

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Fermi - 2 DOCKET NUMBER (2) 050003411 PAGE 1 OF 03

TITLE (4)

EVENT DATE (6)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER (8)	
07	01	85	85	030	01	12	12	85		050003411	

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 6. (Check one or more of the following) (11)									
POWER LEVEL (10) 0.02	20.402(b)	20.408(a)	X	60.73(a)(2)(iv)	73.71(b)					
	20.408(a)(1)(i)	60.36(a)(1)		60.73(a)(2)(v)	73.71(c)					
	20.408(a)(1)(ii)	60.36(a)(2)		60.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)					
	20.408(a)(1)(iii)	60.73(a)(2)(i)		60.73(a)(2)(vii)(A)						
	20.408(a)(1)(iv)	60.73(a)(2)(ii)		60.73(a)(2)(vii)(B)						
	20.408(a)(1)(v)	60.73(a)(2)(iii)		60.73(a)(2)(viii)						
	20.408(a)(1)(vi)	60.73(a)(2)(iv)		60.73(a)(2)(ix)						

LICENSEE CONTACT FOR THIS LER (12) NAME L.P. Bregni, Compliance Engineer TELEPHONE NUMBER AREA CODE 313 586 5311

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) X NO EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

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

On July 1, 1985, at 1432 hours while in Operational Condition 2 and with reactor power at 2 percent, a reactor scram occurred. The scram was caused by a spurious reactor water level 3 signal. The signal was generated when an instrument valve was opened during surveillance testing of a narrow range reactor water level instrument.

The cause of the event was failure to follow procedure on the part of the technician performing the surveillance test. Appropriate testing personnel have been informed of this event by placing this LER on a required reading list. Also, an instrument rack test stand has been built using similar valves and the I&C technicians have been trained on the test stand. In addition to improving their skill, this training has enhanced the I&C technicians' awareness of the need to exercise caution while manipulating valves on instrument racks.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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			
Fermi-2	05000341	85	030	010	2	OF	03

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

On July 1, 1985, at 1432 hours while in Operational Condition 2 and with reactor power at 2 percent, a reactor scram occurred. The scram was caused by a spurious reactor water level 3 signal. The plant responded properly. All withdrawn control rods fully inserted. Isolation valve group 13 isolated as designed, and groups 4 and 15 were already closed.

The spurious signal was generated by reactor water level instruments that sensed a momentary low pressure condition in the common process variable sensing line to which they are all connected. The low pressure spike occurred when an instrument valve was opened during surveillance testing of a reactor water level instrument that is connected to the same common process variable sensing line.

The instrument, level transmitter B21-N095C located on instrument rack H21-P004, had been removed from service to perform a surveillance test. This involved isolating the instrument for the reference and process variable sensing lines by closing the appropriate instrument rack isolation valves. The instrument technician performing the surveillance connected the test equipment used to apply the test pressure for calibrating the level transmitter to the instrument drain valves instead of the vent valves as directed by the procedure. Although this was a deviation from the procedure, the technician felt it would ensure that the instrument lines to the level transmitter were full of water and free of air.

With the test equipment connected properly to the instrument vent valves, there are two valves in series that isolate the instrument under test from the reference and process variable sensing lines. These are the instrument rack isolation valves and the instrument isolation valves. The alternate connection to the drain valves used in this case provides only one isolation valve; the instrument rack isolation valve.

When the technician opened the drain valves to equalize the pressure between the test equipment and the level transmitter, the scram occurred. The technician immediately reverified the valve lineup after he learned that a scram had occurred. Upon verifying the lineup, the technician found that the instrument rack isolation valve to the process variable sensing line was not closed completely. This valve was checked during the initial valve lineup and was considered to be fully closed based on the amount of torque applied to the valve handle. (Technicians have been cautioned not to over torque these valves because it can cause the seats to gall resulting in leaky

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U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

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Fermi-2	050003418	5	030	01	03	OF 03

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

valves). The technician applied what he considered an appropriate closing torque considering the caution on these valves.

Because this instrument rack isolation valve was not fully closed when the drain valve was opened, the pressure in the process variable sensing line decreased. The low pressure condition that momentarily existed in the sensing line was the same condition that would exist if reactor water level had actually decreased to level 3. The reduced pressure was sensed by other reactor water level instruments that were connected to the common sensing line. These instruments, which were still in operation, properly caused the reactor water level 3 scram.

The cause of this event was a failure to follow procedure. Personnel were counseled on the proper steps to take when a procedure is thought to be in error or requires changes. This LER has been included in required reading for all I&C testing personnel. Also, an instrument rack test stand has been built using similar valves and the I&C technicians have been trained on the test stand. In addition to improving their skill, this training has enhanced the I&C technicians' awareness of the need to exercise caution while manipulating valves on instrument racks.

Detroit
Edison

Robert S. Lenart
Plant Manager

Fermi-2
6400 North Dixie Highway
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December 12, 1985
NP850248



Nuclear
Operations

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

Gentlemen:

Reference: Fermi 2
NRC Docket No. 50-341
NRC Operating License No. NPF-43

Subject: Transmittal of Licensee
Event Report 85-030-01

Please find enclosed LER No. 85-030-01, dated December 12, 1985, for a reportable event which occurred on July 1, 1985. As indicated below, a copy of this LER is being sent to the Administrator Region III.

If you have any questions, please contact us.

Sincerely,

R. S. Lenart
Plant Manager

Enclosure: NRC Forms 366, 366A

cc: P.M. Byron
M.D. Lynch

Regional Administrator
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Director/Coordinator
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