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On November 10, 1986 at 1727 hours with the unit at 100% power, the High Pressure Coolant Injection (HPCI) inboard steam supply isolation valve closed (an Engineered Safety Feature) upon receipt of a Nuclear Steam Supply Shutoff System (NSSSS) Division 4 isolation signal. During the event, Instrumentation and Control (I&C) technicians were using a Rosemount calibration unit to read thermocouple temperatures for HPCI piping area switch TTS-55-1N603D because the Riley meter module for the temperature switch was inoperable. The probable cause of this event was a technician mistakenly obtaining the temperature reading with the calibration unit in the "output" mode, which would have imposed a high temperature signal on the temperature module and caused the isolation. The isolation was reset following verification that a valid high temperature condition did not exist.

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Unit Conditions Prior to the Event:

Operating Mode 1 (Power Operation) Reactor Power 100%

## Description of the Event:

On November 10, 1986 at 1727 hours, the High Pressure Coolant Injection (HPCI) inboard steam supply isolation valve closed upon receipt of a Nuclear Steam Supply Shutoff System (NSSSS) Division 4 isolation signal. During the event, Instrument and Control (I&C) technicians were using a Rosemount calibrator unit to read the thermocouple temperatures for HPCI piping area temperature switch TTS-55-1N603D because the Riley meter module for the switch was inoperable. The isolation was reset following verification that a valid high temperature condition did not exist. The HPCI system was restored to service in accordance with plant procedures.

The EIIS code for the affected system, HPCI, is BJ. The Rosemount digital thermocouple calibrator/indicator unit is model 266.

## Consequences of the Event:

The only consequence of this event was the closure of the HPCI inboard steam supply isolation valve. The isolation valve responded properly by closing and remaining closed throughout the event. No radiation was released as a result of this event. The possible consequences were minimal because the balance of the Emergency Core Cooling Systems required by the Technical Specifications remained operable during the short duration of the event.

#### Cause of the Event:

CAUSE CODE: Personnel Error (A)

The investigation of this event could not positively identify the cause. The probable cause of this event was a personnel error by

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an I&C technician while obtaining a reading on a temperature switch. The technician was using a Rosemount calibrator unit to read thermocouple temperature. The Rosemount calibrator unit hastwo operating modes; it can either read temperature signals or generate temperature signals. Changing modes and ranges on the calibrator is accomplished by use of a pressure sensitive keyboard and observation of a LCD readout. The LCD readout is similar in both the input and output modes. If the technician had mistakenly manipulated the calibrator unit in the "output" mode, a high temperature signal would have been generated and introduced to the temperature module which would cause the isolation.

#### Corrective Actions:

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The isolation was reset immediately upon determination that a valid high temperature condition did not exist. The HPCI system was returned to service in accordance with plant procedures.

# Actions Taken to Prevent Recurrence:

The similarities between the Rosemount calibrator unit's input and output modes will be included in the lesson, plans for the Testing and Laboratories' "Test Equipment Training". In addition, this event will be discussed in an I&C "All Hands" meeting by December 31, 1986.

# Previous Similar Occurrences:

Limerick LER 85-016 reported a HPCI isolation resulting from personnel error.

# PHILADELPHIA ELECTRIC COMPANY

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PHILADELPHIA, PA. 19101

(215) 341-4000

December 10, 1986

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 concerns an isolation of the High Pressure Coolant Injection (HPCI) system, an Engineered Safety Feature. The probable cause of this event was personnel error.

Reference:

Docket No. 50-352

Report Number:

86-052

Revision Number:

00

Event Date: Report Date: November 10, 1986 December 10, 1986

Facility:

Limerick Generating Station

P.O. Box A, Sanatoga, PA 19464

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

Very truly yours,

R. H. Loque

Assistant to Manager

Nuclear Support Department

cc: Dr. Thomas E. Murley, Administrator, Region I, USNRC E. M. Kelly, Senior Resident Site Inspector See Service List