

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OWS NO 3190-0104

EXPIRES 8/31/85

FACILITY NAME (1)

Limerick Generating Station  
Unit 1

DOCKET NUMBER (2)

0 5 0 0 0 3 5 2

LER NUMBER (3)

YEAR

SEQUENTIAL

REVISION

NUMBER

NUMBER

NUMBER

PAGE (3)

85

- 0 4 0

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0 2 OF

0 3

TEXT (if more space is required, use additional NRC Form 366A (1))

Description of the Event:

On March 30, 1985, at 2111 hours with Unit 1 in cold shutdown, a Division 4 Loss-of-Coolant-Accident (LOCA) signal occurred. The 'D' Core Spray and 'D' Residual Heat Removal pumps of the ECCS started and began injecting water into the reactor vessel and the 'D-14' Diesel Generator started. In addition, Division 4 load shedding and primary containment group isolation occurred. A review of redundant equipment in the main control room, which also monitors drywell pressure, could not confirm a high drywell pressure. In addition, the trip units in the auxiliary equipment room did not indicate a drywell pressure transient. The 'D' Core Spray and 'D' RHR pumps were shutdown, the LOCA signal was reset and load restored to the equipment tripped upon receipt of the Division 4 LOCA signal using Special Event Procedure SE-10 'LOCA' by 2130 hours. The primary containment isolation was reset using General Plant Procedure GP-8, "Primary and Secondary Containment Isolation Verification and Reset", by 2145 hours. Vessel inventory increased approximately 10 inches as a result of the emergency core cooling system injection.

Investigation has determined that a valving error during the performance of a surveillance test of the containment instrument gas differential pressure switch pressurized a sensing line with instrument gas resulting in the actuation of pressure indicating switches PIS-42-1N694D and PIS-42-1N694H.

Consequences of the Event:

The drywell pressure transmitters, PT-1N094D and PT-1N094H, and their associated pressure indicating switches, PIS-1N694D and PIS-1N694H, functioned as designed and resulted in a Division 4 LOCA actuation. Following confirmation that no drywell pressure transient had occurred, the primary containment isolation was reset, the LOCA signal was reset, and load shed was restored. There were no adverse consequences.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

EXPIRES 8-31-85

FACILITY NAME (1) Limerick Generating Station Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 5 2 8 5 -	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0	4	0	0	0	3

TEXT (If more space is required, use additional NRC Form 366A's. (17))

Cause of the Event:

Investigation has determined that Instrument and Control technicians, while performing surveillance test, ST-2-059-603-1, "Channel B Calibration/Functional of the Test Primary Containment Instrument Gas Isolation on Low Differential Pressure (PDS-59-106B)", had not completely closed an equalizing valve prior to opening the 'HI' side isolation valve LBVH-059-105-1 when returning the instrument to service. The failure to completely close the equalizing valve resulted in the pressurization of the drywell pressure sensing line with instrument gas, ultimately resulting in the inadvertent initiation of a Division 4 LOCA signal. The LOCA signal was received from other drywell pressure transmitters which share a common sensing line with PDS-59-106B.

Corrective Actions:

Following identification of the origin of the inadvertent initiation, an investigation was performed to determine if the cause of the event was due to procedural error. The surveillance test was reperfomed to determine if the procedure results in the pressurization of the drywell sensing line. Although this reperformance did not repeat the event, a revision was made to the surveillance test to include the precaution that the 'LO' side of PDS-59-106B is connected to the drywell pressure transmitters for ECCS and NSSSS/RPS and that the valve sequence, as listed in the procedure, must be followed. In addition, the surveillance test has been revised to require double isolation of the 'HI' side prior to opening the equalizing valve.

As a further corrective action, the technicians performing the surveillance test were counseled on the proper method of valving and the importance of following valving procedures. As an additional precaution to the counseling of the responsible technicians, this event was discussed with the instrument and control technicians.

Previous Similar Occurrence:

None.

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April 25, 1985

Docket No. 50-352

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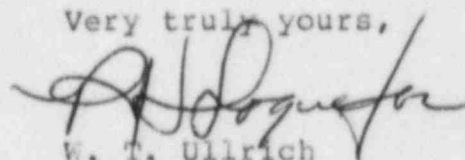
SUBJECT: Licensee Event Report  
Limerick Generating Station - Unit 1

This LER concerns an inadvertent initiation of an engineered safety feature during surveillance testing.

Reference:	Docket No. 50-352
Report Number:	85-040
Revision Number:	00
Event Date:	March 30, 1985
Report Date:	April 25, 1985
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,



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Nuclear Generation Division

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IE22  
1/1

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January 16, 1985

