

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3160-0104
EXPIRES - 6/31/85

FACILITY NAME (1) Limerick Generating Station - Unit 1										DOCKET NUMBER (2) 0 5 0 0 0 1 3 1 5 1 2 1				PAGE (3) of 0 3	
TITLE (4) Main Control Room Ventilation System Isolation															

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)			
1	1	1	38	4	8	4	1	2					0 5 0 0 0 1 1 1			
1	1	1	38	4	8	4	1	2					0 5 0 0 0 1 1 1			

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)													
5		20.402(a)				20.406(a)	<input checked="" type="checkbox"/>			80.73(a)(2)(iv)				73.71(a)	
POWER LEVEL (10)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)													
0 0 0		20.406(a)(1)(ii)				80.38(a)(1)				80.73(a)(2)(v)				73.71(a)	
		20.406(a)(1)(iii)				80.38(a)(2)				80.73(a)(2)(vi)					
		20.406(a)(1)(iv)				80.73(a)(2)(i)				80.73(a)(2)(vii)(A)					
		20.406(a)(1)(iv)				80.73(a)(2)(ii)				80.73(a)(2)(vii)(B)					
		20.406(a)(1)(v)				80.73(a)(2)(iii)				80.73(a)(2)(viii)					

LICENSEE CONTACT FOR THIS LER (12)										TELEPHONE NUMBER					
NAME B. L. Clark, Senior Engineer-Special Projects										AREA CODE 2 1 5 8 4 4 - 5 0 4 7					

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yw, complete EXPECTED SUBMISSION DATE)														
<input type="checkbox"/> NO														

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

Abstract: 84-006

On November 13, 1984, the main control room ventilation system received an isolation signal as a result of a temporary loss of power to the 'A' chlorine analyzer. The isolation was caused by cycling the feed switch to the 'A' chlorine analyzer. The control room ventilation system isolated properly. Immediately after the event, the isolation was reset and control room ventilation was returned to normal.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		84	0 0 6	0 0	0 2	OF	0 3

TEXT (if more space is required, use additional NRC Form 368a) (17)

Description of the Event:

On November 13, 1984 at 1:00 p.m., prior to initial criticality, the main control room ventilation system received an isolation signal from the 'A' channel chlorine analyzer. The feed switch for the 'A' chlorine analyzer also provides control for a drywell purge fan. At the time of the event, operators were attempting to resolve a problem with the drywell purge system. Cycling the feed switch to the drywell purge fan also removed power to the 'A' chlorine analyzer. Loss of power to the 'A' chlorine analyzer isolates a portion of the main control room ventilation system. As a result, control room ventilation valves, HV-78-21A, HV-78-52A, HV-78-57A, and HV-78-71A, moved to the closed position. The isolation was reset and normal control room ventilation was restored.

Consequences of the Event:

The 'A' channel chlorine analyzer operated properly during the power transient by isolating the control room ventilation system as designed. Therefore, there were no adverse consequences.

Cause of the Event:

The cause of the event was inadequate investigation by the operators attempting to resolve the drywell purge problem. Prior to cycling the subject feed switch, a review of the equipment being controlled by this feed switch should have been performed.

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TEXT (if more space is required, use additional NRC Form 364A (17))

Corrective Actions:

The electrical print that was used to troubleshoot the drywell purge system will be revised to indicate the common chlorine analyzer feed. Additionally, the operator responsible for cycling the subject feed switch was counseled on the importance of adhering to station administrative procedures and the proper methods of troubleshooting plant equipment.