

PHILADELPHIA ELECTRIC COMPANY

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

June 09, 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 reports an event which resulted in a condition prohibited by Technical Specifications (TS) in that the 'A' Loop of the Emergency Service Water system was inoperable, and the required TS actions were not taken in the required time as a result of the late performance of a surveillance test procedure caused by personnel error.

Reference:	Docket Nos. 50-352 50-353
Report Number:	1-92-009
Revision Number:	00
Event Date:	May 15, 1992
Report Date:	June 09, 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)(i)(B).

Very truly yours,

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 1	DOCKET NUMBER (2): 0 5 0 0 0 3 5 2 1	PAGE (3): 1 OF 0 4
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TITLE (4): This LER reports a condition where the 'A' Loop of the Emergency Service Water System was inoperable as a result of an overdue Surveillance Test 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	5	9	2	9	2	0	Limerick, Unit 2		0 5 0 0 0 3 5 3
0	5	1	5	9	2	9	2	0			0 5 0 0 0 1 1 1

OPERATING MODE (9): 5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11):									
POWER LEVEL (10): 0 0 1 0	20.402(b)	20.405(c)	50.731(a)(2)(iv)	73.71(b)						
	20.405(a)(1)(i)	50.38(c)(1)	50.731(a)(2)(v)	73.71(c)						
	20.405(a)(1)(ii)	50.38(c)(2)	50.731(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	20.405(a)(1)(iii)	X 50.731(a)(2)(ii)	50.731(a)(2)(vii)(A)							
	20.405(a)(1)(iv)	50.731(a)(2)(ix)	50.731(a)(2)(vii)(B)							
20.405(a)(1)(v)	50.731(a)(2)(iii)	50.731(a)(2)(ix)								

LICENSEE CONTACT FOR THIS LER (12)									
NAME: G. J. Madsen, Regulatory Engineer, Limerick Generating Station							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 NRCDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRCDS

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 May 15, 1992, sections of Surveillance Test (ST) Procedure ST-6-011-231-0, "'A' Loop Emergency Service Water (ESW) Pump, Valve, and Flow Test," used for testing the 'A' Loop ESW discharge check valves 11-0064A and 11-0065A, were identified by plant personnel to be out of surveillance (OOS). Operations personnel were notified and the affected equipment was declared inoperable. The sections of the ST procedure were satisfactorily performed, and the equipment was declared operable on May 15, 1992. The ST procedure had been OOS since May 7, 1992; a time period of 8 days and 45 minutes. As a result of the ST procedure being OOS, the 'A' Loop of the ESW system and the associated equipment it serves should have been declared inoperable. Since plant personnel were unaware that the ST procedure was OOS, this resulted in the failure to comply with various Unit 1 and Unit 2 Technical Specifications ACTION statements. The actual and potential consequences were minimal in that the affected ESW system check valves were 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 ST Coordinator (STC) failed to perform an adequate daily review of the ST Procedure Partial Log. A detailed review of the Unit 1 and Unit 2 ST Procedure Partial Logs was performed and no additional discrepancies were identified. The Unit 1 and Unit 2 STCs were counseled on the need for attention to detail and the importance of reviewing the ST Procedure Partial Logs in detail each day.

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TEXT (If more space is required, use additional NRC Form 306A (1/77))

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.

On January 13, 1992, at 2045 hours, the quarterly inservice inspection (ISI) Surveillance Test (ST) Procedure ST-6-011-231-0, "A' Loop Emergency Service Water (ESW) Pump, Valve, and Flow Test," was satisfactorily performed. Technical Specifications (TS) Section 4.0.5, "Surveillance Requirements for Inservice Inspection and 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-6-011-231-0 was due by May 7, 1992, at 2045 hours.

On April 16, 1992, and on April 20, 1992, sections of Procedure ST-6-011-231-0 were completed, leaving the incomplete sections to be due by May 7, 1992.

Description of the Event:

On May 15, 1992, at 1430 hours, the incomplete sections of Procedure ST-6-011-231-0, which test the 'A' Loop ESW discharge check valves 11-0064A and 11-0065A, were identified by Surveillance and Performance Group personnel to be out of surveillance (OOS). Operations personnel were immediately notified and the 'A' Loop of the ESW system and the associated equipment it services was declared inoperable at 1430 hours on May 15, 1992. The incomplete sections of the ST procedure were satisfactorily performed at 1845 hours, and the affected equipment was declared operable at 2130 hours on May 15, 1992. The ST procedure and the affected equipment had been OOS for a time period of 8 days and 45 minutes.

The purpose of the sections of Procedure ST-6-011-231-0 that were not completed by May 7, 1992, was to ensure that adequate water flow is obtained through the 'A' Loop ESW discharge check valves (EIIS:VLV) 11-0064A and 11-0065A. These check valves are provided in the 'A' ESW Loop to prevent reverse water flow from the Residual Heat Removal (RHR) Service Water system (EIIS:BI) from entering the ESW system (EIIS:BI).

As a result of the ST procedure and the affected equipment being OOS, the 'A' Loop of the ESW system was inoperable from 2045 hours on May 7, 1992, until 2130 hours on May 15, 1992 (i.e., eight (8) days, 45 minutes). TS Section 3.7.1.2 requires that with one ESW system loop inoperable, all the equipment aligned to the inoperable loop must be declared inoperable and to restore the inoperable loop to operable status within 72 hours or be in hot shutdown within the next 12 hours and cold shutdown in the following 24 hours. Accordingly, the equipment served by the 'A' Loop of the ESW system was also considered inoperable for that

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TEXT (If more space is required, use additional NRC Form 266A's) (17)

time period. The 'A' Loop of the ESW system provides cooling water to the following equipment:

- o the four heat exchangers for the Unit 1 and Unit 2 Emergency Diesel Generators (EDGs) (EIIS:EK) aligned to the 'A' Loop of the ESW system (i.e., EDGs D11, D13, D21, D23),
- o the Reactor Core Isolation Cooling (RCIC) system (EIIS:BN) pump compartment room coolers for Unit 1 and Unit 2,
- o the common 'A' Control Enclosure Chiller (EIIS:V1),
- o the 'A' and 'C' Core Spray system (EIIS:BG) pump compartment room coolers for both Unit 1 and Unit 2,
- o the 'A' and 'C' RHR system (EIIS:BO) pump compartment room coolers for both Unit 1 and Unit 2; and
- o the 'A' and 'C' RHR pump motor oil coolers and seal coolers for both Unit 1 and Unit 2.

When the 'A' Loop of the ESW system became inoperable on May 7, 1992, at 2045 hours, the equipment serviced by the 'A' Loop was not declared inoperable since plant personnel were unaware that the ST procedure and the affected equipment were OOS. This resulted in a failure to comply with the corresponding TS ACTION statements of the Unit 1 TS Sections 3.7.1.2.b.1, 3.8.1.2.a and the Unit 2 TS Sections 3.7.1.2.a.3, 3.5.1.a.1, and 3.5.1.b.4 in the specified time periods. Therefore, this report is being submitted in accordance with the requirements of 10 CFR 50.73(a)(2)(i)(B).

Analysis of the Event:

The actual and potential consequences of this event were minimal in that the affected ESW system check valves were verified to be operable following the event, and would have functioned as designed had an accident or operating transient occurred during the time period in which the ESW check valves were OOS. 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 in that the Unit 1 ST Coordinator (STC) failed to perform an adequate daily review of the Unit 1 ST Procedure Partial Log prior to and on May 7, 1992. The Unit 1 ST procedure had been properly annotated on the Unit 1 ST Procedure Partial Log with a component OOS date of May 7, 1992 prior to this event. A secondary cause was that the Unit 1 STC failed to manually enter the ST procedure onto the Surveillance Test and Records System (STARS) (EIIS:LT) "Approaching Overdue Report." This should

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TEXT (If more space is required, use additional NRC Form 288A's) (17)

have been performed three days prior to May 7, 1992, to alert appropriate plant personnel of the potential for the ST procedure and the affected equipment to become OOS, as required under the Administrative (A) Procedure A-43, "Surveillance Testing Program." Additionally, a contributing factor was that this event occurred during a transition period in which the Unit 1 STC was being replaced. The Unit 2 STC was transferred on May 7, 1992, to perform the Unit 1 STC's responsibilities and was not fully familiar with the details of the open items concerning the Unit 1 ST procedures. As a result, the ST procedure and the affected equipment were not identified to be OOS by the STC until May 15, 1992.

Corrective Actions:

1. A detailed review of the Unit 1 and Unit 2 ST Procedure Partial Logs was performed and no additional discrepancies were identified.
2. The STCs were counseled on the need for attention to detail and the importance of reviewing the ST Procedure Partial Logs in detail each day.

Previous Similar Occurrences:

LERs 89-001, 88-003, 87-054, and 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 resultant condition which caused this event.

Tracking Codes: A9 - Failure to properly interpret information/results