10 CFR 50.73

PHILADELPHIA ELECTRIC COMPANY

LIMERICK GENERATING STATION

P. O. BOX A

SANATOGA, PENNSYLVANIA 19464

(215) 327-1200 EXT. 2000

M. J. McCORMICK, JR., P.E.
PLANT MANAGER
LIMERICK GENERATING STATION

December 20, 1990
Docket No. 50-352
License No. NPF-39

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

SUBJECT: Licensee Event Report
Limerick Generating Station - Unit 1

This LER reports a condition prohibited by Technical Specifications (TS) in that a TS Surveillance Requirement and the associated TS Action were not performed in the specified period of time. Firewatch employees did not perform the daily Unit 1 fire door position check surveillance test therefore failing to verify the operability of non-electrically supervised fire doors as required by TS Section 4.7.7.2.b.

Reference:	Docket No. 50-352
Report Number:	1-90-031
Revision Number:	00
Event Date:	December 2, 1990
Discovery Date:	December 3, 1990
Report Date:	December 20, 1990
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)(i)(B).

Very truly yours,

M. J. McCormick Jr.

DMS:cah

cc: T. T. Martin, Administrator, Region I, USNRC
T. J. Kenny, USNRC Senior Resident Inspector, LGS

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NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES 8/31/88

LICENSEE EVENT REPORT (LER)

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

TITLE (4) Firewatch Employees did not Perform the Daily Unit 1 Fire Door Check therefore Failing to verify the Operability of the Fire Doors as Required by Technical Specifications

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 2	0 2	9 0	9 0	— 0 3 1 —	0 0	1 2	2 0	9 0		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): 4

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

[ ] 20.402(b)	[ ] 20.405(c)	[ ] 50.73(a)(2)(iv)	[ ] 73.71(b)
[ ] 20.405(a)(1)(i)	[ ] 50.36(c)(1)	[ ] 50.73(a)(2)(v)	[ ] 73.71(c)
[ ] 20.405(a)(1)(ii)	[ ] 50.36(c)(2)	[ ] 50.73(a)(2)(vii)	[ ] OTHER (Specify in Abstract below and in Text, NRC Form 366A)
[ ] 20.405(a)(1)(iii)	[X] 50.73(a)(2)(i)	[ ] 50.73(a)(2)(viii)(A)	
[ ] 20.405(a)(1)(iv)	[ ] 50.73(a)(2)(ii)	[ ] 50.73(a)(2)(viii)(B)	
[ ] 20.405(a)(1)(v)	[ ] 50.73(a)(2)(iii)	[ ] 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
G. J. Madsen, Regulatory Engineer, Limerick Generating Station	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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
[ ] YES (If yes, complete EXPECTED SUBMISSION DATE)	[X] NO				

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

On December 3, 1990, at 0850 hours, a contract Firewatch Coordinator discovered that Surveillance Test (ST) procedure ST-7-022-371-1, "Unit 1 Fire Door Daily Position Check," had not been performed on December 2, 1990. Instead, ST procedure ST-7-022-371-2, "Unit 2 Fire Door Daily Position Check," was inadvertently performed twice on December 2, 1990. The Unit 1 Technical Specifications (TS) Surveillance Requirement (SR) 4.7.7.2 was not met and the TS Action of establishing a fire watch within one hour was not taken in the required time. The consequences of this event were minimal, and there was no release of radioactive material to the environment. The cause of this event was two personnel errors and an informal work practice. The Fire Watch Supervisor (FWS) failed to recognize and hand out the correct fire door daily position check ST procedure to be performed. The Firewatch, after performing the ST procedure, failed to observe that an incorrect procedure had been used. A white photocopy, instead of the unitized yellow colored copy of the Unit 1 ST procedure, was used during the actual plant inspection of the fire doors which is an informal work practice. The FWS and Firewatch involved in this event were counseled to stress the importance of a higher level of attention to detail while performing their daily tasks. All photocopies of the Unit 1, Unit 2, and Common Plant fire door daily position check ST procedures kept on file are now color coded identical to the original ST procedures. This action was completed on December 4, 1990.

Unit Conditions Prior to the Event:

Unit 1 Operating Condition was 4 (Cold Shutdown) at 0% power level.

Description of the Event:

On December 3, 1990, at 0850 hours, a contract Firewatch Coordinator discovered that Surveillance Test (ST) procedure ST-7-022-371-1, "Unit 1 Fire Door Daily Position Check," had not been performed on December 2, 1990. Instead, ST procedure ST-7-022-371-2, "Unit 2 Fire Door Daily Position Check," was inadvertently performed twice on December 2, 1990. The Unit 1 Technical Specifications (TS) Surveillance Requirement (SR) 4.7.7.2 was not met and the TS Action of establishing a fire watch within one (1) hour was not taken in the required time. This resulted in a condition prohibited by TS. On December 3, 1990, at 0907 hours, the Unit 1 ST was satisfactorily performed and no Unit 1 doors were found open.

This report is being submitted in accordance with the requirements of 10CFR50.73(a)(2)(i)(B), since this event resulted in a condition prohibited by TS.

Analysis of the Event:

During the period in which the Unit 1 fire doors were technically inoperable, a fire did not occur in any of the Unit 1 fire areas that could have challenged the fire barriers. The smoke detection systems located in the vicinity of the Unit 1 fire doors were operable and would have provided early detection of a fire in any of the fire areas. Appropriate detection and suppression equipment is in place to detect and contain a fire that would have occurred in any of the affected Unit 1 fire areas. When the Unit 1 ST procedure was performed no fire doors were found open. Furthermore, plant operators make regular rounds in the plant and they would have identified any fire doors that were propped open and would have initiated the appropriate TS Action of closing the door. There was no release of radioactive material to the environment as a result of this event. Therefore, the actual and potential consequences of this event were minimal.

Cause of the Event:

The cause of this event was two personnel errors and an informal work practice.

1. The Fire Watch Supervisor (FWS) failed to recognize and hand out the correct fire door daily position check ST procedure to be performed.

2. The Firewatch, after performing the ST procedure, failed to observe that an incorrect procedure was being filled out during the transfer of information from the white photocopy to the original color coded ST procedure.

3. A white photocopy ST procedure was used during the actual plant inspection of the fire doors, instead of the unitized yellow colored copy, which is an informal work practice.

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 0	— 0 3 1 —	0 0	0 3 OF 0 3

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

The normal routine for performing the fire door daily position check was as follows. The FWS maintained white photocopies of the original Unit 1, Unit 2, and Common Plant fire door daily position check ST procedures in their files. The original ST procedures, which are also on file, are color coded by Unit (i.e., Unit 1 - yellow, Unit 2 - green, Common Plant - white). For the daily fire door check, the FWS gave a white photocopy of the procedure to the Firewatch to use during their walkdown, and kept the original ST on their desk. After the walkdown was performed, the fire watch filled out, signed, and submitted the original ST procedure to the FWS for review and approval. The firewatch then disposed of the photocopies.

In this event, the first shift FWS handed out photocopies of the Unit 2 and Common Plant ST procedures to be performed. These ST procedures were completed, and the firewatch filled out, signed, and submitted both original ST procedures for review and approval. Prior to shift turnover, the first shift FWS informed the second shift FWS that the Unit 2 and Common Plant ST procedures had been completed.

During the second shift, the FWS inadvertently handed out another photocopy of the Unit 2 ST procedure to be performed. While the Unit 2 ST procedure was being performed, the FWS placed the original Unit 1 ST procedure on his desk for the firewatch to later complete. After the Unit 2 ST procedure was performed, the firewatch inadvertently transferred the information from the Unit 2 white photocopy to the Unit 1 color coded procedure. The Unit 1 and Unit 2 ST procedures are almost identical in format with only the door numbers being the major difference. The completed Unit 1 ST procedure was then submitted to the FWS for review and approval. On December 3, 1990, the Firewatch Coordinator, during his routine review of the previous day's tests, discovered the mistake.

Corrective Actions:

1. The FWS and Firewatch involved in this event were counseled to stress the importance of a higher level of attention to detail while performing their daily tasks.

2. All photocopies of the Unit 1, Unit 2, and Common Plant fire door daily position check ST procedures kept on file are now color coded identical to the original ST procedures. This action was completed on December 4, 1990.

Previous Similar Occurrences:

LER 1-90-016 reported a condition prohibited by TS in that a TS SR and the associated TS Limiting Condition for Operation Action were not performed within the specified period of time. On various occasions, two firewatch employees falsified the performance of a ST procedure and failed to verify the operability of non-electrically supervised fire doors as required by TS Section 4.7.7.2.b. The actions taken to prevent recurrence for LER 1-90-016 would not have prevented this event.

Tracking Codes: A Personnel Error