

PHILADELPHIA ELECTRIC COMPANY

LIMERICK GENERATING STATION
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J. DOERING, JR.
 PLANT MANAGER
 LIMERICK GENERATING STATION

May 12, 1992
 Docket Nos. 50-352
 50-353
 License Nos. NPF-39
 NPF-85

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

SUBJECT: Licensee Event Report
Limerick Generating Station - Units 1 and 2

This LER concerns the failure to comply with Technical Specifications Sections 3.3.7.9 and 3.7.7 and the associated Action within the specified time period in that a one hour firewatch inspection was not performed during a security system computer outage due to personnel error.

Reference: Docket Nos. 50-352
 50-353
 Report Number: 1-92-005
 Revision Number: 00
 Event Date: April 15, 1992
 Report Date: May 12, 1992
 Facility: Limerick Generating Station
 P.O. Box 2300, Sanatoga, PA 19464-2300

This LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(1)(B).

Very truly yours,

J. Doering

DMS:cah

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

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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1): Limerick Generating Station, Unit 2	DOCKET NUMBER (2): 0 5 0 0 0 3 5 2	PAGE (3): 1 OF 0 4
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TITLE (4): Failure to comply with Technical Specifications in that a one hour firewatch inspection was not performed during a security system computer outage 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 (8):
0 4	1 5	9 2	9 2	0 0 5	0 0 2	5	1 2	9 2	Limerick, Unit 2		0 5 0 0 0 3 5 3
											0 5 0 0 0 1 1 1

OPERATING MODE (9): 5

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 50. (Check one or more of the following) (11):

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

LICENSEE CONTACT FOR THIS LER (12):

NAME: G. J. Madsen, Regulatory Engineer, Limerick Generating Station	TELEPHONE NUMBER: AREA CODE: 211 531 2171 - 1121010
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13):

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14):

YES (1) NO (2)

EXPECTED SUBMISSION DATE (15):

DAY	YEAR

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

On April 15, 1992, from 0426 hours to 0452 hours, the security system computer experienced an unscheduled outage causing security door card readers to be inoperable thereby prohibiting normal access to certain areas within the Reactor and Control Enclosures. During this twenty-six minute security computer outage, the previously established firewatch inspections for thirteen impairments located within the Reactor and Control Enclosures were not performed within one hour of the previous inspections, violating Technical Specifications Sections 3.3.7.9 and 3.7.7. The actual consequences of this event were minimal in that a fire did not occur during the time period in which the thirteen impairments were not firewatched. Had a fire occurred, fire detection and suppression systems were available. The cause of this event was cognitive personnel error in that the contractor employed security Shift Sergeant failed to adequately utilize security personnel during the security computer outage, therefore causing the delay in the performance of the firewatch inspections. The security Shift Sergeant was counseled, and an Assistant Director of the contractor employed security force has been assigned to monitor and instruct the security Shift Sergeant. A Lessons Learned Bulletin discussing this event was disseminated to all security supervision.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	TICKET NUMBER (2)	LER NUMBER (3)			PAGE (3)	
		Y. & R.	SEQUENTIAL NUMBER	REVISION NUMBER		
Limerick Generating Station, Unit 1	0 5 0 0 0 7 5 2	9 1 2	0 0 5	0 0	0 2	OF 0 4

TEXT (IF ANY) SHOULD BE TYPED, USE ADDITIONAL NRC FORM 366A (1) (7)

Unit Conditions Prior to the Event:

Unit 1 was in Operational Condition 5 (Refueling) at 0% power level.

Unit 2 was in Operational Condition 1 (Power Operations) at 100% power level.

Description of the Event:

On April 15, 1992, at 0426 hours, the security system computer experienced an unscheduled outage. This caused the security system door card readers to be inoperable, thereby prohibiting normal access to certain areas within the Reactor and Control Enclosures. Compensatory actions were immediately implemented and all required security posts were manned within nine minutes in accordance with security procedures. The unscheduled security outage was terminated at 0452 hours, and lasted a period of twenty-six minutes. During this twenty-six minute time period, the firewatch inspections for thirteen impairments located on the Unit 1 Reactor Enclosure elevations 201' and 283', the Unit 2 Reactor Enclosure elevation 331', and the Control Enclosure elevations 239' and 254' were delayed, and were not performed within one hour of the previous inspection as required by Technical Specifications (TS). The thirteen impairments consisted of smoke detection systems (EIS:28) out of surveillance, inoperable fire seals, a propped open fire door, and a fire panel trouble alarm. The failure to firewatch these areas within one hour is a violation of the TS Section 3.3.7.9, "Fire Detection Instrumentation," and TS Section 3.7.7, "Fire Rated Assemblies." Both TS sections require the establishment of an hourly firewatch patrol with one or more fire detection instruments, or fire rated assemblies and/or sealing devices inoperable.

An hourly firewatch had been established prior to this event, and the previous inspection had been successfully performed during the firewatch round which began at 0330 hours, on April 15, 1992. When the firewatch returned to begin the next firewatch round at 0430 hours, the security system card readers to the areas were inoperable. The firewatch notified security at 0428 hours and again at 0438 hours, in accordance with their training, to gain access to the areas. However, the responsible security force member (SFM), who was to be assigned to assist the firewatch, was being used as part of the compensatory actions and was not immediately dispatched during the security system computer outage. As a result, the SFM arrived at 0454 hours to escort the firewatch; twenty-six minutes after the firewatch initially notified security. This caused a one hour and twenty-four minute time period to elapse since the start of the last inspection. As a result, the thirteen impairments were inspected eighteen to twenty-two minutes past their one hour TS action time limit. Therefore, this LER is being submitted in accordance with the requirements of 10CFR50.73(a)(2)(i)(B).

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Limerick Generating Station, Unit 1	0500035292	—	005	—	00	03 OF 04

TEXT (if more space is required, use additional NRC Form 200A 2/177)

Analysis of the Event:

The actual consequences of this event were minimal in that a fire did not occur during the additional eighteeen to twenty-two minute time period in which the thirteen impairments were not in compliance with TS Sections 3.3.7.9 and 3.7.7. There was no release of radioactive material to the environment as a result of this event.

Had a fire occurred during the time period in which the thirteen impairments were not in compliance with TS, the following systems would have been available to mitigate the consequences of a fire. On the Unit 1 Reactor Enclosure elevation 201', and the Control Enclosure elevation 239', all smoke and heat detection instrumentation, as well as automatic fire suppression capability consisting of either wet pipe or preaction sprinkler systems (EISS:KP) were operable. On the Unit 1 Reactor Enclosure elevation 283', the Unit 2 Reactor Enclosure elevation 331', and the Control Enclosure elevation 254', the smoke detection systems were inoperable due to the systems being out of surveillance. However, the smoke detectors would have functioned since their Class A Supervisory Systems, which monitor for system malfunctions, were not in the alarm state and did not have trouble indication lights illuminated during or after the event. Additionally, on elevations 283', 331', and 254', the fire suppression capability consisting of either wet pipe or preaction sprinkler systems were operable. Operable fire detection and/or suppression capability existed on the opposite sides of the impairments involving the inoperable fire seals and the propped open fire door. With the activation of any of these detection or suppression systems, annunciators in the Main Control Room would have alarmed and the Fire brigade would have been dispatched to the affected areas. Therefore, the potential consequences of this event were minimal.

Cause of the Event:

The cause of this event was cognitive personnel error in that the contractor employed security Shift Sergeant failed to adequately and effectively utilize available personnel resources during the unscheduled security system computer outage, resulting in the unnecessary posting and double-teaming of SFMs. Although compensatory actions were adequately implemented, the responsible SFM should have been immediately dispatched by the Shift Sergeant to meet and escort the firewatch within 10 minutes of being notified. This action is required by security procedures and is adequately covered in training to ensure compliance with TS actions involving roving firewatches. The responsible SFM was not properly dispatched during the security system outage, and as a result, the SFM arrived at 0454 hours to escort the firewatch; twenty-six minutes after the firewatch initially notified security.

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 2	— 0 0 5	— 0 0	0 4	OF 0 4

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

Corrective Actions:

1. The security Shift Sergeant involved in this event was counseled on the need for attention to detail and the effective use of available personnel during an unplanned security system computer outage.
2. On April 16, 1992, an Assistant Director of the contractor employed security force was assigned to monitor and instruct the security Shift Sergeant involved in this event. The Shift Sergeant will receive continuous on-shift instruction from the Assistant Director. The Assistant Director will be removed after positive performance indicator trends are observed by the Assistant Director and the Limerick Generating Station (LGS) Nuclear Security Branch Head.
3. A Lessons Learned Bulletin discussing this event was disseminated on April 20, 1992, to all security supervision. Security supervisors are required to read and comply with the expectations presented in the bulletin.

Previous Similar Occurrences:

LGS LERs 85-053, 86-009, 86-019, 86-036, 87-28, and 89-20 reported a failure to meet the one hour maximum time limit of TS Section 3.7.7 during other security system computer outages. These previous events were due to communication errors and procedural deficiencies. The cause of this event was cognitive personnel error, and therefore, the corrective actions from these previous events would not have prevented this event from occurring.

Tracking Codes: A2 - Failure to follow implementing procedures.