



PECO NUCLEAR

A UNIT OF PECO ENERGY

PECO Energy Company
PO Box 2300
Sanatoga, PA 19464-0920

10CFR50.73

March 19, 1996
Docket No. 50-353
License No. NPF-85

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

SUBJECT: License Event Report
Limerick Generating Station - Unit 2

This LER reports a condition prohibited by Technical Specifications in that two independent Standby Gas Treatment subsystems were inoperable due to personnel error.

Reference:	Docket No. 50-353
Report Number:	2-96-001
Revision Number:	00
Event Date:	February 20, 1996
Report Date:	March 19, 1996
Facility:	Limerick Generating Station P.O. Box 2300, Sanatoga, PA 19464-2300

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

Very truly yours,

DMS:cah

cc: T. T. Martin, Administrator Region I, USNRC
N. S. Perry, USNRC Senior Resident Inspector, LGS

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PDR ADOCK 05000353
S PDR

LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Limerick Generating Station, Unit 2

DOCKET NUMBER (2)

05000

PAGE (3)

1 OF 3

TITLE (4) Condition Prohibited by Technical Specifications in that Two Independent Standby Gas Treatment Subsystems were Inoperable 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 NAME	DOCKET NUMBER
02	20	96	96	-- 001 --	0	03	19	96	FACILITY NAME	DOCKET NUMBER
										05000
										05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)						
POWER LEVEL (10)	100	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
		20.405(a)(1)(iii)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		(Specify in
		20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		Abstract below
		20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME

J. L. Kantner, Manager - Experience Assessment, LGS

TELEPHONE NUMBER (Include Area Code)

(610) 718-3400

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

YES

(If yes, complete EXPECTED SUBMISSION DATE).

X

NO

EXPECTED SUBMISSION DATE (15)

MONTH

DAY

YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On 02/20/96, Unit 1 was in a refueling outage, Unit 2 was at 100% power, and the common plant 'B' Standby Gas Treatment (SBGT) system was rendered inoperable for scheduled outage work. At 1146 hours, the 'A' SBGT system tripped when a non-licensed utility equipment operator (EO) inadvertently opened breakers on an incorrect Motor Control Center (MCC). The EO was deenergizing MCCs associated with a Division II Safeguard Bus Outage, which required opening of the 'B' SBGT system breakers. The EO inadvertently opened the breakers for the 'A' SBGT system. Both MCCs for the SBGT systems are located adjacent to each other on the same plant elevation. Technical Specifications (TS) Limiting Condition for Operation (LCO) 3.6.5.3 was entered for Units 1 and 2, and TS LCO 3.0.3 was entered for Unit 2. TS LCO 3.0.3 was not applicable for Unit 1. Within 4 minutes, the 'A' SBGT system was returned to operation. No power reduction occurred on Unit 2 since the 'A' SBGT system was restored within 1 hour. This event is reportable as a condition prohibited by TS for Unit 2. The consequences of this event are minimal. The cause of this event was personnel error resulting from less than adequate self check by the EO. The EO was counseled and operator standdown meetings were conducted to discuss this event and Event Free Operation Practices.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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Limerick Generating Station, Unit 2		05000 353		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
				96	--001 --	0	

TEXT (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) 5* (Refueling) and was in its sixth refueling outage. Unit 2 was in OPCON 1 (Power Operation) operating at 100% power level.

On February 20, 1996, Operations and Engineering personnel were preparing the plant for the Division II Safeguard Bus (EIIS:BU) outage per Special Procedure (System) SP-S-068, "Procedure for Deenergizing and Reenergizing the D12 Safeguard Bus During a Refuel Outage." In support of this activity, by 1053 hours, both trains of the Refuel Floor Ventilation system were isolated, the 'B' train of the Standby Gas Treatment (SBGT, EIIS:BH) system was declared inoperable, and the 'A' train of the SBGT system was in operation maintaining Refuel Floor ventilation.

Description of the Event:

At 1146 hours on February 20, 1996, the common plant 'A' SBGT system tripped due to the loss of power to the inlet and outlet dampers HV-076-011A and HV-076-012A, respectively. The 'A' SBGT system trip occurred when a non-licensed utility equipment operator (EO) inadvertently opened electrical breakers on an incorrect Motor Control Center (MCC) panel (EIIS:BKR). Per procedure SP-S-068, Step 7.6.3, the EO was to deenergize the MCC panel associated with the 'B' SBGT system. Instead of opening the breakers on MCC panel D124-R-C1 for the 'B' SBGT system, the EO inadvertently opened the breakers on MCC panel D114-R-C1 for the 'A' SBGT system. The MCC panels are located adjacent to each other on the same plant elevation.

MCR Operations personnel immediately: 1) entered the appropriate actions of Technical Specifications (TS) Limiting Condition for Operation (LCO) 3.6.5.3 for Units 1 and 2, 2) entered TS LCO 3.0.3 for Unit 2, and 3) commenced restoration of the MCC panel D114-R-C1 and the 'A' SBGT system. Within 4 minutes, the 'A' SBGT system was returned to operation and the applicable TS LCOs were exited. No power reduction per TS LCOs 3.6.5.3 or 3.0.3 occurred on Unit 2 since the 'A' SBGT system was restored to an operable condition within 1 hour. The TS LCO 3.6.5.3 was met for Unit 1, and the provisions of TS LCO 3.0.3 were not applicable. This report is being submitted in accordance with the requirements of 10CFR50.73(a)(2)(i)(B) as a condition prohibited by TS for Unit 2.

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Limerick Generating Station, Unit 2	05000 353	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 OF 3
		96	--001--	0	

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

Analysis of the Event:

The consequences of this event are minimal, and there was no release of radioactive material to the environment as a result of this event. The 'A' SBT system was restored within 4 minutes by Operations personnel. This prompt action prevented any adverse affects to plant equipment or systems.

Cause of the Event:

The cause of this event was personnel error resulting from less than adequate self check by the EO. The EO failed to recognize that he was at the incorrect MCC panel when he commenced opening the electrical breakers. MCC panels D114-R-C1 and D124-R-C1 have similar alpha-numeric designations, and the EO believed that he was at the correct MCC panel. Additionally, both MCC panels are located adjacent to each other on the same plant elevation.

Corrective Actions:

The EO was interviewed by the Senior Manager of Operations and counselled for not utilizing Event Free Operation Practices. These documented practices describe the appropriate operator actions to minimize the occurrence of human performance events. During the week beginning on February 21, 1996, operator standdown meetings were conducted with each shift by the Senior Manager of Operations to discuss this event with an emphasis on using proper Event Free Operation Practices.

Previous Similar Occurrences:

None