

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Perry Nuclear Power Plant, Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 4 4 0 1 OF 0 2										PAGE (3) 1 OF 0 2									
TITLE (4) Reactor Protection System Actuation Results From Inadvertent Isolation of Instrument Air to Containment During System Restoration.																													
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	2	8	8	8	8	0	0	7	0	0	0	2	1	8	8	8	0	5	0	0	0						
OPERATING MODE (9) 4			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																										
POWER LEVEL (10) 0 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)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)														
			20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 365A)														
			20.405(a)(1)(iii)				50.73(a)(2)(i)				50.73(a)(2)(viii)(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)(x)																		
LICENSEE CONTACT FOR THIS LER (12)																													
NAME Gregory A. Dunn, Compliance Engineer Ext. 6484															TELEPHONE NUMBER 2 1 6 2 5 9 - 3 7 3 7														
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																			
SUPPLEMENTAL REPORT EXPECTED (14)															EXPECTED SUBMISSION DATE (15)					MONTH	DAY	YEAR							
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)															<input checked="" type="checkbox"/> NO														

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

On January 22, 1988 at 0626 a Reactor Protection System (RPS) actuation occurred due to high Scram Discharge Volume (SDV) level. During restoration of a tagout on the Instrument Air System, the supply to Containment was inadvertently isolated, depressurizing the scram valve air header. Depressurization of the air header caused the Scram Valves and SDV drain valve to reposition. Consequently, the SDV filled resulting in a RPS actuation on high level.

The cause of the event was personnel error. The Unit Supervisor, authorizing clearance of the tagout, failed to specify the correct sequence to prevent impact upon the plant during the review. Consequently, tag removal and the restoration of the Instrument Air system was performed in an incorrect order causing the loss of Instrument Air to containment.

To prevent recurrence, the Unit Supervisor involved with this event has been counseled on the need to perform a more thorough review and ensure proper controls are utilized and sufficient guidance given when performing tag clearance and/or system restoration.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Perry Nuclear Power Plant, Unit 1	0 5 0 0 0 4 4 0	8 8	— 0 0 7	— 0 0 0	2	OF	0 2

TEXT (If more space is required, use additional NRC Form 365A's) (17)

On January 22, 1988 at 0626 a Reactor Protection System (RPS) [JC] actuation occurred on high Scram Discharge Volume (SDV) [AA] level due to a loss of Instrument Air [LD]. At the time of the event, the plant was in Operational Condition 4 (Cold Shutdown) with a planned maintenance outage in progress. Reactor coolant temperature was approximately 128 degrees and reactor vessel [RPV] pressure atmospheric.

The normal Instrument Air supply to Containment [NH] had been removed from service to repair a containment isolation check valve. A temporary hose had been installed to bypass the check valve during the repair. Upon completion of repairs and retesting at 0610, the Control Room Unit Supervisor authorized clearance of the tagout. The operator removing the tags, shut the supply valves for the temporary line prior to opening the normal supply isolation valves. Instrument Air pressure in Containment decreased, depressurizing the scram valve air header. Depressurization of the air header caused Scram Valves and SDV drain valve to reposition. Consequently, the SDV filled resulting in a RPS actuation on high level at 0626. Additionally, the Containment and Drywell Purge [VC] fans tripped due to repositioning of dampers when the Instrument Air pressure decreased.

The operators promptly restored Instrument Air to Containment. The SDV was drained and RPS logic reset. Containment purge was reestablished and the operators verified no other systems had been affected by the Instrument Air System pressure decrease.

The cause of the event was personnel error. The Unit Supervisor, authorizing clearance of the tagout, failed to specify the correct sequence to prevent impact upon the plant during the review. Consequently, tag removal and the restoration of the Instrument Air system was performed in an incorrect order causing the loss of Instrument Air to containment.

The check valve repair required a temporary hose to pass through the Containment Air Lock. This can only be performed with the plant in Cold Shutdown, therefore, the effect on the plant and plant equipment was minimized. Plant systems responded to the decrease in Instrument Air pressure as designed to maintain the plant in a safe condition. FSAR section 15.2.10 analyzed the Loss of Instrument Air at full reactor power and concluded there would be no effect on the safe shutdown of the reactor since all equipment using Instrument Air is designed to fail to a safe position. Air operated equipment that must be available for use in the event of a failure of the Instrument Air system is provided with backup accumulators to provide the required air supply. Therefore, this event is considered to have no safety significance. No previous similar events have been identified.

To prevent recurrence, the Unit Supervisor involved with this event has been counselled on the need to perform a more thorough review and ensure proper controls are utilized and sufficient guidance given when performing tag clearance and/or system restoration.

Energy Industry Identification System Codes are identified in the text as [XX]