**Garrett D. Edwards**
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PECO ENERGY

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September 6, 1994

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

Docket Nos. 50-277 & 50-278

SUBJECT: Licensee Event Report
Peach Bottom Atomic Power Station - Units 2 and 3

This LER concerns a Technical Specification violation when a fire watch was not properly performed.

| | | |
|---|---|---|
| Reference: | Docket Nos. | 50-277 & 50-278 |
| Report Number: | 2-94-006 | |
| Revision Number: | 00 | |
| Discovery Date: | 08/04/94 | |
| Report Date: | 09/06/94 | |
| Facility: | Peach Bottom Atomic Power Station<br>RD1, Box 208, Delta, PA 17314 | |

This LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(i)(B).

Sincerely,

GDE/GAJ:gaj

enclosure

cc: R.A.Burricelli, Public Service Electric & Gas
R. R. Janati, Commonwealth of Pennsylvania
INPO Records Center
T. T. Martin, US NRC, Administrator, Region I
R. I. McLean, State of Maryland
W. L. Schmidt, US NRC, Resident Inspector
A. F. Kirby III, DelMarVa Power
H. C. Schwemm, VP - Atlantic Electric

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CCN 94-14135



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NRC FORM 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

| FACILITY NAME (1) | DOCKET NUMBER (2) | PAGE (3) |
|---|---|---|
| Peach Bottom Atomic Power Station Units 2 & 3 | 0 5 0 0 0 2 7 7 | 1 OF 0 3 |

TITLE (4)
Technical Specification Violation due to a Missed Firewatch

| 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 | DOCKET NUMBER(S) |
| 0 8 | 0 4 | 9 4 | 9 4 | — 0 0 6 | — 0 0 | 0 9 | 0 6 | 9 4 | Peach Bottom - Unit 3 | 0 5 0 0 0 2 7 8 |
| | | | | | | | | | | 0 5 0 0 0 |

| OPERATING MODE (9) | N | THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11) | | | |
|---|---|---|---|---|---|
| POWER LEVEL (10) | 0 8 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) | 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 |
|---|---|
| Anthony J. Wasong, Manager - Experience Assessment | AREA CODE 7 1 1 7 4 5 6 - 7 0 1 4 |

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 08/04/94 at 1630 hours, fire watches which were posted in both HPCI Rooms and the Cable Spreading Room were prematurely relieved from their watch prior to the return of the carbon dioxide fire suppression system to an operable status. Since no firewatches were in these areas during a 50 minute period when the carbon dioxide fire suppression system was inoperable, a violation of Tech Spec section 3.14.B.4 occurred. The cause of the event was that a firewatch was not maintained in these areas due to inadequate communication between the Work Control Station Coordinator and the Fire Protection Individual (FPI). Since the FPI believed that the clearance had been removed, the fire watches associated with both HPCI and the Cable Spreading Room were prematurely removed. An evaluation will be performed on the Firewatch Process to identify if additional corrective actions are needed to minimize future firewatch violations. The involved individual has been counselled regarding this event and Management's expectations that all communication is clear and understood by all individuals. The pertinent information from the event will be provided to the appropriate Operations and Fire Protection personnel. There were no actual safety consequences as a result of this event. No previous similar events have been identified.

## Requirements for the Report

This LER is being submitted pursuant to the requirements of 10 CFR 50.73 (a)(2)(i)(B) due to a violation of Technical Specifications (Tech Spec) 3.14.B.1, 2, and 4 concerning a missed firewatch in the High Pressure Coolant Injection (HPCI) rooms and the Cable Spreading Room.

## Unit Conditions at the time of the Event

Units 2 and Unit 3 were in the "RUN" mode at approximately 80 % reactor thermal power. There were no inoperable structures, systems or components that contributed to this event.

## Description of the Event

On 08/04/94 at approximately 1630 hours, fire watches which were posted in both HPCI Rooms and the Cable Spreading Room were prematurely relieved from their watch prior to the return of the carbon dioxide fire suppression system to an operable status. Tech Spec 3.14.B.4 specifies that a continuous firewatch with backup fire suppression equipment be established when the HPCI or Cable Spreading Room fire systems are inoperable. Therefore, since no firewatches were in these areas during a 50 minute period when the carbon dioxide fire suppression system was inoperable, a violation of Tech Spec section 3.14.B.4 occurred.

On 08/04/94 at approximately 1200 hours, a clearance was applied to the fire suppression system for personnel safety reasons to support the performance of (ST)-F-37A-310-2 "CABLE SPREADING ROOM CARDOX SIMULATED ACTUATION AND AIR FLOW TEST". The clearance makes the system inoperable for the HPCI Rooms and the Cable Spreading Room. This ST inspects fire barriers and it requires that a clearance be applied to prevent carbon dioxide discharge during the test. Firewatches were posted in the applicable areas while the clearance was applied. At approximately 1400 hours, the ST was aborted due to the fact that the ST could not be totally completed in the allowable time frame. At 1445 hours, a Fire Protection Individual (FPI) went to the Main Control Room to obtain the status of the ST and clearance from the Work Control Station Coordinator (WCSC). Based on conversations between the WCSC and the FPI, the FPI believed that the clearance had been removed thus restoring the carbon dioxide fire suppression system to an operable status. At 1630 hours, in accordance with approved fire protection system impairment procedures, the FPI prematurely relieved the firewatches from their duties prior to the return of the fire suppression system to an operable status. Following discovery of the condition at 1700 hours, the system was promptly restored to an operable status at 1720 hours.

## Cause of the Event

The cause of the event was that a firewatch was not maintained in these areas due to inadequate communication between the WCSC (Utility : Licensed) and the FPI (Utility : Non Licensed). Since the FPI believed that the clearance had been removed, the fire watches associated with both HPCI and the Cable Spreading Room were prematurely removed. Communication which is not clearly understood by all individuals does not meet the expectation of Management.

## Analysis of the Event

There were no actual safety consequences as a result of this event.
No fires occurred in this area during the period of non-compliance. The probability of not detecting a fire in this area during the period of non-compliance was extremely low. Had a fire occurred in the areas of concern, operable smoke detection in each area would have provided early warning of a fire. In addition, there was no entry of transient combustibles or ignition sources into the affected fire area during the period of non compliance. During the time that the carbon dioxide systems in the HPCI and Cable Spreading Rooms were inoperable, the systems could have been returned to an operable condition by opening one valve.

## Corrective Actions

Following discovery of the condition, the carbon dioxide fire suppression system was promptly restored to an operable status.

An evaluation will be performed on the Firewatch Process to identify if additional corrective actions are needed to minimize future firewatch violations.

The involved individual has been counselled regarding this event and Management's expectations that all communication is clear and understood by all individuals. The pertinent information from the event will be provided to the appropriate Operations and Fire Protection personnel to re-emphasize the importance of clear communication.

## Previous Similar Events

No previous similar events have been identified which involved the removal of a fire watch prior to the equipment being returned to an operable condition.