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Abstract: 85-015

On January 18, 1985, with Unit 1 in the startup mode at 3.6 percent power, while performing an inspection of the fire suppression system, it was discovered that the sprinkler system for the Cable Spreading Room was out-of-service. Subsequently, the sprinkler system for the Control Enclosure Fan Room was also found out-of-service. Both systems were immediately returned to service. Since both sprinkler systems were out-of-service without a continuous fire watch, this event is a violation of Technical Specification 3.7.6.2. Investigation of the event revealed that contractor personnel working on the blocked portion of the system performed a modification hydrostatic test and closed the two supply valves for these systems without properly notifying operating personnel. Following completion of the modification, operating personnel cleared the block without performing adequate operational verification.

IEAR

MRC form 384

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Description of the Event:

On January 8, 1935, portions of the water fire protection system in the Control Enclosure were tagged out-of-service for modification work. This modification involved the transfer of the supply piping for certain hose stations from one supply line to another. Appropriate fire watches and back-up suppression equipment were provided as required by the Technical Specifications for the hose stations and sprinkler systems rendered inoperable.

For a hydrostatic test, contractor personnel closed valves 22-1155 and 22-1156 for the Cable Spreading Room sprinkler system and the Control Enclosure Fan Room sprinkler system, respectively. Closure of these valves without notifying operating personnel was permitted by job rule. The hydrostatic test was completed and the blocking removed on January 10, 1985. The Maintenance Request Form (MRF) for the modification was closed on January 11, 1985, and the fire watches terminated.

On January 18, 1985, while performing an inspection of the fire systems, contractor personnel discovered that valve 22-1155 was closed and, therefore, the sprinkler system for the Cable Spreading Room was inoperable. Subsequently, valve 22-1156 for the Control Enclosure Fan Room sprinkler system was also discovered to be closed. The sprinkler systems were immediately returned to service. The absence of a continuous fire watch during the period these systems were out-of-service was a violation of Technical Specification 3.7.6.2.

Investigation into the event revealed that the closed valves were located inside the scope of equipment controlled by the tag-out for the modification. In addition, operating personnel preparing the operation verification form were unaware of the fact that the job rule for hydrostatic testing permitted closure of valves. The Administrative Procedure for the removal of systems from service and restoration of these systems (Procedure A-41) describes the controls which apply to safety related systems but does not describe actions to be taken for restoration of non-safety related systems required to be operable by the Technical Specifications. As a result, no operability verification was specified or performed.

NAC / NA 364A 19431	LICENSEE	ULATORY COMMISSION ME NO. 3150-0104									
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Consequences of the Event:

The sprinkler systems of the Cable Spreading Room (Elevation 254) and the Control Enclosure Fan Room (Elevation 304) were out-of-service between January 10, 1985 and January 19, 1985 without a continuous fire watch being established. However, early warning of a fire would have been accomplished by operable smoke detectors. A manually initiated total flooding carbon dioxide system also provided additional fire protection for the Cable Spreading Room.

Cause of the Event:

This event was the result of an inadequate procedure for the performance of hydrostatic testing during the operations phase; and personnel error resulting from an inadequate procedure for restoration of plant systems and components.

Corrective Actions:

The immediate corrective action taken in response to the event was to restore the inoperable systems to service. Short term corrective action was to instruct contractor supervision and craft personnel that equipment within the confines of an equipment tag-out must only be operated by PECo operating personnel or involve specific notification and approval from operating personnel.

Interim corrective action involved the generation and issuance of a new procedure, which controls the pressure testing of plant components and prohibits operation of valves by craft personnel. This procedure was issued on February 22, 1985.

Additionally, the generic long term corrective action involves the revision of administrative procedure for control of plant equipment to apply the removal/restoration controls which presently apply to safety related equipment to equipment which is required to be operable by the Technical Specifications but is not classified as safety-related. This procedure is presently expected to be PORC approved by March 15, 1985.

PHILADELPHIA ELECTRIC COMPANY

2301 MARKET STREET

P.O. BOX 8699

PHILADELPHIA, PA. 19101

(215) 841-4000

March 6, 1985

Docket No. 50-352

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

SUBJECT: Licensee Event Report

Limerick Generating Station - Unit 1

This Licensee Event Report concerns failure to establish fire watches in accordance with Technical Specification 3.7.6.2.

Reference:

Docket No. 50-352

Report Number:

85-015

Revision Number: 00

Event Date:

January 21, 1985

Report Date:

Facility:

March 6, 1985 Limerick Generating Station

P.O. Box A, Sanatoga, PA 19464

This LER is submitted pursuant to the requirements of 10CFR50.73 (a)(2)(i). We regret the late submission date of the LER. The delay in the reporting of this LER was the result of our desire to provide completion dates of the long term corrective actions taken by Philadelphia Electric Company in response to this event.

Very truly yours,

200 Wellind

W. T. Ullrich Superintendent

Nuclear Generation Division

cc: Dr. Thomas E. Murley, Administrator, Region I, USNRC J. T. Wiggins, Senior Site Inspector See Service List

IE22

cc: Judge Helen F. Hoyt Judge Jerry Harbour Judge Richard F. Cole Troy B. Conner, Jr., Esq. Ann P. Hodgdon, Esq. Mr. Frank R. Romano Mr. Robert L. Anthony Ms. Phyllis Zitner Charles W. Elliott, Esq. Zori G. Ferkin, Esq. Mr. Thomas Gerusky Director, Penna. Emergency Management Agency Angus Love, Esq. David Wersan, Esq. Robert J. Sugarman, Esq. Martha W. Bush, Esq. Spence W. Perry, Esq. Jay M. Gutierrez, Esq. Atomic Safety & Licensing Appeal Board Atomic Safety & Licensing Board Panel Docket & Service Section (3 Copies) James Wiggins

Timothy R. S. Campbell