CCN 92-14131

PHILADELPHIA ELECTRIC COMPANY

PEACH BOTTOM ATOMIC POWER STATION

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KEN POWERS
PLANT MANAGER

November 20, 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 Technical Specification violation when an hourly firewatch was not performed for the Unit 2 & 3 Emergency Switchgear and the Unit 3 Recirculating Motor Generator Set Rooms.

Reference:	Docket Nos. 50-277 50-278
Report Number:	2-92-023
Revision Number:	00
Event Date:	10/28/92
Report Date:	11/20/92
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

IE22
1/1

NRC FORM 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

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.

LICENSEE EVENT REPORT (LER)

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) Technical Specification Violation When An Hourly Fire Was Not Performed For The Unit 2 and 3 Emergency Switchgear and the Unit 3 Recirculating Motor Generator Set Rooms

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 5 0 0 0
1 0	2 8	9 2	9 2	0 2 3	0 0		1 1	2 0	9 2		0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
N		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 0 0		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. Pulvio, Regulatory Engineer	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 10/28/92, the hourly roving firewatches for the Unit 2 & 3 Emergency Switchgear and the Unit 3 Recirculating Motor Generator Set Rooms were not performed between 2300 and 2400 hours. This is a violation of Technical Specification 3.14.D.2. The firewatch was in place as a result of an inoperable Thermo-lag encapsulation as discussed in NRC Bulletin 92-01. The encapsulation protected cabling for the safe shutdown equipment in the event of an Appendix R fire. The cause of the event is that a Security Supervisor (SS) and a Central Alarm Station (CAS) operator did not ensure that the firewatches were performed. There were no actual safety consequences as a result of this event. The SS and CAS operator involved have been counselled concerning this event. This event and the importance of firewatch inspection were discussed with Nuclear Security Section Personnel. Training and programmatic enhancements are being incorporated as necessary. There were no actual safety consequences as a result of this event. There were three previous similar events.

s for the Report

This report is being submitted pursuant to the requirements of 10 CFR 50.73 (a)(2)(i)(B) as a violation of Technical Specification (Tech Spec) 3.14.D.2 concerning a missed 1 hour roving firewatch in the Unit 2 & 3 Emergency Switchgear and the Unit 3 Recirculating Motor Generator Set Rooms.

Unit Conditions at the time of the Event

Unit 2 & 3 were in the "REFUEL" Mode at 0% power. There were no inoperable structures, systems or components that contributed to this event.

Description of the Event

On 10/28/92, the roving firewatches for the Unit 2 "A" & "C" Emergency Switchgear, Unit 3 "B" & "D" Emergency Switchgear, and the Unit 3 Recirculating Motor Generator Set Rooms were not performed between 2300 and 2400 hours. 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. This occurred when the firewatch was reassigned to a medical emergency. Upon returning from the medical emergency, the individual notified the Security Supervisor (SS) at 0110 hours on 10/29/92 that the firewatch was missed between 2300 and 2400 hours on 10/28/92. The firewatch was established in June of 1992 as a result of an inoperable Thermo-lag encapsulation as discussed in NRC Bulletin 92-01. The encapsulation protected cabling (EIIS:CBL) for the safe shutdown equipment in the event of a Appendix R fire in these rooms.

Cause of the Event

The cause of the event is that the SS (Non-Utility:Non-Licensed) did not ensure that the firewatches were perform for a particular round. A Security Protection Technician (SPT) had been assigned to perform a roving firewatch. The SS was informed by the SPT that the round would not be able to be patrolled due to a medical emergency. The SPT was a Emergency Medical Technician who responded to a medical emergency at another location. The SS failed to act on this information due to the failure to comply with established procedures which require that he make the proper notifications and assign personnel to continue firewatch rounds in the event that the security protection technicians are dispatched to a medical emergency. In addition, the Central Alarm Station (CAS) operator, who is responsible for dispatching the SPTs to the appropriate areas which require firewatch, failed to check with the SS after having knowledge that the established firewatch was being reassigned to a medical emergency.

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 these rooms, fire detection equipment was fully operable to alert fire brigade personnel to promptly extinguish the fire. There was no entry of transient combustibles into the affected fire areas during the period of non compliance.

Corrective Actions

The SS involved has been counselled concerning the failure to comply with established procedures and the CAS operator was counseled for the failure to communicate the need to assign other personnel to continue firewatch rounds. This event and the importance of firewatch inspections, were discussed with Nuclear Security Section Personnel (NSSP) immediately following this event.

Training will be conducted for NSSP regarding the aspects of firewatch inspections. Security procedures will be revised by 11/30/92 to enhance tracking of future firewatches. In addition, an emergency checklist will be generated which will specify the necessary requirements in the event that firewatch personnel are reassigned.

Previous Similar Events

There were three previous similar events in which security personnel missed a firewatch round due to inadequate instruction from security supervision. LER 2-92-18 involved a missed firewatch due to a SS failure to post a particular round. LER 3-86-17 involved a missed firewatch due to SS 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 while 3-86-17 involved discipline. The corrective action for 2-92-18 involved changing the methodology that firewatches are posted and discipline. The previous events did not prevent this event since the corrective actions were limited to the individuals involved or specific programmatic deficiencies. Therefore, it is expected the training addressed in this event will minimize future occurrences.