



PECO ENERGY

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10CFR 50.73

August 31, 1994  
Docket No. 50-353  
License No. NPF-85

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

SUBJECT: Licensee Event Report  
Limerick Generating Station - Unit 2

This LER reports an event which resulted in a condition prohibited by Technical Specifications (TS) in that two Reactor Coolant System Recirculation flow units were inoperable, and the required TS actions were not taken in the required time as a result of the failure to perform a surveillance test procedure.

Reference:	Docket No. 50-353
Report Number:	2-94-007
Revision Number:	00
Event Date:	March 28, 1994
Discovery Date:	August 1, 1994
Report Date:	August 31, 1994
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,

DBN:cah

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

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## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Limerick Generating Station, Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 3 5 3										PAGE (3) 1 OF 4			
TITLE (4) Reactor Coolant System Recirculation Flow Units Inoperable and the Required Tech Spec ACTIONS not Taken Due to a Failure to Perform a Surveillance Test Procedure																							
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					
0 3		2 8		9 4		9 4		0 0 7		0 0 0		8 3		1 9		4		DOCKET NUMBER (8) 0 5 0 0 0 0 0 0					
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)																							
OPERATING MODE (9)		1		20.402(a)		20.406(a)		20.406(a)(1)(i)		20.406(a)(1)(ii)		20.406(a)(1)(iii)		20.406(a)(1)(iv)		20.406(a)(1)(v)		20.406(a)(1)(vi)		20.406(a)(1)(vii)			
POWER LEVEL (10)		1 0 0		20.406(a)(1)(i)		20.406(a)(1)(ii)		20.406(a)(1)(iii)		20.406(a)(1)(iv)		20.406(a)(1)(v)		20.406(a)(1)(vi)		20.406(a)(1)(vii)		20.406(a)(1)(viii)		20.406(a)(1)(ix)			
OTHER (Specify in Abstract below and in Text, NRC Form 388A)																							
LICENSEE CONTACT FOR THIS LER (12)																							
NAME J. L. Kantner - Manager, Experience Assessment																TELEPHONE NUMBER AREA CODE 6 1 0 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 NRC		CAUSE		SYSTEM		COMPONENT		MANUFACTURER		REPORTABLE TO NRC					
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 fifteen single-space typewritten lines) (16)

On 8/1/94, during an audit of the Surveillance Testing Program, a Quality Assurance auditor identified that the weekly performance of Instrumentation and Controls (I&C) Surveillance Test (ST) procedure ST-2-074-424-2 had not been performed by the required due date. This ST procedure was performed satisfactorily on 3/21/94, but not again until 4/4/94. As a result, the 'A' and 'C' Reactor Coolant System Recirculation flow units were inoperable. Since personnel were not aware at the time that the ST procedure had not been performed, the associated Technical Specification (TS) Section 3.3.1.1 action was not taken resulting in a condition prohibited by TS. The actual and potential consequences of this event were minimal in that the affected flow units were satisfactorily tested on 4/4/94, and only a slight adjustment was made at that time due to a planned core flow change, not due to instrument drift. The causes of this event are less than adequate administrative controls and communications. The performance of the ST procedure is normally accomplished on the afternoon shift, however, the computer generated work list (foreman's list) for the afternoon shift I&C foreman did not include this ST procedure. The computer program that automatically schedules the weekly ST procedures has been revised to include the appropriate foreman codes for all weekly ST procedures for all work groups.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
Limerick Generating Station, Unit 2	05000353	94	007	00	02	OF	04

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

Unit Conditions Prior to the Event:

Unit 2 was in Operational Condition 1 (Power Operation) at 100% power level.

On March 21, 1994, the weekly channel calibration Surveillance Test (ST) procedure ST-2-074-424-2, "Reactor Coolant System Recirculation Flow Units A and C Summer Operational Calibration Test (FY-43-2K607A and FY-43-2K607C)," was satisfactorily performed. This ST procedure satisfies Technical Specification (TS) Surveillance Requirement (SR) Table 4.3.1.1-1 items 2.B.1 and 2.B.2 which require a channel calibration on a weekly basis with a maximum extension of 25% of the TS SR interval. Therefore, the next performance of this ST procedure was due by March 30, 1994. These flow units provide the flow biased input to the 'A', 'C', and 'E' Average Power Range Monitor (APRM) Neutron Flux-upscale, flow biased SCRAM channels (EIIS: IG). The ST procedure calibrates the flow units to a calibrated reactor coolant system recirculation flow signal (EIIS: AD).

Description of the Event:

On August 1, 1994, during an audit of the Surveillance Testing Program, a Nuclear Quality Assurance Division auditor identified that the weekly performance of Instrumentation and Controls (I&C) ST procedure ST-2-074-424-2 had not been performed on the scheduled day of March 28, 1994. This ST procedure was performed satisfactorily on March 21, 1994, but not again until April 4, 1994. As a result, the weekly channel calibration TS SR for the 'A' and 'C' Reactor Coolant System Recirculation flow units was not performed within the required TS SR frequency. Since personnel were not aware at the time that the ST procedure had not been performed, the two channels were not declared inoperable and the associated TS Section 3.3.1.1 action was not taken. This TS action requires a half SCRAM signal to be inserted within 12 hours. As a result, a condition prohibited by TS occurred. Therefore, this report is being submitted in accordance with the requirements of 10CFR50.73 (a)(2)(i)(B).

Analysis:

The actual and potential consequences of this event were minimal in that the affected flow units were satisfactorily tested on April 4, 1994, and only a slight adjustment was made at that time. A review of actual plant performance data concluded that an adjustment would not have been required on March 28, 1994. The slight adjustment was needed as a result of a small increase in core flow which was implemented on April 4, 1994, not due to instrument drift. Channel checks performed every twelve (12) hours for these instruments would have identified if the flow units started to provide abnormal readings.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO 3150-0104  
EXPIRES 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

Cause of the Event:

The causes of this event are less than adequate administrative controls and less than adequate communications. As per the normal work management routine, the work coordination schedule for the weekly ST procedures scheduled to be performed on Monday, March 28, 1994, was issued on Monday and reviewed during that day's daily work coordination meeting. The I&C section work coordinator who attends the daily meeting reviewed the listing of the ST procedures and discussed the work with the day shift I&C foreman. The performance of procedure ST-2-074-424-2 is normally accomplished on the afternoon shift, however, the computer generated work list (foreman's list) for the afternoon shift I&C foreman did not include this ST procedure. The foreman's list and the weekly scheduled ST procedure list are different. The foreman's list only contains those tasks assigned by foreman code in the computer and the weekly scheduled ST procedure list contains all of the scheduled ST procedures for the specific schedule day for each work group. The I&C work coordinator and the afternoon shift I&C foreman did not adequately communicate during turnover that the ST procedure was to be performed. The I&C foreman for the afternoon shift on Monday, March 28, 1994, performed the work assigned to his shift as contained on his foreman's list printout and did not perform procedure ST-2-074-424-2 as it did not appear on his foreman's work list. On Tuesday, March 29, 1994, the I&C section work coordinator reviewed the scheduled work that had been performed on Monday and did not identify that procedure ST-2-074-424-2 had not been performed. As a result, the ST procedure was not performed by March 30, 1994, when the test was due.

Corrective Actions:

The computer program that automatically schedules the weekly ST procedures has been revised to include the foreman code for all weekly ST procedures for all work groups. The I&C weekly ST procedures are now included in the foreman's list along with the other scheduled work for that foreman.

Upon identification of the event, a meeting was held with all I&C section foremen to emphasize the requirement for weekly ST procedures to be performed on the designated days.

The I&C work coordinator was counseled on the need for thoroughness in the review of scheduled ST procedures to ensure the TS SR are met within the required times.

A review is being performed to determine if the existing ST procedure scheduling tools are adequate for the other work groups.

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Previous Similar Occurrences:

LERs 2-94-006, 1-92-009, 1-89-001, 1-88-003, 1-87-054, and 1-86-057 all reported overdue events involving ST procedures not completed within the required SR interval as a result of personnel error. However, none of these previous events were the result of inadequate work group / foreman tracking tools for scheduled ST procedures. Therefore, the previous corrective actions could not have prevented the event reported in this LER.