LICENSEE EVENT REPORT (LER)								U.S. M	U.S. NUCLEAR REQULATORY COMMISSION APPROVED ONS NO. 3180-0104 EXPIRES - 9/31/95						
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YES III FM. COMPANY EXPECTED SUBMISSION DATE!								EXPECTE BUBMISSI DATE (1	ON	TH CAY	YEAR				

Abstract: 84-046

Prior to initial criticality, a failure of the 'D' control room chlorine detector caused the normal ventilation to isolate and the 'B' train of the Control Room Emergency Fresh Air System to start. Investigation determined that the sample tape had broken causing the analyzer to indicate full scale. The tape was repaired and the analyzer was tested and returned to service.

IE22

MRC Form 366

	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION								U.S. NUCLEAR REGULATURY COMMISSION APPROVED OMB NO. 3150CION EAPIRES 8/31/85					
Timoxick Consult		DOCKET NUMBER (2)		L	-	EA (6)			PAGE 131					
Limerick Generat Unit 1	ing Station		*64A				ALVISION							
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### Description of the Event:

At approximately 1014 on December 30, 1984, the operators received an alarm "Control Room Chlorine Isolation Initiated" and the 'B' train of Control Room Emergency Fresh Air System (an engineering safety feature) started. A similar event was reported in LERS 84-006, 84-008, 84-010, 84-020, 84-028, and 84-033.

### Consequences of the Event:

Technical Specification 3.3.7.8.la permits operation in the normal ventilation mode with one chlorine detection subsystem inoperable for up to seven days. The failed analyzer was returned to service within 24 hours, so the consequences of this event are minimal.

### Cause of the Event:

Investigation determined that the sample tape of the 'D' chlorine analyzer (AE-78-0167), an MDA Scientific, Inc. Model 740 FAN, had broken causing the analyzer to indicate full scale.

# Corrective Actions:

Instrument and Controls technicians repaired the sample tape and a checkout and caribration was completed. The analyzer was tested satisfactorily and returned to service.

# Actions to Prevent Recurrence:

An investigation into the cause of the tape breakage has been undertaken in concert with the equipment manufacturer. Several modifications are being considered as the result of these investigations.

### PHILADELPHIA ELECTRIC COMPANY

2301 MARKET STREET
P.O. BOX 8699
PHILADELPHIA, PA. 19101

(215) 841-4000

January 23, 1984

Docket No. 50-352

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

SUBJECT:

Licensee Event Report

Limerick Generating Station - Unit 1

This LER deals with the failure of a Control Room Chlorine Analyzer prior to initial criticality.

Reference:

Docket No. 50-352

Report Number:

84-046

Revision Number: Event Date:

December 30, 1984

Report Date:

January 23, 1985

Facility:

Limerick Generating Station P.O. Box A, Sanatoga, PA 19464

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

Very truly yours,

m Well

W. T. Ullrich Superintendent

Nuclear Generation Division

cc: Dr. Thomas E. Murley, Administrator Region I, USNRC

See Service List

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