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)
Wolf Creek Generating Station	0 5 0 0 0 4 8 2	1 OF 0 3

TITLE (4)

Technical Specification Violation - Missed Hourly 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)
1 0	3 1	8 5	8 5	0 7 7	0 0	1 1	2 7	8 5		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1
POWER LEVEL (10)	1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (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 (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
Merlin G. Williams - Superintendent of Regulatory, Quality and Administrative Services	AREA CODE 3 1 6 — 3 6 4 - 8 3 1 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 November 1, 1985, at approximately 0600 CST, a violation of Technical Specification 3.7.11, Action Statement "a", was discovered. While reviewing the fire watch logs, the Shift Supervisor discovered that hourly fire watches had not been initiated as required when the fire barrier enclosure around an Auxiliary Feedwater alternate supply valve had been removed for surveillance testing of the valve at approximately 1400 CST on October 31, 1985. Upon discovery, the area was checked and hourly fire watches were initiated. During this period, the plant operated in Mode 1, Power Operation, at 100 percent Reactor power.

The cause of this event was a cognitive personnel error by a Shift Supervisor who approved removal of the valve encolsure but failed to recognize that the valve enclosure was a fire barrier. There have been no previous similar occurrences.

The involved personnel have been counseled and this Licensee Event Report will be assigned as required reading for Operations personnel to emphasize recognition of fire barriers when approving work activities. A request to change the design of the valve enclosure has been issued and a note identifying the valve enclosure as a fire barrier is being added to the surveillance test procedure.

This event caused no damage to equipment or release of radiation. At no time did conditions develop that could have posed a threat to the health or safety of the public.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

On November 1, 1985, at approximately 0600 CST, a violation of Technical Specification 3.7.11, Action Statement "a", was discovered. While reviewing the fire watch logs, the Shift Supervisor discovered that hourly fire watches had not been initiated as required by Technical Specifications when the fire barrier enclosure around Auxiliary Feedwater alternate supply valve AL HV-32[BA-ISV] had been removed for surveillance testing. Upon discovery, the area was immediately checked by fire watch personnel, a Fire Protection Impairment Permit was prepared, and hourly fire watches were initiated. During this event, the plant was operating in Mode 1, Power Operation, at 100 percent Reactor power.

AL HV-32, the alternate supply valve to the turbine-driven Auxiliary Feedwater Pump (AFP)[BA-P] from the Essential Service Water System [BI] is normally closed. The AFP is normally supplied from the Condensate Storage Tank [KA-TK]. When the Condensate Storage Tank reaches a low level, the supply to the AFP shifts to the alternate water supply of Essential Service Water through valve AL HV-32. The fire barrier enclosure around AL HV-32 ensures this valve is operable if there is a fire in the area. Surveillance testing of valve AL HV-32 introduces service water into a short section of pipe which is normally empty. After the surveillance test is complete, this piping section is drained to ensure impure water is not supplied to the AFP. The drain valve [BA-LOV] for this section of pipe is also enclosed by the fire barrier.

On October 25, 1985, surveillance test procedure STS AL-201, "Auxiliary Feedwater System Inservice Valve Test", was started. Upon reaching the section of the test which cycles valve AL HV-32, it was determined that the fire barrier enclosure around AL HV-32 needed to be removed to permit draining of the pipe section after valve actuation. This section of the test was deferred and a Work Request was written to remove and replace the enclosure.

On October 31, 1985, the Work Request was brought to the Shift Supervisor for his permission to start work. In reviewing the Work Request, the Shift Supervisor failed to recognize that a fire barrier was involved and issued the Work Request for implementation without initiating a Fire Protection Impairment Permit. Because of this oversight, the area was not added to the hourly fire watch log. At approximatey 1400 CST on October 31, 1985, the fire barrier enclosure was removed and the deferred section of test STS AL-201 was performed. Consequently, a violation of Technical Specification 3.7.11, Action Statement "a", existed from approximately 1400 CST on October 31, 1985, until discovery at approximately 0600 CST on November 1, 1985. The fire barrier material was replaced on November 4, 1985.

The cause of this event was a cognitive personnel error by the Shift Supervisor, who failed to associate the Work Request wording "remove/replace thermolag" with the existence of a fire barrier. Consequently, a Fire Protection Impairment Permit was not prepared and issued as required by administrative procedures.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

This event has been discussed with the Shift Supervisors who were involved. This Licensee Event Report will be assigned as required reading for Operations personnel to emphasize recognition of fire barriers when issuing Work Requests. To prevent recurrence, a Plant Modification Request has been issued requesting a change to the design of the fire barrier such that its removal is not necessary for routine surveillance testing. Additionally, a note is being added to surveillance procedure STS AL-201 to remind performers that the enclosure around valve AL HV-32 is a fire barrier, requiring a Fire Protection Impairment Permit prior to opening.

Upon initiation of the hourly fire watch, no evidence of fire or transient combustibles was detected. There was no damage to plant equipment or release of radioactivity as a result of this event. At no time did conditions develop which could have posed a threat to the health or safety of the public.

Missed hourly fire watch patrols have been the subject of Licensee Event Reports 85-004-00, 85-047-00, 85-059-00 and 85-068-00. In each of those events, the Impairment Permit was initiated and the hourly fire watches were commenced. There have been no previous occurrences where the failure to initiate an impairment permit caused an hourly fire watch to be missed.

KANSAS GAS AND ELECTRIC COMPANY

GLENN L. KOESTER
VICE PRESIDENT - NUCLEAR

November 27, 1985

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

Mr. E.H. Johnson, Acting Director
Division of Reactor Safety and Projects
U.S. Nuclear Regulatory Commission
Region IV
611 Ryan Plaza Drive, Suite 1000
Arlington, Texas 76011

KMLNRC 85-262
Re: Docket No. STN 50-482
Subj: Licensee Event Report 85-077-00

Gentlemen:

The attached Licensee Event Report is submitted pursuant to 10 CFR 50.73 (a) (2) (i) concerning a Technical Specification violation.

Yours very truly,

for John A. Bailey

Glenn L. Koester
Vice President - Nuclear

GLK:see

Enclosure

xc: PO'Connor (2), w/a
JCummins, w/a

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