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A false high chlorine signal from the ventilation chlorine detector, on sample rack WOA-SR-15, started the Control Room Emergency Filtration System. The false chlorine signal was a result of depletion of chlorine sensitive paper tape which discolors on contact with chlorine or extended exposure to moisture.

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# LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85 PAGE TY NAME (1) DOCKET NUMBER (2) LER NUMBER (8) PAGE (3) YEAR SEQUENTIAL REVISION NUMBER

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Washington Nuclear Plant - Unit 2

### Plant Conditions

		Event 1	Event 2
a)	Rx Power	0%	3%
b)	Mode witch	4 - Refueling	2 - Startup

#### Event

- 1. On 6-5-84 WOA-SR-15, the Chlorine Detector on the inlet for the Control Room ventilation, ran out of tape. This tape is chemically treated to produce a color change when exposed to chlorine in the air stream. The resulting color change is measured by an optics block and converted to a signal proportional to ppm chlorine present in the influent. When the tape in the detector ran out the last portion was left in front of the optics block and began to discolor as dirt and moisture accumulated. This discoloration was sensed as increasing chlorine, eventually causing a hi alarm which started the Control Room Emergency Filtration System. A fresh roll of paper tape will run for approximately 7 days.
- 2. On 6-12-84 WOA-SR-15 again ran out of tape with the same consequences listed above.

## Immediate Corrective Action

1 both cases the tape was replaced in WOA-SR-15, the alarm reset, and the Emergency Filtration System returned to its normal standby configuration.

# Future Long Term Corrective Action

Daily checks of this sample rack are provided in plant procedure PPM 10.24.166, PM Daily Check of WOA-SR-15 & 16 Chlorine Monitors. The importance of implementing the directions contained in this procedure has been re-emphasized to the maintenance organization. In response to this, the Instrument and Controls group has developed a checklist of required daily actions to ensure the chlorine detectors are properly serviced.

# Safety Significance

This event carries no safety significance as an equipment operated correctly to place the Control Room Ventilation System in an isolation configuration.

# **Washington Public Power Supply System**

P.O. Box 968 3000 George Washington Way Richland, Washington 99352 (509) 372-5000

Docket No. 50-397 June 28, 1984

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

Subject: NUCLEAR PLANT NO. 2

LICENSEE EVENT REPORT NO. 84-057

Dear Sir:

Transmitted herewith is Licensee Event Report No. 84-057 for WNP-2 Plant. This report is submitted in response to the report requirements of Technical Specification Section 6.9.1.7 and discusses the item of reportability, corrective action taken, and action taken to preclude recurrence.

This is the follow-up report to the verbal notification given at 0215 & 1655 hours on June 5 & June 12, 1984 respectively.

Very truly yours,

J. D. Martin (M/D 927M) WNP-2 Plant Manager

JDM: mm

Enclosure:

Licensee Event Report No. 84-057

Farmington, CT. 06032

cc: Mr. John B. Martin, Administrator
Region V, Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
1450 Maria Lane
Walnut Creek, California 94596
Mr. A. D. Toth, NRC Resident Inspector (901A)
Ms. Dottie Sherman
American Nuclear Insurers
The Exchange Suite 245
270 Farmington Ave.

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