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FACIL: 50-361 San Onofre Nuclear Station, Unit 2, Southern Californ 05000361
AUTH. NAME AUTHOR AFFILIATION
MORGAN, H. E. Southern California Edison Co.
RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 87-008-00: on 870629, discovered that continuous fire watches not established during removal of compensatory measures. Caused by personnel error. Disciplinary action taken & fire protection procedure enhanced. W/870729 ltr.

DISTRIBUTION CODE: IE22D COPIES RECEIVED: LTR 1 ENCL 1 SIZE: 3
TITLE: 50.73 Licensee Event Report (LER), Incident Rpt, etc.

NOTES: ELD Chandler 1cy. 05000361

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	NRR/PMAS/ILRB	1	1	NRR/PMAS/PTSB	1	1
	REG FILE 02	1	1	RES DEPY GI	1	1
	RES TELFORD, J	1	1	RES/DE/EIB	1	1
	RGN5 FILE 01	1	1			
EXTERNAL:	EG&G GROH, M	5	5	H ST LOBBY WARD	1	1
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NRC Form 366
(9/83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
SAN ONOFRE NUCLEAR GENERATING STATION, UNIT 2	0 5 0 0 0 3 6 1	1 OF 0 2

TITLE (4)
FAILURE TO ESTABLISH CONTINUOUS FIRE WATCHES

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQ. NUMBER	REV. NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 6	2 7	8 7	8 7	0 0 9	0 0	0 7	2 9	8 7	SONGS, UNIT 3	0 5 0 0 0 3 6 2
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	0 9 0	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)	X 50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		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
	AREA CODE
H. E. MORGAN, STATION MANAGER	7 1 4 — 3 6 8 - 6 2 4 1

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 fifteen single-space typewritten lines) (16)

On 6/27/87, at 0130, with Unit 3 at 100% power and at 0745, with Unit 2 at 90% power, the fire suppression systems in the Unit 3 and Unit 2 Auxiliary Feedwater Pump (AFWP) Rooms, respectively, were removed from service for planned fire protection outages. On 6/27, at 1830, and 6/28, at 0300 the Unit 3 and the Unit 2 AFWP Room fire suppression systems, respectively, were returned to service. On 6/29, at approximately 1300, during the process of removing the compensatory measures, it was identified that continuous fire watches had not been established, contrary to Technical Specification 3.7.8.2, Action Statement 'a'. There was no safety significance since the fire detection equipment in both rooms remained operable.

The cause of this event was personnel error. Miscommunication between Emergency Services Officer (ESO) personnel and the ESO Shift Captain resulted in the failure to establish the required compensatory fire watches. In addition, contrary to procedural requirements and training, the ESO Shift Captain did not verify that all appropriate compensatory measures were in place.

Similar failures to establish appropriate fire watches due to personnel error have been reported previously in LERs 84-034 and 85-038 (Docket No. 50-361), and 85-022 (Docket No. 50-362). Corrective action taken for those occurrences involved disciplinary action and training, as appropriate. For this occurrence, the ESO Shift Captain has received disciplinary action. Additionally, the fire protection impairment procedure will be enhanced by requiring an additional signature explicitly for verifying that fire watches have been established. A computerized fire protection information system is under development which will provide on-line tracking of fire protection impairments.

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On June 27, 1987, at 0130, with Unit 3 at 100% power and at 0745, with Unit 2 at 90% power, the fire suppression systems (EIIS Component Code SRNK)(EIIS System Code KP) in the Unit 3 and Unit 2 Auxiliary Feedwater Pump (AFWP) Rooms, respectively, were removed from service for planned fire protection outages. In accordance with Technical Specification 3.7.8.2, Action Statement 'a', backup fire suppression equipment was put into place, however, the required continuous fire watches were not established. On June 27, at 1830, and June 28, at 0300 the Unit 3 and the Unit 2 AFWP Room fire suppression systems, respectively, were returned to service. On June 29, 1987, at approximately 1300, during the process of removing the compensatory measures, it was identified that the required continuous fire watches had not been established. Hourly fire watches, previously established in the Units 2 and 3 Auxiliary Feedwater Pump Rooms under different fire protection impairments, remained in effect during the time the suppression systems were isolated.

The cause of this event was personnel error. Miscommunication between Emergency Services Officer (ESO) personnel and the ESO Shift Captain resulted in the failure to establish the required compensatory fire watches. In addition, contrary to procedural requirements and training, the ESO Shift Captain did not verify that all appropriate compensatory measures were in place.

Similar failures to establish appropriate fire watches due to personnel error have been reported previously in LERs 84-034 and 85-038 (Docket No. 50-361), and 85-022 (Docket No. 50-362). Corrective action taken for those occurrences involved disciplinary action and training, as appropriate.

For this occurrence, the ESO Shift Captain has received disciplinary action. Additionally, the fire protection impairment procedure will be enhanced by requiring an additional signature explicitly for verifying that fire watches have been established.

A computerized Fire Protection Information System (FPIS), providing on-line tracking and implementation of fire protection impairments, is currently under development. The FPIS will improve the communication and record keeping associated with fire protection impairments and provide a safeguard in preventing future implementation errors.

There was no safety significance since the fire detection equipment remained operable and hourly fire watches had been instituted in both rooms for other fire protection impairments.

Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128

SAN CLEMENTE, CALIFORNIA 92672

H. E. MORGAN
STATION MANAGER

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July 29, 1987

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

Subject: Docket No. 50-361
30-Day Report
Licensee Event Report No. 87-009
San Onofre Nuclear Generating Station, Unit 2

Pursuant to 10 CFR 50.73(a)(2)(i)(B) and 10 CFR 50.36(c)(2), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving the establishment of continuous fire watches. Neither the health and safety of plant personnel nor the health and safety of the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely,

HEMorg

Enclosure: LER No. 87-009

cc: F. R. Huey (USNRC Senior Resident Inspector, Units 1, 2 and 3)

J. B. Martin (Regional Administrator, USNRC Region V)

Institute of Nuclear Power Operations (INPO)

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