

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Limerick Generating Station, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 5 2 1	PAGE (3) 1 OF 0 4
--	--	----------------------

TITLE (4) This LER reports a condition prohibited by Tech. Spec. (TS) in that a Primary Containment Isolation Valve was inoperable and the required TS ACTION was not taken due to personnel error.

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)																																		
0 5	1 6	9 3	9 3	0 0 7	0 0	0 6	2 1	9 3			0 5 0 0 0																																		
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">OPERATING MODE (9)</td> <td style="width:15%;">1</td> <td colspan="10">THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (11)</td> </tr> <tr> <td rowspan="6">POWER LEVEL (10) 1 0 0</td> <td>20.402(b)</td> <td>20.405(c)</td> <td>50.73(a)(2)(iv)</td> <td>73.71(b)</td> </tr> <tr> <td>20.405(a)(1)(ii)</td> <td>50.36(c)(1)</td> <td>50.73(a)(2)(v)</td> <td>73.71(c)</td> </tr> <tr> <td>20.405(a)(1)(iii)</td> <td>50.36(c)(2)</td> <td>50.73(a)(2)(vii)</td> <td rowspan="4">OTHER (Specify in Abstract below and in Text, NRC Form 365A)</td> </tr> <tr> <td>20.405(a)(1)(iv)</td> <td>X 50.73(a)(2)(i)</td> <td>50.73(a)(2)(viii)(A)</td> </tr> <tr> <td>20.405(a)(1)(v)</td> <td>50.73(a)(2)(iii)</td> <td>50.73(a)(2)(viii)(B)</td> </tr> <tr> <td>20.405(a)(1)(vi)</td> <td>50.73(a)(2)(iii)</td> <td>50.73(a)(2)(ix)</td> </tr> </table>												OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (11)										POWER LEVEL (10) 1 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)	20.405(a)(1)(ii)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)	20.405(a)(1)(iii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)	20.405(a)(1)(iv)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(viii)(B)	20.405(a)(1)(vi)	50.73(a)(2)(iii)	50.73(a)(2)(ix)
OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5 (Check one or more of the following) (11)																																											
POWER LEVEL (10) 1 0 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)																																									
	20.405(a)(1)(ii)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)																																									
	20.405(a)(1)(iii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)																																									
	20.405(a)(1)(iv)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)																																										
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(viii)(B)																																										
	20.405(a)(1)(vi)	50.73(a)(2)(iii)	50.73(a)(2)(ix)																																										

LICENSEE CONTACT FOR THIS LER (12)											
NAME J. L. Kantner, Manager - Experience Assessment, LGS								TELEPHONE NUMBER 2 1 5 3 2 7 - 1 2 0 0			

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS		

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

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

On May 21, 1993, a section of Surveillance Test (ST) procedure ST-6-059-200-1, "PCIV Valve Test," which includes obtaining the stroke time of the Primary Containment Isolation Valve (PCIV) XV-059-1410, was identified by the Operations Surveillance Test Scheduler (OSTS) to be out of surveillance (OOS). Operations personnel were notified and the affected PCIV was declared inoperable. The ST procedure section was satisfactorily performed, and the PCIV was declared operable on May 21, 1993. The ST procedure and the PCIV had been OOS for a time period of 5 days and 74 minutes. Plant personnel were unaware that the ST procedure was OOS, and this resulted in the failure to comply with Technical Specifications (TS). The actual and potential consequences were minimal in that the PCIV was verified to be operable, and would have functioned as designed had an accident or operating transient occurred. The cause of this event was personnel error in that the Shift Technical Advisor (STA) incorrectly cancelled the ST procedure from a work order (WO). Contributing factors were that the WO had inadequate instructions, and an incorrect overdue date was assigned to the ST procedure. A detailed review of all open Unit 1 and Unit 2 Operations Department ST procedures was performed and no additional discrepancies were identified. The OSTs will ensure that explicit instructions and correct overdue dates are included in WOs when an incomplete ST procedure is involved. A letter has been issued to appropriate plant personnel which discusses this event.

9306280320 930621
PDR ADOCK 05000352
S PDR

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Limerick Generating Station, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 5 2	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 3	— 0 0 7	— 0 0	0	2	OF 0 4

TEXT (If more space is required, use additional NRC Form 365A's) (17)

Unit Conditions Prior to the Event:

Unit 1 Reactor was in Operational Condition 1 (Power Operation) operating at 100% power level.

On January 21, 1993 at 1425 hours, the quarterly Inservice Testing (IST) Surveillance Test (ST) Procedure ST-6-059-200-1, "Primary Containment Instrument Gas Valve Test," was satisfactorily performed. Technical Specifications (TS) Section 4.0.5, "Surveillance Requirements for Inservice Testing," requires the Surveillance Requirements (SR) interval for a quarterly ISI ST to be 92 days, and allows a maximum extension of 25% of the SR interval (i.e., 92 days plus an extension of 23 days). Therefore, the next performance of procedure ST-6-059-200-1 was due by May 16, 1993, at 1425 hours.

On April 23, 1993, sections of procedure ST-6-059-200-1 were completed, leaving an incomplete section due to be completed by May 16, 1993. This incomplete section involved stroke timing the Primary Containment Isolation Valve (PCIV) (EIIS:ISV) XV-59-141D, "TIP Guide Tube Ball Valve," for the Instrument Gas System (EIIS:LK). Performance of this section in the ST procedure could not be completed on April 23, 1993, since the 'D' Transversing Incore Probe (TIP) machine was removed from service for the implementation of a Maintenance Work Order (WO). As a result of this WO, no maintenance activities were being done on the PCIV; however, this PCIV could not be stroked timed in accordance with the ST procedure while the 'D' TIP machine was removed from service. Therefore, instructions were included in the WO to perform the section of the ST procedure ST-6-059-200-1 to stroke time the PCIV following the completion of the maintenance activities on the 'D' TIP machine. The WO is utilized to provide a 'closing mechanism' to ensure that the SR is satisfied prior to returning the PCIV to an operable status.

Description of the Event:

On May 21, 1993, at 1530 hours, the incomplete section of procedure ST-6-059-200-1, which includes obtaining the stroke time for the PCIV XV-059-141D, was identified by a non-licensed Operations Surveillance Test Scheduler (OSTS) to be out of surveillance (OOS) (i.e., the SR interval for the PCIV had been exceeded). The OSTS identified that performance of the ST procedure had been cancelled following completion of the WO on May 3, 1993.

The OSTS immediately notified Main Control Room (MCR) Operations personnel of the ST procedure being OOS, and the PCIV was declared inoperable at 1530 hours on May 21, 1993. The incomplete section of the ST procedure was satisfactorily performed at 1539 hours on May 21, 1993, and the PCIV was declared operable. The ST procedure had been OOS, and therefore the PCIV was inoperable from 1425 hours on May 16, 1993, to 1539 hours on May 21, 1993; a time period of 5 days and 74 minutes.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Limerick Generating Station, Unit 1	0 5 0 0 0 3 5 2	9 3	— 0 0 7	— 0 0	0 3	OF 0 4

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

When the PCIV became inoperable on May 16, 1993, at 1425 hours, the PCIV was not declared inoperable since MCR Operations personnel were unaware that the ST procedure was OOS. This resulted in a failure to comply with the corresponding TS ACTION statement of the TS Section 3.6.3(a). Therefore, this report is being submitted in accordance with the requirements of 10CFR50.73(a)(2)(i)(B).

Analysis of the Event:

The actual and potential consequences of this event were minimal. The PCIV XV-059-141D was verified to be operable following the event. Additionally, the PCIV remained in the closed position during the event. This is the position the PCIV would have achieved had an accident or operating transient occurred during the time period in which the PCIV was inoperable. There was no release of radioactive material to the environment as a result of this event.

Cause of the Event:

The primary cause of this event was personnel error. Following completion of the Maintenance WO on May 3, 1993, the activity to stroke time PCIV XV-059-141D was cancelled by a non-licensed Operations Shift Technical Advisor (STA). The STA reviewed the WO and incorrectly concluded that performance of the ST procedure was only required following physical work on the PCIV. The WO provided maintenance activities only on the 'D' TIP machine, not the PCIV, and therefore, the STA concluded that the performance of the ST procedure was not necessary. Additionally, information concerning the partially completed ST procedure was available in the Plant Information Management System (PIMS) which generated the WO. Had the STA reviewed the specific WO for the incomplete ST procedure in PIMS, the STA could have determined that the incomplete ST procedure section was being performed to satisfy an overdue TS SR.

The first contributing factor to the cause of this event was that instructions provided in the Maintenance WO to direct Operations personnel to perform the partially completed procedure ST-6-059-200-1 upon finishing the WO were less than adequate. The instructions did not provide a clear expectation that performance of the incomplete ST procedure section was required to satisfy an overdue TS SR.

A second contributing factor to the cause of this event was the creation of a second WO which had an incorrect overdue date for the ST procedure, by the plant Surveillance Test Coordinator (STC). The incomplete ST procedure was sent to the STC on April 23, 1993, and the STC created a specific WO for the incomplete ST procedure. The STC is required to create WOs to track open/incomplete ST procedures. Based on information available on April 23, 1993, the STC made a conservative decision that the PCIV had failed its ST procedure. Henceforth, the STC indicated on this second WO that the ST procedure was overdue on April 23, 1993, not May 16, 1993. On April 24, 1993, the OSTs dispositioned the ST procedure as having the proper 'closing mechanism' (i.e., the ST procedure was scheduled to be completed following completion of the WO). Therefore, no

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Limerick Generating Station, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 3 5 2 9 3	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		93	— 0 0 7	— 0 0	0 4	OF 0 4

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

further review of the ST procedure status was performed by the OSTs after this disposition was completed. As a result, the procedure required 'normal three day approaching overdue warning period' was not initiated by the STC, and the incomplete ST procedure went OOS on May 16, 1993, without any notification.

Corrective Actions:

1. A detailed review of all open Unit 1 and Unit 2 Operations Department ST procedures was performed and no additional discrepancies were identified.
2. The OSTs reviews all failed and partially completed Operations Department ST procedures performed from the previous day. If an open action request, work order, or clearance affects the successful completion of these particular ST procedures, the OSTs will now ensure that the basis for the ST procedure completion (i.e., TS SR) is included with the action request, work order, or clearance. The OSTs will review the Operations Department ST procedure approaching overdue list and communicate with the STC to ensure correct overdue dates are entered. Specific instructions concerning these corrective actions are expected to be incorporated into an appropriate document by July 1, 1993.
3. A review of Administrative (A) procedure A-43, "Surveillance Testing Program," was performed and no deficiencies were identified. However, a letter has been issued to MCR Shift Supervision personnel discussing this event and emphasizing the requirement of procedure A-43 that any ST procedure which cannot be completed in full must have a closing mechanism. The letter also instructs that the closing mechanism include the basis for the ST procedure completion. Additionally, this letter will be sent to other appropriate work planning groups.

Previous Similar Occurrences:

LERs 1-92-009, 1-92-001, 1-88-003, 1-87-054, and 1-86-057 all reported overdue STs as a result of personnel error. However, none of these LERs were a result of the same error and the resultant condition which caused this event.