

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3180-0104
EXPIRES - 9/31/85

FACILITY NAME (1)

Limerick Generating Station - Unit 1

DOCKET NUMBER (2)

0 5 0 0 0 3 5 2 1 OF 0 1 3

PAGE (3)

TITLE (4)

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	0	3	1	8	4	8	4	0	0	3	0 5 0 0 0					
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																
OPERATING MODE (9)			20.402(b)								20.406(a)		50.73(a)(2)(iv)		73.71(a)	
POWER LEVEL (10)			20.406(a)(1)(ii)								50.34(a)(1)		50.73(a)(2)(v)		73.71(a)	
0 0 0			20.406(a)(1)(iii)								50.34(a)(2)		50.73(a)(2)(vi)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
			20.406(a)(1)(iv)								50.73(a)(2)(vii)(A)		50.73(a)(2)(viii)(B)			
			20.406(a)(1)(v)								50.73(a)(2)(ix)		50.73(a)(2)(x)			

LICENSEE CONTACT FOR THIS LER (12)

NAME

TELEPHONE NUMBER

B. L. Clark, Senior Engineer-Special Projects

AREA CODE

2 1 5 8 4 4 - 5 0 1 4 7

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

YES (If yes, complete EXPECTED SUBMISSION DATE)

NO

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

Abstract: 84-003

On October 31, 1984 prior to initial criticality, it was discovered that the CO2 pilot gas supply valve to the control valve for the control room Low Pressure CO2 Hose Racks OHR601 and OHR602 was found in the closed position rendering this equipment inoperable.

Technical Specification 3.7.6.3 requires that whenever equipment protected by the CO2 system is required to be operable, the CO2 system must be operable. This condition existed for approximately five days. During this time, alternate means of fire protection was available in the control room via eight permanently installed hand-held, halon fire extinguishers. Additional fire protection equipment is available at various locations throughout the plant. The valve was opened immediately upon discovery.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0 1 0 3	0 1 0	0 2	OF	0 3	

TEXT (If more space is required, use additional NRC Form 364A (1-7))

Description of the Event:

On October 31, 1984 with Unit 1 undergoing initial fuel loading, it was discovered that the CO2 pilot gas supply valve to the control valve for the Low Pressure CO2 Hose Racks OHR601 and OHR602 at the control room entrance was in a closed position, thus causing this sytem to be inoperable. This condition existed for five days.

Consequences of the Event:

Eight hand-held, halon fire extinguishers are permanently installed in the control room; therefore fire suppression was available. During this period, initial fuel loading operations were in progress with less than 25% of the fuel loaded and with all appropriate control rods fully inserted. A fire in the control room would therefore have minimum impact.

Cause of the Event:

During the period of time from system turnover on September 6, 1984 until October 25, 1984, this system was removed from service and permits were applied with appropriate valve blocking for various maintenance and testing activities on several occasions. During this time period, it appears that the CO2 pilot gas supply valve was closed.

On October 25, 1984, the permits were cleared and system check-off list (COL), S22.1B, was completed; however, this valve was not included on the COL and was therefore not verified to be open.

On October 31, 1984, the pilot gas supply valve was discovered to be in the closed position by the system start-up engineer who immediately notified operations personnel.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION
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TEXT (if more space is required, use additional NRC Form 366a) (17)

Corrective Actions:

Upon discovery, the valve was immediately opened to return the system to operability.

Check-off list, S22.1B, has been reviewed to assure that all pertinent valves are included and necessary revisions have been made to include the pilot gas supply valve. Additonally, this valve will be locked in the open position.

PHILADELPHIA ELECTRIC COMPANY

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PHILADELPHIA, PA. 19101

(215) 841-4000

November 30, 1984

Docket No. 50-352

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Washington, DC 20555

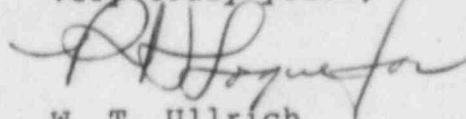
SUBJECT: Licensee Event Report
Limerick Generating Station - Unit 1

This Licensee Event Report concerns an out-of-service condition for the Low Pressure CO2 Hose Racks at the control room entrance prior to initial criticality.

Reference:	Docket No. 50-352
Report Number:	84-003
Revision Number:	00
Event Date:	October 31, 1984
Report Date:	November 30, 1984
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)(i)(B).

Very truly yours,



W. T. Ullrich
Superintendent
Nuclear Generation Division

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

See Service List

IE22
11

cc: Judge Lawrence Brenner
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