

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Calvert Cliffs, Unit 1

DOCKET NUMBER (2) 05000317  
PAGE (3) 1 OF 2

TITLE (4)

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)
04	06	85	85	004	00	05	02	85		050000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8: (Check one or more of the following) (11)

OPERATING MODE (9)	20.402(b)	20.406(e)	80.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	20.406(a)(1)(i)	80.36(e)(1)	80.73(a)(2)(v)	73.71(c)
	20.406(a)(1)(ii)	80.36(e)(2)	80.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.406(a)(1)(iii)	80.73(a)(2)(i)	80.73(a)(2)(viii)(A)	
	20.406(a)(1)(iv)	80.73(a)(2)(ii)	80.73(a)(2)(viii)(B)	
	20.406(a)(1)(v)	80.73(a)(2)(iii)	80.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME John F. Lohr, Supervisor Procedural Development

TELEPHONE NUMBER

AREA CODE

301 2610-4776

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS

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-space typewritten lines) (16)

An inadvertent Engineered Safety Features Actuation occurred during surveillance testing while the unit was in MODE 4. The pressurizer pressure signals which initiate a Safety Injection Actuation Signal were blocked in accordance with the plant cooldown procedure. The inadvertent actuation occurred while attempting to remove the block signal for pressurizer pressure so that surveillance testing could be performed on the motor operated safety injection tank outlet valves.

There was no injection of water from the Emergency Core Cooling System into the Reactor Coolant System.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

During a plant cooldown with the unit in MODE 4 (292°F, 344 psia), an inadvertent Safety Injection Actuation Signal (SIAS) (JE) occurred on 6 April, 1985 at 2132, while performing a surveillance test on the Safety Injection Tank Motor Operated Outlet Valves (20). The purpose of the surveillance test was to verify the Safety Injection Tank Outlet Motor Operated valves (20) would open on a SIAS. To permit this verification for each of the four channels of pressurizer pressure, it was necessary to remove the block signal of pressurizer pressure which had been manually initiated during Reactor Coolant System (AB) cooldown in accordance with plant procedures (refer to figure 1 for block and actuation logic). The surveillance test procedure being used for this test did not assume that SIAS would be blocked as it should have and consequently did not provide detailed steps on how to remove the SIAS block signal.

It can be seen by referring to figure 1 that the SIAS block signal needs three of four channels tripped to permit the blocked condition whereas the SIAS signal only needs two of four channels to initiate a SIAS. As the operators attempted to remove the SIAS pressurizer pressure block signal and clear the tripped SIAS pressurizer pressure sensor channels, they lowered the trip setpoint potentiometers for both the SIAS pressurizer pressure sensor channels and the SIAS pressurizer pressure block channels on one of the four sensor channels. As the operators repeated the process on the second sensor channel the three of four logic necessary for blocking SIAS was lost but two SIAS sensor channels were still tripped which was enough to satisfy the SIAS actuation logic.

There was no injection of water into the Reactor Coolant System from the emergency core cooling system. The operators had placed the handswitches for the High Pressure Safety Injection pumps in "Pull to Lock" prior to the actuation as a precautionary action. This incident was not a threat to the safety of the public or the plant.

To prevent recurrence of this type or similar events the following corrective actions will be taken:

1. Include detailed instructions on how to remove and reestablish block of SIAS in the procedure that was being used at the time of the incident (STP-0-35).
2. Review all Surveillance Test Procedures to determine if additional guidance is needed to remove or reestablish blocks of SIAS or other Engineered Safety Features Signals which have blocks associated with them.
3. Make all licensed operators aware of this incident.

Contact for this event is J. F. Lohr, 301-260-4776.



BALTIMORE GAS AND ELECTRIC COMPANY

P.O. BOX 1475

BALTIMORE, MARYLAND 21203

NUCLEAR POWER DEPARTMENT  
CALVERT CLIFFS NUCLEAR POWER PLANT  
LUSBY, MARYLAND 20657

May 2, 1985

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

Docket No. 50-317

License No. DPR 53

Dear Sirs:

The attached LER 85-04 is being sent to you as required by  
10 CFR 50.73.

Should you have any questions regarding this report, we would  
be pleased to discuss them with you.

Very truly yours,

*LBR Russell*  
L. B. Russell  
Plant Superintendent

*JL*  
LBR/JFL/pah

cc: Dr. Thomas E. Murley  
Director, Office of Management Information  
and Program Control

Messrs: A. E. Lundvall, Jr.  
J. A. Tiernan

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