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	REPORT (LER) TEXT CONTIN	
IACILITY MANE III	BOGAST BURBER BU	ASPALL LOI MA
Limerick Generating Station Unit 1		TEAR REALER IN PAGE IN
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Unit Conditions Prior to	i de la compañía de l	
Shite conditions Prior to	o the Event:	
Operating Mode 1 (Power Reactor Power 100%	Operation) .	
Description of the Event	<u>.</u> ,	
On September 1, 1986, du completed and reviewed w 450-1, "Division I-IV 12 Alignment and Voltage Ch 14, 1986 test was not co specified by Technical S Safeguard Bus. This sup engineers as an extra ch	weekly surveillance 25/250 VDC Safeguard neck", it was discov ompleted within the Specification 4.8.3. oplemental review is	test (ST) ST-6-095- Power Distribution ered that the August time frame as 1 for the Division IV performed by the test
This event consisted of performance of this ST. step 6.6.2 which verifie Division IV 125 VDC batt marked "N/A" indicating verified during the perf	The first is incomes that the battery (ery (lDDl01) is into that the condition of the cond	plete performance of discharge fuse for the act. This step was of this fuse was not
The second concern is a verifies that circuit br distribution panel 1DD16 ST. Pages 11 and 12 of ST was given a supplement	eaker 29-D162 is sup 2. Step 6.6.5 is of 12 were discovered	pplying power to n page 11 of 12 of the to be missing when the
Technical Specification "Each of the above requi shall be determined ener verifying correct breake busses/MCCs/panels." Th	gized at least once r alignment and vol	ion system divisions per 7 days by tage on the

on August 14, 1986. When the ST was performed on August 21, 1986, it was completed correctly. The time between the completed steps 6.6.2 and 6.6.5 was two weeks, which exceeds the 125% (8.75 day) allowable limit defined in Technical Specification 4.0.2.

The EIIS Code for the DC Power System is EI.

LICENSEE E	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION						US MUCLEAR REGULATORY COMMISSIN APPROVED ONE NO. 3168-6184 EXPRES 601 84				
		BOCKET MUMBER (3)									
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Consequences of the Event:

There are two areas of concern for the consequences to this event. The first is step 6.6.2 and the second is step 6.6.5 of the ST. The consequences of these events are minimal because:

The supply fuse from the Division IV 125 VDC battery (operational status verified by step 6.6.2 of the ST) provides DC power to distribution panels 1PPD1, 1PPD2 and 1PPD3. The condition of this circuit is indicated on a local panel and, in the event of a blown supply fuse, would result in an indicating light extinguishing. It is reasonable to expect that this would be noted by plant operators during their rounds and actions to alleviate the situation would be taken. In the unlikely event that the fuse had failed in conjunction with a loss of offsite power and the requirement for Emergency Core Cooling Systems, certain systems supplied by the Division IV batteries would not be available to assist in core cooling until the fuse was replaced. No operating problems were encountered with the Division IV battery fuse during the period August 7, 1986 - August 21, 1986 and its operability was properly verified on August 21, 1986.

Circuit Breaker 29-D162 (operational status verified by step 6.6.5 of the ST) supplies power to 125 VDC distribution panel 1PPD3 which provides power to the Containment Enclosure Steam Flooding Dampers. In the unlikely event that this breaker opens, the control room personnel would receive an annunciator alarm indicating undervoltage problems for the dampers. The operators would then be able to determine the cause of the open breaker and return it to the closed position. No log entries were made which indicated the occurrence of this alarm for the period August 7, 1986 - August 21, 1986. The bus was verified to be energized on August 21, 1986 by the proper performance of the ST.

Cause of the Event:

<u>Cause Code</u>: A2 (Failure to Follow Implementing Procedure) D99 (Procedure Steps Difficult to Follow)

A-3

	LICENSEE EVENT P				
Limerick General	ting Station		The second se		ALEE LA
Unit 1		0 18 10 10 10 13 1 5		ALLA REPAYED	

The cause of this event was a combination of the following factors:

- The ST was issued to the operator with two pages missing. This was due to an error on the part of clerical personnel who perform the duty of duplicating the STs to be issued to the operators.
- 2) The operator performing the test did not properly complete step 6.6.2. This ST has been evaluated and has been determined to be confusing in certain areas.
- 3) The operator performing the test did not realize that pages 11 and 12 were missing, thereby omitting step 6.6.5.
- The supervisors who reviewed the ST failed to notice that pages 11 and 12 were missing.

All of the personnel involved in the above factors are utility employed. The operator who performed this ST is a licensed operator and the supervisor who reviewed this ST is a senior licensed operator.

Corrective Actions:

Immediate corrective actions were not required since the ST was successfully completed on August 21, 1986 which was prior to the discovery of the incomplete steps on the August 14, 1986 ST.

An investigation into the reason for the missing sheets 11 and 12 revealed that six other unissued copies of this ST were also missing sheets 11 and 12. Previously completed versions of this ST were reviewed to insure completeness and no incomplete versions were found.

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Limerick Generating Unit 1	Station		TEAN REAL			
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Actions Taken to Prevent Recurrence:

Appropriate plant operators and supervisory personnel were made aware of this situation and counseled as to the extra care needed to be taken when performing and reviewing STs. ST-6-095-450-1 was rewritten from a human factors standpoint to alleviate the misinterpretation of certain steps to be completed. Appropriate administrative controls were reviewed and personnel involved in the duplication of controlled procedures will be informed by October 31, 1986 of the importance of ensuring the correct number of pages are included in a ST. As an additional measure, the plant operators will be informed of this LER and will discuss the procedural changes made to the ST during the next requalification cycle.

Previous Similar Occurrences:

Limerick LERs 86-032 and 85-069 reported events in which surveillance tests were not performed within their specified periods due to personnel error.

1157

PHILADELPHIA ELECTRIC COMPANY

USNRC

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P.O. BOX 8699

PHILADELPHIA, PA. 19101

(215) 841-4000

OFFICE OF BEURLINEY DOCKETING & SERVICE. BRENCH

'86 DCT 20 P1:21

October 10, 1986

Docket No. 50-352/353-01

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

> SUBJECT: Licensee Event Report Limerick Generating Station - Unit 1

This LER concerns non-compliance with the Technical Specifications resulting from an incomplete performance of a Surveillance Test due to personnel error and procedural deficiency.

Reference:	Docket No. 50-352
Report Number:	86-042
Revision Number:	00
Event Date:	August 14, 1986
Discovery Date:	September 1, 1986
Report Date:	October 10, 1986
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). The submittal of this LER was delayed due to an administrative oversight during its processing. We apologize for any inconvenience the delay may have caused.

Very truly yours, m. Alle for

G. M. Leitch Superintendent Nuclear Generation Division

CC: Dr. Thomas E. Murley, Administrator, Region I, USNRC E. M. Kelly, Senior Resident Site Inspector See Service List cc: Troy B. Conner, Jr., Esq. Benjamin H. Vogler, Esq. Mr. Frank R. Romano Mr. Robert L. Anthony Ms. Maureen Mulligan Charles W. Elliott, Esq. Barry M. Hartman, Esq. Mr. Thomas Gerusky Director, Penna. Emergency Management Agency Angus Love, Esq. David Wersan, Esq. Robert J. Sugarman, Esq. Kathryn S. Lewis, Esq. Spence W. Perry, Esq. Jay M. Gutierrez, Esq. Atomic Safety & Licensing Appeal Board Atomic Safety & Licensing Board Panel Docket & Service Section (3 Copies) E. M. Kelly Timothy R. S. Campbell

July 21, 1986