NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION
(6-1998)

LICENSEE EVENT REPORT (LER)

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

APPROVED BY OMB NO. 3150-0104 EXPIRES 06/30/2001

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), 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. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Limerick Generating Station, Units 1 and 2	05000352/05000353	1 OF 3

TITLE (4)

Maintenance performed on an uncompensated safeguard system

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
08	02	1999	1999	-- 009	-- 00	09	01	1999		05000
									FACILITY NAME	DOCKET NUMBER
										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	20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	X 73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
K. P. Bersticker, Manager - Experience Assessment	(610) 718-3400

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
☐ YES (If yes, complete EXPECTED SUBMISSION DATE).	☒ NO				

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

On 08/02/99, at 14:48 hours, maintenance was performed that required disabling certain monitoring capabilities on a safeguard system. At 17:31 hours, a SAS (Secondary Alarm Station) operator discovered the required compensatory measures were not implemented in accordance with plant procedures. This resulted in two vital areas that were not adequately posted. The cause of this event was a failure to properly use the plant procedure that specifies compensatory measures for inoperable safeguard monitoring systems.

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Limerick Generating Station Units 1 and 2	05000 -352/-353	1999	009	00	2 OF 3

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

Background

At the time of the event, Unit 1 was in Operational Condition (OPCON) 1 (Power Operation) at 100% power level. Unit 2 was in Operational Condition (OPCON) 1 (Power Operation) at 100% power level. There were no systems, structures, or components out of service that contributed to this event.

Issue Description

On August 2, 1999, at 14:48 hours, the SAS operator deactivated certain security monitoring capabilities to support maintenance activities. Although this was an infrequently performed task, the procedure that provides instructions for the required postings was not referenced prior to establishing the compensatory measures for this activity. At 17:31 hours (2 hours and 43 minutes after deactivation), the SAS operator on duty discovered that the compensatory measures required had not been fully established. This SAS operator had relieved the SAS operator on duty when the monitoring equipment was removed from service.

At 17:32 hours (one minute after discovery), additional compensatory measures were established as required by plant procedures. A camera was immediately utilized to check the affected vital area and the vehicle patrol was dispatched within one minute of discovery. All protected and vital area patrols were directed to perform sweeps in accordance with plant procedures. The affected vital areas were searched and no abnormalities were found. At 20:41 hours, maintenance was completed and monitoring capabilities were restored.

The reportability review conducted by Security during the event required several hours and determined this event was reportable. Shift management confirmed the reportability requirement and a late one hour ENS notification was made to the NRC at approximately 23:46 hours, in accordance with the requirements of 10CFR73.71(b)(1). This 30-day follow-up report is being submitted in accordance with the requirements of 10CFR73.71(b)(2).

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

Cause of the Event

The cause of this issue is the failure of the SAS operator to reference the procedure which specifies the required compensatory measures prior to deactivating security monitoring capabilities. Also incomplete instructions were provided by the security supervisor regarding the equipment to be removed from service.

Consequences of the Event

There were no actual consequences of this event. No release of radioactive material to the environment occurred. The potential consequences of this event were minimal. This uncompensated degradation existed for a short period of time (2 hours and 44 minutes) and was unknown to security and other plant personnel until the moment of discovery. Once discovered it was promptly compensated. Therefore, it was not predictable or exploitable. Access to the protected area was not affected by this event.

Corrective Actions Completed

1) The monitoring capability was restored to service and tested.
2) Cement blocks were placed on the accesses to the vital areas.
3) Security procedures were evaluated for proper level of procedure use and revised as required.
4) Post Order #66 was revised to require approval from supervisor, nuclear security prior to inactivating, accessing or taking any security equipment out of service.
5) Program to formalize use of pre-job briefs prior to security equipment planned outages has been implemented per SI-26 "Prejob Brief / Work Control Standard".
6) The SAS operator and security supervisor were coached.
7) The lessons learned from this event have been distributed to the security force.

Corrective Actions Planned

1) Procedure use and compliance remedial training will be conducted with Security Force personnel by November 1, 1999.

Previous Similar Occurrences

There are no previous similar occurrences.