

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Perry Nuclear Power Plant Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 4 4 0										PAGE (3) 1 OF 0 2																			
TITLE (4) Failure To Properly Restore Instrument Results In Instrument Isolation And AEGTS Actuation																																							
EVENT DATE (5) MONTH DAY YEAR 0 6 2 7 8 6									LER NUMBER (6) YEAR SEQUENTIAL NUMBER REVISION NUMBER 8 6 - 0 2 9 - 0 0 0 7 2 3 8 6									REPORT DATE (7) MONTH DAY YEAR 0 6 2 3 8 6									OTHER FACILITIES INVOLVED (8) FACILITY NAMES DOCKET NUMBER(S) 0 5 0 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)(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)(ix)																		
LICENSEE CONTACT FOR THIS LER (12)																																							
NAME Paul Russ, Compliance Engineer, ext.6472																				TELEPHONE NUMBER AREA CODE 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)																																							
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)																				<input checked="" type="checkbox"/> NO										EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR									
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																																							
<p>On June 27, 1986, at 1954, the Annulus Exhaust Gas Treatment system "B" exhaust fan automatically started due to a false low flow signal from the "A" train. The low flow signal originated from the "A" train differential (dp) pressure switch which had been isolated from the process stream during calibration and maintenance of the switch. During investigation of the fan actuation the d/p switch isolation valves were found closed. The valves were then reopened and the fan restored to the "Standby" condition.</p> <p>Investigation of the event determined the cause to be a personnel error in that the technicians performing the maintenance did not properly restore the instrument to operability in accordance with approved procedures. An instrument restoration checklist providing independent verification of valve position was implemented after the calibration but not after completion of the electrical repairs.</p> <p>The technicians involved have been counseled on the necessity of performing complete valve and electrical verification when restoring equipment to service after completion of all maintenance. Additionally, instrument administrative procedures are being revised to require complete reverification of instrument restorations which have been suspended for greater than one shift.</p>																																							

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Perry Nuclear Power Plant Unit 1	0 5 0 0 0 4 4 0	8 6	— 0 2 9	— 0 0	0 2	OF	0 2

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

On June 27, 1986, at 1954 Annulus Exhaust Gas Treatment (AEGT) system [VC] "B" exhaust fan [FAN] automatically started due to a false low flow signal from the "A" differential pressure (dp) switch [PS]. At the time of the event the plant was in Operational Condition 4 (Cold Shutdown), reactor vessel [RPV] pressure was approximately 10 psig and reactor coolant temperature approximately 140 degrees.

On June 26, 1986, at 0700, AEGT d/p switch M15-N0061A and the "B" exhaust fan had been taken out of service for routine calibration of the switch. During restoration of the switch a defective electrical termination was found on the switch. Repair of the termination proceeded over the following three shifts. On June 27, 1986, at 1954, when the system was restored to the "Standby" condition the fan automatically started. Investigation of the cause of the fan actuation found the d/p switch isolation valves closed, isolating the switch from the process stream. This caused the switch to sense low differential pressure, indicating low "A" system flow. At 2145, the instrument valves were returned to the "Open" position and the fan restored to the "Standby" condition.

Investigation of the event determined the cause to be a personnel error in that the technicians performing the maintenance did not properly restore the instrument to operability in accordance with approved procedures. An instrument restoration checklist providing independent verification of valve position was implemented after the calibration but not after completion of the electrical repairs.

The AEGT system continuously discharges filtered air from the reactor building annulus. This maintains annulus pressure negative with respect to atmospheric pressure. AEGTS consists of two identical trains, one normally in standby. The exhaust fan of the standby train will automatically start if the operating train air flow is low. Recirculation and exhaust dampers regulate air flow to maintain the required negative pressure. The AEGT system was not required to be operable at the time of the event. Spurious actuation of the standby AEGTS train during full power operation would have no adverse safety consequences. Therefore, this event had no safety significance. No previous similar events were identified.

The technicians involved have been counseled on the necessity of performing complete valve and electrical verification when restoring equipment to service after completion of all maintenance. Additionally, instrument administrative procedures are being revised to require complete reverification of instrument restorations which have been suspended for greater than one shift.

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