious alarms from this monitor were discussed in Licensee Event Reports (LER) 85-013-00 and 85-037-00. One additional actuation due to a spurious alarm occurred on July 12, 1985, and will be reported in a separate LER.

MONTH

EXPECTED SUBMISSION DATE (16) YEAR

NRC Form 366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OM8 NO. 3150-0104 EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)		ER NUMBER (6)	PAGE (3)					
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Wolf Creek Generating Station	0 5 0 0 0 4 8 2	8 5	-	0 4 0	_	010	012	OF	0 2

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

On seven different occasions between July 2 and July 12, 1985, an Engineered Safety Features actuation was initiated by a spurious electronic "spike" in Control Room intake radiation monitor [IL-MON] GK-RE-04. The incidents occurred at 2002 CDT on July 2, 1506 CDT on July 5, 0550 CDT on July 7, 0215 CDT and 2205 CDT on July 8, 0932 CDT on July 9, and 0736 CDT on July 12. Each of these spikes resulted in a Control Room Ventilation Isolation Signal (CRVIS). In each instance, all required Engineered Safety Features equipment responded properly.

The plant was in Mode 3, Hot Standby, prior to the events on July 2 and July 12, 1985, and in Mode 1, Power Operation, with the Reactor power levels ranging between 36 percent and 50 percent, prior to the five events occurring between July 5 and July 9, 1985. Each event occurred with the Reactor Coolant System [AB] at normal operating pressure and temperature.

On each occasion, no radiation above normal background was present, as determined by redundant radiation monitor GK-RE-05, and the actuated systems were restored to a normal configuration per plant operating procedures.

Subsequent investigation of each event identified a mismatch between the software and hardware in the RM-80 microprocessing unit for the radiation monitor as the probable cause of the spurious alarms. Prior CRVIS actuations attributed to this mismatch were identified in Licensee Event Reports (LER) 85-013-00 and 85-037-00. One additional CRVIS due to the same cause occurred on July 12, 1985, and will be reported in a separate LER.

The radiation monitor was supplied by General Atomic Co. and is a Particulate, Iodine and Gas Monitor (Assembly 0356-1601). Several of these radiation monitors are installed in the plant and are now being modified in accordance with directions provided by General Atomic to resolve the software/hardware mismatch problems. This modification involves replacement of several integrated circuit chips and some software reprogramming in each radiation monitor. Modification of GK-RE-04 was completed on 7/13/85 and no further events due to the mismatch problem have occurred.

No damage to plant equipment occurred as a result of these events and at no time did conditions develop which could have threatened the public health or safety.



GLENN L KOESTER

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August 1, 1985

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

Mr. R.P. Denise, Director Wolf Creek Task Force U.S. Nuclear Regulatory Commission Region IV 611 Ryan Plaza Drive, Suite 1000 Arlington, Texas 76011

KMLNRC 85-188

Re: Docket No. STN 50-482

Subj: Licensee Event Report 85-040-00

Dear Gentlemen:

The enclosed Licensee Event Report is submitted pursuant to 10 CFR 50.73(a) (2) (iv) concerning an Engineered Safety Feature actuation.

If you have any questions concerning this matter, please contact me or Mr. Otto Maynard of my staff.

Yours very truly,

Glenn L. Koester

Vice President - Nuclear

GLK:dab

Enclosure

xc: PO'Connor (2), w/a
JCummins, w/a