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Plant Manager Limerick Generating Station

PECO Energy Company Limerick Generating Station PO Box 2300 Sanatoga, PA 19464-0920 610 718 2000

10CFR50.73

May 5, 2000

Docket Nos. 50-352

License No. NPF-39

U.S. Nuclear Regulatory Commission Attn.: Document Control Desk Washington, DC 20555

SUBJECT:

Licensee Event Report

Limerick Generating Station - Units 1

This LER reports an unplanned actuation of the Engineered Safety Features during refueling. The actuation caused two (2) valves in the Containment Instrument Gas system and four (4) valves in the Drywell Chilled Water system to close as a result of a blown fuse. The most probable cause of the blown fuse was testing in progress on the affected equipment.

Reference:

Docket No. 50-352

Report Number:

1-00-001

Revision Number:

00

Event Date:

April 7, 2000 April 7, 2000

Discovery Date: Report Date:

May 5, 2000

Facility:

Limerick Generating Station

P.O. Box 2300, Sanatoga, PA 19464

This LER is being submitted pursuant to the requirements of 10CFR50.73(a)(2)(iv).

Very truly yours,

Mutall P. Galley

cc: H. J. Miller, Administrator Region I, USNRC

A. L. Burritt, USNRC Senior Resident Inspector, LGS

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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION (6-1998)										APPROVED BY OMB NO. 3150-0104 EXPIRES 06/30/2001 Estimated burden per response to comply with this mandatory information							
10 10007									collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding								
LICENSEE EVENT REPORT (LER)										burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork							
(See reverse for required number of										Regulatory Commission, Washington, DC 2059-0001, and the Paperwood Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a							
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					and a person is not required to respond to, the information collection.  DOCKET NUMBER (2) PAGE (3)												
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Eng	inee	red Safet	y Features	s (ESF) actu	ation (C	hannel [	) wh	ich isol	ated	d six pri	mary contai	inment	isolatio	n valves			
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NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION

(6-1998)

# LICENSEE EVENT REPORT (LER)

**TEXT CONTINUATION** 

FACILITY NAME (1)	DOCKET (2)		PAGE (3)		
	05000	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF
Limerick Generating Station Unit 1	-352	2000	- 001 -	00	2

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

#### **BACKGROUND**

At the time of the event Unit 1 was in Operational Condition 5 (Refueling) with the reactor cavity flooded and reactor coolant temperature at approximately 82 degrees Fahrenheit(F). The B loop of the Residual Heat Removal (RHR) {EIIS:RO} system was in the alternate decay heat removal mode of operation. The Fuel Pool Cooling (FPC) {EIIS:DA} system was inservice and removing decay heat. Various refueling and surveillance tests and fuel movement were in progress.

#### **EVENT DESCRIPTION**

On April 7, 2000 at 10:56 hours, Unit 1 while in Mode 5 for refueling outage 1R08 experienced an unplanned Engineered Safety Features (ESF) {EIIS; JM } actuation (Channel D) which isolated six primary containment isolation valves. A licensed operator observed the valves were closed at 14:05 hours and commenced an investigation.

The affected valves were the Containment Instrument Gas supply valves (HV-059-129B & 135 and the Drywell Chilled Water [EIIS:KM] loops A & B supply & return valves (HV-087-122,123,128 & 129). The isolation was a result of a blown fuse (B21H-F15D) in panel (10-C623). Reactor Water Cleanup (RWCU) {EIIS: CE} system time response testing (ST-2-044-401-1) was being conducted. A test recorder was being installed at the approximate time of the event.

A 4 hour notification was made to the NRC for ESF actuation per 10CFR50.72(b)(2)(ii) on April 7, 2000 at 17:55 hours. The event was determined to be reportable under the requirements of 10CFR50.73(a)(2)(iv).

### CAUSE OF THE EVENT

The most probable cause of the blown fuse was testing in progress on the affected equipment. No actual cause could be identified during the investigation. However, a test recorder was being installed at the approximate time of the event. The investigation included interviews of the technicians; lab analysis of the fuse, inspection of the test leads; inspection of panel 10-C623; inspection, testing and failure analysis on the recorder; testing of the RWCU differential flow timer; stroking of the affected valves; cycling of the handswitch; and testing of the logic relays. Each inspection and test indicated no evidence of problems or abnormalities.

#### CONSEQUENCES OF THE EVENT

There were no actual consequences of the event. The reactor was in a refueling condition, and the Drywell hatch was removed. The potential consequences of the event were minimal. All valves closed upon reciept of the isolation signal. Failure of logic control power causes the equipment to actuate to its accident mitigation position. No release of radioactivity and no Emergency Core Cooling System actuations occurred as a result of this event.

# CORRECTIVE ACTION COMPLETED

The blown fuse was replaced and the logic was reset. The Containment Instrument Gas and the Drywell Chilled Water supply and return valves were returned to service. The RWCU surveillance test (ST-2-044-401-1) was completed satisfactory.

## CORRECTIVE ACTION PLANNED

The test recorder in use during the event has been removed from service. The recorder will be refurbished prior to return to service.

PREVIOUS SIMILAR EVENTS: LER 1-94-004-00

FAILURE DATA: Fuse; Bussman Model-5A, 250 VAC MIN-5