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On May 21, 1988 at 1847 hours, a "B" channel Reactor Enclosure Secondary Containment isolation occurred and the "B" trains of the Standby Gas Treatment System (SGTS) and Reactor Enclosure Recirculation System (RERS), Engineered Safety Features, started as designed. The isolation occurred when differential pressure between the Reactor Enclosure (RE) and outside atmosphere decreased below the setpoint of negative 0.1 inches water gauge. The "B" train of the SGTS restored and maintained Reactor Enclosure differential pressure at less than negative 0.1 inches water gauge, thus preventing the initiation of an "A" channel Reactor Enclosure isolation signal. The SGTS maintained Secondary Containment during the event as designed. The cause of the event was a severed instrument air line servicing the "B" Reactor Enclosure exhaust air fan blade pitch device. The cause c) the severed instrument air line tubing was vibration induced .atique. The instrument air line was repaired, the Reactor Enclosure isolation reset, and normal Reactor Enclosure ventilation was restored at 2000 hours. Similar instrument air line tubing was inspected, with no vibration problems noted. There was no release of radioactive material as a result of this event.

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NRC Form 366

NRC Form 366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION APPROVED DMS NO. 3150-0104

EXPIRES 8/31/85

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Unit Conditions Prior to the Event:

Operating Mode 1 (Power Operation)

Reactor Power 90%

Description of the Event:

On May 21, 1988 at 1847 hours, a "B" channel Reactor Enclosure Secondary Containment isolation occurred and the "B" trains of the Standby Gas Treatment System (SGTS) and Reactor Enclosure Recirculation System (RERS), Engineered Safety Features, started as designed. The isolation occurred when differential pressure between the Reactor Enclosure and outside atmosphere decreased below the negative 0.1 inch water gauge setpoin. The "B" train of the SGTS restored and maintained Reactor Enclosure differential pressure at less than negative 0.1 inches water gauge, thus preventing the initiation of an "A" channel Reactor Enclosure isolation signal. The SGTS maintained Secondary Containment during the event as designed.

Prior to the isolation, Operations personnel discovered a severed instrument air line servicing the "B" Reactor Enclosure exhaust air fan blade pitch positioner. Instrumentation and Controls (IsC) personnel were attempting to repair the severed tubing; however, air pressure dropped low enough to cause the blade positioner to readjust the "B" exhaust fan blades to a minimum settling limiting the fan's exhaust capacity. Reactor Enclosure to outside atmosphere differential pressure decreased, and the isolation occurred. The isolation was reset and normal Reactor Enclosure ventilation was restored by 2000 hours. The Reactor Enclosure Secondary Containment remained isolated for 1 hour, 13 minutes.

Consequences of the Event:

Normal Reactor Enclosure ventilation tripped, and the Reactor Enclosure isolated as designed on low differential pressure. The "B" trains of SGTS and RERS initiated as designed and the redundant "A" trains of SGTS and RERS were available for operation. There was no release of radioactive material to the environment as a result of this event.

Cause of the Event:

The cause of the event was vibration induced fatigue of the tubing, resulting in a severed instrument air line at a Swagelok

NRC Form 366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104 EXPIRES 8/31/85

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fitting servicing the "B" Reactor Enclosure exhaust air fan blade pitch positioner. The Reactor Enclosure air pressure is automatically maintained by a pressure sensing device which supplies a pneumatic signal to the exhaust air fan's blade pitch positioner to vary the Reactor Enclosure exhaust air flow rate. Due to the severed instrument air line, air pressure decreased shutting off the air supply to the exhaust air fan's blade pitch positioner. The exhaust air fan blades went to a minimum pitch reducing exhaust air fan capacity. As a result, the required differential pressure could not be maintained.

Corrective Actions:

The severed instrument air line tubing was repaired, the Reactor Enclosure isolation reset, and normal Reactor Enclosure ventilation was restored at 2000 hours.

Actions Taken to Prevent Recurrence:

The severed air line was sent to the metallurgical laboratory for failure mode analysis. The results of the metallurgical laboratory analysis confirmed that the mode of failure was vibration induced fatigue. The Technical Group and Engineering are currently investigating actions to be taken which will protect the tubing from future vibrational damage.

EIIS Codes:

VB - Reactor Enclosure Ventilation

AD - RERS

BH - SGTS

FM - Positioner

FAN " Fan

DUCT - Duct

Previous Similar Occurrences:

Limerick LERs 87-50 and 88-002 reported Reactor Enclosure Secondary Containment isolations due to a leak in the instrument air line tubing servicing the "B" Reactor Enclosure exhaust air fan.

Tracking Codes: (B2) Equipment failure due to Abnormal Wear

(B9) Construction/Installation error

PHILADELPHIA ELECTRIC COMPANY 2301 MARKET STREET

P.O. BOX 8699

PHILADELPHIA, PA 19101

(215) 841-5020

10 CFR Part 50 Section 73

> September 1, 1988 Docket No. 50-352

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

SUBJECT:

E. P. FOGARTY

MANAGER NUCLEAR SUPPORT DIVISION

Licensee Event Report Limerick Generating Station - Unit 1

This revised LER concerns an isolation of the Reactor Enclosure Secondary Containment on low differential pressure due to the inability of the exhaust air fans to maintain differential pressure as a result of a severed instrument air line tube.

Reference:

Docket No. 50-352

Report Number:

88-020

Revision Number:

01

Event Date: Report Date: May 21, 1988

September 1, 1988

Facility:

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

This revised LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(iv) to provide the laboratory analysis results for determining the cause of the instrument air line tubing failure. The changes are identified by a vertical bar in the right margin.

Very truly yours

E. P. Fogarty

Manager

Nuclear Support Division

W. T. Russell, Administrator, Region /, USNRC cc: T. J. Kenny, USNRC Senior Resident Inspector INPO Records Center