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10CFR 50.73

January 22, 1996 Docket Nos. 50-352 50-353 License Nos. NPF-39 NPF-85

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

PECO ENERGY

SUBJECT: Licensee Event Report Limerick Generating Station - Units 1 and 2

This LER reports Engineered Safety Feature actuations when a manual isolation of the Unit 1 Reactor Enclosure (RE) Secondary Containment was performed causing the common plant Standby Gas Treatment System and the Unit 1 Reactor Enclosure Recirculation System to automatically start. The cause of this event was a combination of equipment malfunctions encountered with the Reactor Enclosure Equipment Compartment Exhaust and the RE ventilation exhaust fan systems.

Reference:

Report Number: Revision Number: Event Date: Report Date: Facility:

Docket Nos. 50-352 50-353 1-95-010 00 December 23, 1995 January 22, 1996 Limerick Generating Station P.O. Box 2300, Sanatoga, PA 19464-2300

This LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(iv).

Very truly yours, Soyre

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T. T. Martin, Administrator Region I, USNRC CC: N. S. Perry, USNRC Senior Resident Inspector, LGS



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

Unit Conditions Prior to the Event:

Units 1 and 2 were in Operational Condition 1 (Power Operation) at the time of this event.

On December 23, 1995, the Unit 1 Reactor Enclosure (RE) Heating, Ventilation, and Air Conditioning (HVAC, EIIS:VA) system was removed from service for scheduled maintenance on the '1C' RE HVAC system exhaust fan due to high vibration concerns. Prior to this event, the '1C' exhaust fan was operated only when absolutely needed until the maintenance commenced. The common plant Standby Gas Treatment System (SGTS, EIIS:BH) and the Unit 1 Reactor Enclosure Recirculation System (RERS, EIIS:AD) were in operation to maintain Unit 1 Secondary Containment (SC) integrity.

Description of the Event:

On December 23, 1995, during restoration of the RE HVAC system following the scheduled maintenance, Operations personnel observed that a low differential pressure (dp) condition existed between the RE SC and the outside atmosphere. During normal RE HVAC system operation, the RE to the outside air dp is maintained at the Technical Specifications (TS) required negative pressure of greater than or equal to 0.25 inches of water gauge. At 0440 hours on December 23, 1995, a manual isolation of the Unit 1 RE SC, an Engineered Safety Feature (ESF) actuation, was performed by Operations personnel per approved procedures to allow investigation of the low dp condition. Following the manual insertion of the isolation signal, the common plant SGTS and the Unit 1 RERS, also ESFs, automatically started per design to restore the RE SC dp to the required TS negative 0.25 inches of water gauge.

Following the manual initiation of the RE SC isolation, Operations personnel observed that the Reactor Enclosure Equipment Compartment Exhaust (REECE) system flow indicator was showing 35,000 scfm, without the system in operation. Normal air flow while this system is in operation is 43,000 scfm. An investigation revealed that the low RE SC dp resulted from a combination of the REECE system flow transmitter FT-076-136 being out of calibration, an air leak on the REECE system flow controller FC-076-136, and an air leak from a cracked copper instrument air tube supplying the '1C' RE HVAC system exhaust fan blade pitch positioner. The aggregate effect of these equipment malfunctions caused the RE HVAC exhaust fans to operate at

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their minimum capacity, which was not sufficient to maintain the negative 0.25 inches of water gauge dp.

On December 23, 1995 at 1930 hours, temporary repairs were made to the relevant equipment, the RE SC isolation signal was reset, and the Unit 1 RE HVAC system was returned to service.

An evaluation concluded that the manual RE SC isolation was reportable, and a notification was made to the NRC on December 23, 1995 at 0950 hours, pursuant to the requirements of 10CFR50.72(b)(2)(ii), since this event resulted in manual and automatic ESF actuations. This report is being submitted in accordance with the requirements of 10CFR50.73(a)(2)(iv).

Analysis:

There were no adverse consequences and no radioactive material was released to the environment as a result of this event. The RE SC isolation system and the SGTS and RERS responded as designed following the receipt of the RE SC low negative dp condition and the manual insertion of the RE SC isolation signal.

Cause of the Event:

The cause of this event was equipment malfunctions on the REECE system air flow control loop and the RE HVAC system exhaust fan blade pitch positioner control system. Specifically, the REECE system flow transmitter FT-076-136 was found out of calibration, an air leak existed on the REECE system flow controller FC-076-136, and a copper instrument air tube supplying the '1C' RE HVAC system exhaust fan blade pitch positioner was cracked and leaking.

When the RE HVAC and REECE systems were placed in operation on December 23, 1995, the false REECE system flow signal caused the REECE air inlet blade pitch positioners to remain at their minimum setting, resulting in significantly reduced air flow. The cracked and leaking instrument air tubing supplying the '1C' RE HVAC system exhaust fan blade pitch positioner is common to the remaining exhaust fan positioners. The air leakage caused all three RE HVAC system exhaust fan blade pitch positioners to remain at their minimum settings, resulting in operation of the RE HVAC exhaust fans at minimum capacity. The aggregate effects of these equipment malfunctions caused the low negative dp condition within the RE.

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An evaluation of the REECE air flow control system revealed that this control loop was last successfully functionally tested and calibrated on June 13, 1992. This loop has a seven year calibration frequency. The REECE transmitter and controller are located within the local control panel 10C205, and therefore, have a low potential for damage or jarring. A component history search indicated that the REECE transmitter and controller and similar components have not experienced previous failures or problems. Therefore, it has been concluded that the REECE system equipment malfunctions are isolated occurrences.

The cause of the cracked instrument air tube was chronic vibration induced failure of the instrument air tubing servicing the '1C' RE HVAC system exhaust fan blade pitch positioner. This particular vibration is the result of normal system operation with a minor contribution from increased vibration of the '1C' exhaust fan. The crack occurred approximately one inch adjacent to a tubing support clamp.

Corrective Actions:

On December 26, 1995, the RE HVAC system was removed from operation to allow calibration of the REECE system flow transmitter FT-076-136, and permanent repairs to the REECE system flow controller FC-076-136. The cracked copper instrument air tube supplying the '1C' RE HVAC exhaust fan blade pitch positioner was replaced. Appropriate corrective actions to minimize future chronic vibration induced tubing failures will be implemented following completion of comprehensive analyses of relevant station HVAC systems.

Previous Similar Occurrences:

There have been no previous events reported at the Limerick Generating Station (LGS) where the RE SC dp was exceeded due to REECE system equipment malfunctions. However, LGS LERS 1-88-020, 1-88-034, and 2-90-011 reported RE SC isolations due to leaks in the instrument air system servicing the RE HVAC system exhaust fans. An evaluation of these previous events revealed that these tubing failures were caused by either Swagelok fittings being over-tightened such that the ferrule cut into the tubing or acute vibration induced fatigue. Therefore, the corrective actions from these previous events would not have prevented the equipment malfunctions identified in this LER.