CCN 92-14116

PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION
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KEN POWERS
PLANT MANAGER

October 9, 1992

Docket Nos. 50-277
50-278

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

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

This LER concerns a supervisor inadvertently not ensuring that a firewatch was posted at the High Pressure Service Water Pump Structure.

Reference:	Docket Nos. 50-277 50-278
Report Number:	2-92-018
Revision Number:	00
Event Date:	09/15/92
Report Date:	10/09/92
Facility:	Peach Bottom Atomic Power Station 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,

Ken Powers

cc: J. J. Lyash, US NRC Senior Resident Inspector
T. T. Martin, US NRC, Region I

16004

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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 and 3	0 5 0 0 0 2 7 7	1 OF 0 3

TITLE (4) Supervisor Inadvertently not Ensuring that a Firewatch was Posted at the High Pressure Service Water Pump Structure

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)
										Peach Bottom - Unit 3	0 5 0 0 0 2 7 8
0 9	1 5	9 2	9 2	—	0 1 8	— 0 0	1 0	0 9	9 2		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 0 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
	AREA CODE
Albert A. Fulvio, Regulatory Supervisor	7 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 9/15/92, at approximately 0625, security personnel discovered that a Technical Specification (Tech Spec) required 1 hour firewatch was performed in excess of the 1 hour interval. This is a violation of Tech Spec 3.14.D.2. The roving firewatch for the Unit 2 High Pressure Service Water Pump structure was performed at approximately 0630 hours, 47 minutes after the allowed 1 hour interval elapsed. The firewatch was in place as a result of an inoperable Thermo-lag encapsulation as discussed in NRC Bulletin 92-01, Supplement 1. The encapsulation protected cabling for the 'B' Emergency Service Water pump in the event of an Appendix R fire. The cause of the event is due to a security supervisor inadvertently not ensuring that a firewatch was posted for a particular round. No formal method was used by the supervisor to remember to ensure the round was posted. There were no actual safety consequences as a result of this event. The methodology for ensuring that the firewatch round is performed has been changed. Other current and future similar rounds will be also be handled in this manner. The Security Supervisor involved has been counselled concerning this event. There were 2 previous similar events.

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 Specification (Tech Spec) 3.14.D.2 concerning a missed 1 hour roving firewatch at the Unit 2 High Pressure Service Water (HPSW) pump structure (EIIS:MK).

Unit Conditions at the time of the Event

Unit 2 was in the REFUEL Mode. Unit 3 was at approximately 100% power. There were no inoperable structures, systems or components that contributed to this event.

Description of the Event

On 9/15/92, at approximately 0625, security personnel discovered that a Technical Specification (Tech Spec) required 1 hour firewatch was performed in excess of the 1 hour interval. This is a violation of Tech Spec 3.14.D.2 which requires a 1 hour firewatch be performed for non-functional fire barriers provided fire detectors are operable on at least one side of the fire barrier. The roving firewatch for the Unit 2 High Pressure Service Water Pump structure was performed at approximately 0630 hours, 47 minutes after the allowed 1 hour interval elapsed. The previous firewatch was performed at 0443 hours. The firewatch was in place as a result of an inoperable Thermo-lag encapsulation as discussed in NRC Bulletin 92-01, Supplement 1. The encapsulation protected cabling (EIIS:CBL) for the 'B' Emergency Service Water (ESW) (EIIS:BI) pump (EIIS:P) in the event of an Appendix R fire in the Unit 2 HPSW pump structure. The 'B' ESW Pump is located in the Unit 3 HPSW Pump Structure while the 'A' ESW Pump is located in the Unit 2 HPSW Pump Structure. Subsequent firewatches were performed on time.

Cause of the Event

The cause of the event is due a security supervisor inadvertently not ensuring that a firewatch was posted for a particular round. A security protection technician had been assigned to perform a roving firewatch to satisfy Tech Spec 3.14.D.2 due to inoperable Thermo-lag fire barriers identified in August, 1992. In early September, because of the large amount of areas in the power block to be looked at, the responsibility for ensuring firewatch rounds for some areas outside the power block was given to protection technician supervision (non-utility, non-licensed) who controlled the issuance of posts. The Supervisor inadvertently did not ensure that the round was posted by 0543 on September 15, 1992. No formal method was used by the supervisor to remember to ensure the round was posted.

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 during the period of non-compliance was extremely low. Had a fire occurred in the Unit 2 HPSW Pump Structure area, operable fire detection equipment would alert fire brigade personnel to promptly extinguish the fire. Because no entries were made in the area during the approximately 47 minute non-compliance, no increase in combustibles or potential for fire existed. Had a design basis Appendix R fire occurred in the Unit 2 HPSW Pump Structure and the A and B ESW Pumps became unavailable, the Emergency Cooling Water (ECW) Pump would be available to cool the emergency diesel generators (EIIS:EK) and the core and containment cooling equipment rooms.

Corrective Actions

The methodology for ensuring that the firewatch round is performed has been changed. The round has been put back on the round list for the security protection technician. If an urgent circumstance would arise that the round in the Unit 2 Pump Structure could not be made, techniciaris would notify appropriate supervision for relief. Other current and future similar rounds will be also be handled in this manner.

The Security supervisor involved has been counselled concerning this event including the need to pay carefui attention to ensure that all rounds are promptly posted.
Other security personnel have been informed of the significance of this event.

Previous Similar Events

There were 2 previous similar events in which security personnel missed a firewatch round due to inadequate instruction from security supervision. LER 3-86-17 involved a missed firewatch due to security supervision issuance of a wrong instruction sheet to firewatch personnel. LER 2-84-14 involved a missed firewatch due to poorly organized log sheets. Corrective actions for LER 2-84-14 involved revising the log sheet and for 3-86-17 involved discipline. Because these events and corrective actions involved specific cases, the corrective actions could not have prevented this event.