

APPROVED OMB NO. 2180-0104
EXPIRES - 8/31/85

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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

FACILITY NAME (1)

Limerick Generating Station
Unit 1

DOCKET NUMBER (2)

05000352

LER NUMBER (5)

YEAR SEQUENTIAL REVISION
NUMBER NUMBER NUMBER

85-050-000

PAGE (3)

02 OF 03

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

Description of the Event:

At 7:48 p.m. on May 6, 1985, the operators received an alarm "Control Room Chlorine Isolation Initiated" and the 'B' train of the Control Room Emergency Fresh Air System (an ESF system) started. In order to verify the high chlorine signal, the remaining three chlorine indicators in the control room were observed, but indicated normal. Investigation determined that the sample tape of the 'D' chlorine analyzer (AE-78-016D), an MDA Scientific, Inc. Model 740 FAN, had broken, causing the analyzer to indicate full scale.

The EIIS code for the affected system is VI.

Consequences of the Event:

Because the Main Control Room Isolation System and Emergency Filtration System responded in accordance with the design, there are no adverse consequences associated with this event.

Cause of the Event:

The control room chlorine isolation and ESF actuation resulted from breakage of the sample tape in the 'D' analyzer, which produced a high reading. The cause of the sample tape breakage is an apparent design deficiency in the analyzer model.

Corrective Actions:

The sample tape was repaired, the analyzer tested and returned to service, and the isolation was reset.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Action Taken to Prevent Recurrence

There are four chlorine analyzers in the control room: A, B, C, and D. The system logic is such that the 'A' and 'B' analyzers merely indicate high chlorine level. The 'C' and 'D' analyzers provide indication and actuate the Control Room Emergency Fresh Air System upon a high reading. Since the 'D' detector has exhibited the greatest frequency of tape failure and the 'A' detector the least, an exchange of the 'D' with the 'A' chlorine analyzer has been approved and implemented. The exchange was completed on May 7, 1985. By placing the unreliable 'D' instrument where it cannot itself initiate the Control Room Emergency Fresh Air System, actuations resulting from tape breakage in that analyzer will be avoided.

In the event this modification is not successful in eliminating recurrence of this event, investigation is progressing into the possibility of modifying the system logic in order to prevent inadvertent initiations due to only one failed analyzer.

Previous Occurrences

LER's 84-008, 84-010, 84-028, 84-033, 84-046, 85-029, 85-030, 85-031, and 85-042 report similar events.

PHILADELPHIA ELECTRIC COMPANY

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June 5, 1985

Docket No. 50-352

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Washington, DC 20555

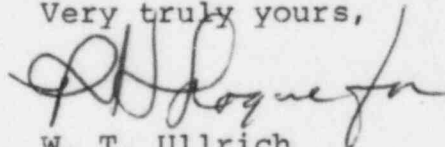
SUBJECT: Licensee Event Report
Limerick Generating Station - Unit 1

This LER deals with the actuation of the Control Room
Emergency Fresh Air System due to a failed chlorine analyzer.

Reference:	Docket No. 50-352
Report Number:	85-050
Revision Number:	00
Event Date:	May 6, 1985
Report Date:	June 5, 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,



W. T. Ullrich
Superintendent
Nuclear Generation Division

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J. T. Wiggins, Resident Site Inspector
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January 16, 1985