

10CFR50.73

June 21, 2006

U. S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Limerick Generating Station, Unit 1
Facility Operating License No. NPF-39
NRC Docket Nos. 50-352

Subject: LER 1-06-003, Accident Monitoring Instrument Channel Inoperable

This Licensee Event Report (LER) addresses a condition prohibited by Technical Specifications. The suppression chamber air temperature recorder was discovered to be inoperable for a period that exceeded the Technical Specification allowed outage time.

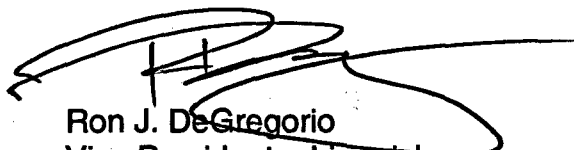
Report Number: 1-06-003
Revision: 00
Event Date: April 11, 2006
Discovered Date: April 22, 2006
Report Date: June 21, 2006

This LER is being submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B).

There are no commitments contained in this letter.

If you have any questions or require additional information, please do not hesitate to contact us.

Sincerely,



Ron J. DeGregorio
Vice President - Limerick
Exelon Generation Company, LLC

cc: S. J. Collins, Administrator Region I, USNRC
S. L. Hansell, USNRC Senior Resident Inspector, LGS

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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Limerick Generating Station, Unit 1	2. DOCKET NUMBER 05000352	3. PAGE 1 OF 4
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4. TITLE
Accident Monitoring Instrument Channel Inoperable For Longer Than Technical Specification AOT

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
04	11	2006	2006	- 003 -	0	6	21	2006		05000
									FACILITY NAME	DOCKET NUMBER
										05000

9. OPERATING MODE 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFRs: (Check all that apply)			
10. POWER LEVEL 100	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)
	<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER
	<input type="checkbox"/> 20.2203(a)(2)(vi)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME Robert E. Kreider, Manager – Regulatory Assurance	TELEPHONE NUMBER (Include Area Code) 610-718-3400
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
B	IK	TR	L130	N					

14. SUPPLEMENTAL REPORT EXPECTED <input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On Saturday April 22, 2006, the reactor operator identified that the suppression chamber air temperature recorder pen was failed downscale. Subsequent troubleshooting identified that the ribbon cable connector was unseated. The connector was re-seated which restored the failed indication. The periodic monitoring of the recorder was enhanced to ensure timely detection.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Limerick Generating Station, Unit 1	05000352	2006	003	00	2 OF 4

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Unit Conditions Prior to the Event

Unit 1 was in Operational Condition (OPCON) 1 (Power Operation) at approximately 100% power. There were no structures, systems or components out of service that contributed to this event.

Description of the Event

On Saturday April 22, 2006, at 09:46 hours, the Unit 1 reactor operator identified that the suppression chamber air temperature recorder (EIS:TR) (TR-57-122) pen was failed downscale while performing the monthly surveillance log (ST-6-107-595-1). Subsequent troubleshooting identified that the ribbon cable connector (EIS:CON) was unseated. The connector was re-seated which restored the failed indication.

The investigation reviewed the recorder chart paper and determined that the indication failed downscale on April 9, 2006 after several hours of erratic indication following replacement of the recorder chart paper.

All other main control room recorder indications were verified to be operating properly with the exception of one channel on the wide range accident monitor that was providing a valid digital reading but was recording downscale. This condition was entered into the corrective maintenance process.

Technical Specification (TS) 3.3.7.5 Accident Monitoring Instrumentation requires the instrumentation channels in Table 3.3.7.5-1 to be operable. With any channel inoperable the action in the table applies. The table requires one channel of suppression chamber air temperature to be operable. Action 80 applies with no suppression chamber air temperature channels operable. Action 80 requires the channel to be restored within 48 hours or be in hot shutdown within the next 12 hours. There is firm evidence that the channel was inoperable for approximately 13 days. Therefore, the allowable outage time (AOT) was exceeded on April 11, 2006.

This event involved a condition prohibited by TS. Therefore, this LER is being submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B).

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Analysis of the Event

There were no actual safety consequences associated with this event. The potential safety consequences of this event were minimal. The drywell air temperature channel remained operable during the event. Emergency operating procedures do not rely on this instrument for identifying a high temperature condition that could adversely affect primary containment barrier integrity. In fact, NUREG-1433 Rev.3, Standard Technical Specifications General Electric Plants BWR/4, does not include suppression chamber air temperature as a required accident monitoring instrument.

A redundant indication of suppression chamber air temperature on an adjacent recorder remained functional during the event. However, this indication is not environmentally qualified as required by Regulatory Guide 1.97, "Instrumentation for Light Water Cooled Nuclear Power Plants to Assess Plant Conditions During and Following an Accident," December 1975. Therefore, this instrument may have failed under some accident conditions and is not credited as satisfying the TS requirement.

The recorder ribbon cable connector is a friction fit type connector that does not lock in place and is susceptible to displacement during chart paper replacement.

Cause of the Event

The event was caused by a failure of the recorder ribbon cable connector, which became unseated during replacement of the recorder paper. A contributing cause was the failure to detect the recorder pen failure following the chart replacement.

Corrective Action Completed

The recorder ribbon cable connector was re-seated which restored the indication.

Periodic monitoring of the recorder was enhanced.

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Previous Similar Occurrences

There were no similar occurrences of TS noncompliance due to recorder failures.

Component data:

Component: TR (Recorder, Temperature)
Manufacturer: L130 (Leeds & Northrup Co)
Model number: Speedomax M