Robert W. Boyce
Plant Manager
Limerick Generating Station

PECO NUCLEAR
A Unit of PECO Energy

PECO Energy Company
Limerick Generating Station
PO Box 2300
Sanatoga, PA 19464-0920
610 718 2000

10CFR50.73

February 4, 1997

Docket Nos. 50-352
50-353
License Nos. NPF-39
NPF-85

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

SUBJECT: Licensee Event Report
Limerick Generating Station - Units 1 and 2

This LER reports operation prohibited by the Technical Specifications when certain fire protection system inspections were not performed due to personnel error.

Reference:	Docket Nos. 50-352 50-353
Report Number:	1-96-023
Revision Number:	00
Event Date:	April 3, 1995
Discovery Date:	August 13, 1996
Report Date:	February 4, 1997
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,

Robert W. Boyce

DBN:dbn
cc: H. J. Miller, Administrator Region I, USNRC
N. S. Perry, USNRC Senior Resident Inspector, LGS

NRC FORM 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES 5/31/95

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.

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Limerick Generating Station, Unit 1	05000 352	1 OF 6

TITLE (4) Fire Protection System Surveillance Tests not Performed Due to Personal 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
									Limerick, Unit 2	05000353
04	03	95	96	-- 023 --	0	02	04	97	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9)	1
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	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 Abstract below and in Text, NRC Form 366A)
	20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
James L. Kantner, Manager - Experience Assessment	610 -718-3400

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

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

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

On 8/12/96, it was determined that a Fire Protection System (FPS) Surveillance Test (ST) procedure, performed on 7/29/96, was not implemented as documented. The individual who signed off the ST procedure admitted to having knowingly falsified the procedure and did not actually perform a visual inspection of the FPS hose stations in the plant as required. Further review identified this individual falsified five other FPS ST procedures. He signed off the procedures indicating satisfactory completion between 4/03/95 and 7/29/96. Two of these ST procedures were performed while the FPS Surveillance Requirements were still contained in the Technical Specifications (TS). Another individual missed a TS required inspection of another FPS component due to an isolated error. Thus, the associated TS Surveillance Requirements were not met resulting in operation prohibited by TS. The affected equipment has been inspected and found to be operable. The individuals were appropriately disciplined. A confirmation of other procedures performed by these individuals and other station personnel was performed. No safety concerns or other reportable conditions were identified. The site VP and other senior management discussed the expectations of truthfulness and integrity with station personnel.

Unit Conditions Prior to the Event

Unit 1 and Unit 2 were both in Operational Condition (OPCON) 1 (Power Operation) operating at 100% power when this event was discovered.

Unit 1 and Unit 2 have operated at various power levels since the concern described in this report first existed. There were no systems, components, or structures out of service that contributed to this event.

Description of the Event

On August 12, 1996, during a review of Fire Protection System (FPS, EIIS:KP) Surveillance Test (ST) procedures, it was identified that procedure ST-7-022-951-0, "Fire Hose Station Visual Inspection," performed on July 29, 1996, had not actually been implemented as documented. This review was initiated as a result of personnel interviews and led to an independent investigation. The ST procedure documents the visual inspection of FPS hose stations and associated equipment located in Unit 1, Unit 2 and common areas of the plant per Technical Requirements Manual (TRM) Surveillance Requirement (SR) 4.7.6.5.a. This SR is required to be performed monthly. Security records indicated that the individual assigned to performed the ST procedure (Individual 1) was either not in the area of the FPS equipment or not in the area for a reasonable amount of time necessary to adequately perform the inspections. The non-licensed and non-supervisory employee who signed off the ST procedure was then interviewed on August 13, 1996. He admitted to having knowingly falsified the procedure. He stated that he did not actually perform a visual inspection of all of the hose stations or equipment as he had documented in the ST procedure. The failure to perform the SR resulted in a violation of the TRM. The unescorted access for this individual was suspended on August 12, 1996, based on the preliminary findings of the investigation. The investigation into this individual's work was expanded to determine if additional falsifications had occurred.

The investigation identified that this individual had similarly falsified five (5) additional FPS ST procedures. He signed off the procedures indicating satisfactory completion between April 3, 1995, and July 29, 1996. The falsified ST procedures were ST-7-022-951-0 and ST-7-022-950-0, "Fire Suppression Water System (FSWS) Spray and Sprinkler Visual Inspection." ST procedure ST-7-022-950-0 is performed to document the visual inspection of fire protection system dry pipe spray and sprinkler heads in common areas of the plant per

TRM SR 4.7.6.2.c. This SR is required to be performed once per eighteen (18) months. Two performances of procedure ST-7-022-951-0 were signed off by the individual on April 3, 1995, and June 8, 1995. A performance of procedure ST-7-022-950-0 was signed off by the individual on June 28, 1995. These performances were before December 20, 1995, when the Fire Protection System Technical Specification (TS) requirements were relocated to the TRM per an approved TS amendment. During this relocation, there were no changes to these SRs and the SR reference numbers remained the same. As a result of the falsification of documentation, TS SRs 4.7.6.2.c and 4.7.6.5.a were not met and the associated TS actions for inoperable FPS equipment were not implemented. This resulted in operation prohibited by TS. The other two falsified performances of ST procedures occurred after December 20, 1995, and resulted in violations of the TRM.

The scope of the investigation was expanded and the work of other members in the onsite Fire Protection Group was reviewed. Errors in ST procedures performed by two other individuals in the group were identified (Individuals 2 and 3).

In the case of Individual 2, the investigation concluded that the inspections of the specific FPS equipment in question were performed. However, Individual 2 mistakenly wrote the wrong date on the completed ST procedure. This individual is a non-licensed and non-supervisory employee.

In the case of Individual 3, the investigation revealed that this person was not in the area long enough to adequately perform the inspection of one (1) specific FPS hose reel and associated equipment. This inspection was documented as being completed on August 23, 1995, using ST procedure ST-7-022-952-0, "Fire Hose Station Refuel Inspection." This ST procedure implements TRM SR 4.7.6.5.b and is required to be performed once per eighteen (18) months. The individual was interviewed and it could not be verified that the individual performed the inspection. The investigation concluded that this was an isolated error on the part of the individual. This individual is a non-licensed and non-supervisory contractor employed technician. Since this incident occurred while the FPS requirements were still in the TS, this also resulted in operation prohibited by TS.

This report is submitted in accordance with the requirements of 10CFR50.73(a)(2)(i)(B) since this issue involved operation prohibited by TS.

On August 13, 1996, ST procedure ST-7-022-951-0 was performed and satisfactorily met the TRM SR 4.7.6.5.a. On August 20, 1996, procedure ST-7-022-950-0 was performed and satisfactorily met the TRM SR 4.7.6.2.c. A review of the other ST procedures performed by Individual 1 determined that the procedures had been performed with another individual or the procedure had been performed later by another individual. It was concluded that these procedures had been performed as documented. Therefore, no additional procedures were required to be re-performed to meet the TRM SRs. On August 27, 1996, the hose reel in question from procedure ST-7-022-952-0 was inspected and satisfactorily met the TRM SR 4.7.6.5.b. All of the inspected equipment was found to be operable.

The results of this investigation were determined to be not reportable during the investigation. Violations of individual TRM requirements are not reportable as TS violations under 10CFR50.73(a)(2)(i)(B). It had been concluded that since the NRC had approved the relocation of the FPS requirements from the TS to the TRM, that historical issues involving TS violations were not necessarily reportable. Under further evaluation, it was decided on January 17, 1997, to report this issue.

Analysis of the Event

The actual consequences for this condition were minimal since a fire did not occur requiring use of the fire protection equipment. Once inspected, all of the equipment was found to be operable. The failure to perform the visual inspection did not affect the capability of the FPS equipment to suppress a fire. Therefore, an actual reduction in the FPS capability did not occur.

The potential for a fire and the impact of a fire in safety related areas of the plant are minimized by a combination of many factors. The design of the Fire Protection Program relies on a 'defense-in-depth' approach which serves to:

1. prevent a fire from starting,
2. quickly detect and suppress fires that do start,
3. provide reasonable electrical isolation and separation of circuits in the event of small fires,
4. prevent the rapid spread of fires by selecting fire retardant construction materials, and
5. protect safety related equipment so that a fire will not prevent safe shutdown of the plant.

Therefore, in the event that an improperly performed inspection of a

fire suppression component did not identify a degraded condition, several other barriers were in place to prevent a fire from starting and to mitigate the consequences of an actual fire.

Cause of the Event

The cause of the issues involving Individual 1 was cognitive personnel error. The individual admitted to having falsified five of the six documents and had acted on his own accord. The individual falsified the first ST procedure within one month after having been assigned to the onsite Fire Protection Group. This individual was an experienced worker with several years experience working at Limerick Generating Station.

Less than adequate supervisory monitoring of Individual 1 and communication of expectations enabled the individual to continue to falsify procedures without detection.

The cause of the issues involving Individuals 2 and 3 was inattention to detail and determined to be individual isolated occurrences and did not involve willful or repetitive violations.

Corrective Actions

The individuals involved were appropriately disciplined. The security access to the plant for Individual 1 has been terminated.

A new supervisor has been assigned to the onsite Fire Protection Group.

The independent investigation was expanded to include all onsite groups. Additional issues were brought to the attention of management. None of these issues resulted in safety concerns or other reportable conditions.

Group meetings were conducted with Limerick Generating Station (LGS) personnel where the LGS Vice President and other senior managers discussed the expectations of truthfulness and integrity. The personnel were reminded that an individual who engages in willful violations will be subject to substantial disciplinary action and may be subject to enforcement action by the Nuclear Regulatory Commission. During the interviews with Individual 1, other potential concerns were identified and were addressed in the independent investigation.

Previous Similar Occurrences

There was one other event in 1996 involving falsification of documentation that occurred after the 1995 falsifications discussed above and was not related to the FPS ST procedure issue.