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	On J	une 25	, 1986,	ati	823 nours	, an	Enginee	i) tr	ain fr	m a si	ne (ESF	trip of Hi	-Radiat	ion Mon	itor		
	2019	Syster	accurre	1) 0	This result	lted	in an f	SF d	amper	actuat	ion whi	ch isolated	the "B	" VC tr	ain fr	mor	
	outs	ide ai	and di	rect	ed the re	circi	lating	air	flow t	hrough	the ch	arcoal filt	ers. Ti	his occ	urred		
	appr	oximat	elv thre	e mi	inutes aft	er th	he deter	ctor	was re	turned	to ser	vice follow	ing a s	ource			
	cali	bratio	n. The	"8"	VC EMU wa	s shu	utdown a	and t	hen su	ccessf	ully re	turned to n	iormal c	onditio	n. At	t	
	the	time o	f the e	vent,	, the "A"	VC/VI	E train	was	in ope	ration	; Unit	1 and Unit	2 were	both in	Cold		
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	The	exact	cause o	f the	e Hi-Radia	tion	monito	r tri	p is u	nknown	. It i	s suspected	that t	he actu	ation		
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The detector was recalibrated successfully on June 30, 1986, at 1225 hours. Radiation detector 2D18-K751C was declared fully operable and returned to service at 1340 hours on July 1, 1986.

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The Station is investigating a logic revision for the VC radiation monitors.

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FACTITY NAME (1)	I DOCKET NUMBER	(2)	LER	NUMBER	Page (3)				
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I. EVENT DESCRIPTION:

On June 25, 1986, at 1823 hours, an Engineered Safety Feature (ESF) actuation of "B" Control Room HVAC System (VC, VI) Emergency Make-up (EMU) train from a spurious trip of Hi-Radiation Monitor, 2D18-K751C, occurred. This resulted in an ESF damper actuation which isolated the "B" VC train from outside air and directed the recirculating air flow through the charcoal filters. This occurred approximately three minutes after the detector was returned to service following a source calibration per approved procedure, LCP-820-22, Source Response Testing and Calibration of the General Atomics Area Radiation Monitor. The "B" VC EMU train was immediately shut down and then successfully returned to normal condition. At the time of the event, the "A" VC train was in operation; Unit 1 and Unit 2 were both in Cold Shutdown.

II. CAUSE:

The exact cause of the Hi-Radiation Monitor Trip is unknown. It is suspected that the actuation was the result of the detector being returned to service prior to the completion of LCP-820-22.

The Radiation Chemistry Department is responsible for the completion of a source calibration of the radiation detector. The execution of this surveillance requires the detector housing to be opened and the trip function is bypassed. After the test was completed, the Operating Department was informed and the Instrument Maintenance Department was requested to remove the trip bypass. While the trip bypass was being removed the detector housing was being reinstalled and this action apparently caused the detector to trip and cause an ESF actuation.

The radiation monitoring module is manufactured by General Atomics Company (G.A. Technologies).

III. PROBABLE CONSEQUENCES OF THE OCCURRENCE

At the time of the occurrence, "A" VC train was in service. Only one monitoring module detecting radiation is required to initiate the Emergency Makeup filter train, OVCOISB. Technical Specification 3.3.7.1 requires two operational channels. Three of the four radiation monitoring modules for the "B" VC HVAC train were fully operational. Redundancy of radiation monitoring detection was maintained. The VC train was placed in a conservative lineup.

IV. CORRECTIVE ACTION

The detector was recalibrated successfully on June 30, 1986, at 1225 hours. Radiation detector, 2D18-K751C, was declared fully operable and returned to service at 1340 hours on July 1, 1986. To reduce the number of spurious ESF actuations, the following intermediate and iong-term corrective actions have been established:

a. AIR 373-200-86-08000 was generated to investigate logic revision for the VC radiation monitors to require more than one detector to cause an actuation of the system.

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IV. CORRECTIVE ACTION (CONTINUED)

b. The procedures will be revised to verify that the radiation detector will not be returned to service until completion of the source calibration and the reinstallation of the detector housing. This will be tracked by AIR 373-200-86-08002.

V. PREVIOUS OCCURRENCES

None.

VI. NAME AND TELEPHONE NUMBER OF PREPARER

Paul S. Watford, Technical Staff Engineer, 815/357-6761, extension 323.



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Commonwealth Edison LaSalle County Nuclear Station Rural Route #1, Box 220 Marseilles, Illinois 61341 Telephone 815/357-6761

September 19, 1986

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

Dear Sir:

Reportable Occurrence Report #86-025-01, Docket #050-373 is being submitted to your office to supercede previously submitted Reportable Occurrence Report 86-025-00 to correct cause analysis.

for G. J. Diederich

G. J. Diederich Station Manager LaSalle County Station

GJD/DRR/kg

Enclosure

xc: NRC, Regional Director INPO-Records Center File/NRC

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