

## LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Joseph M. Farley - Unit 2										DOCKET NUMBER (2) 0 5 0 0 0 3 6 4 1				PAGE (3) OF 0 2									
TITLE (4) Inappropriate Fire Watch Established																							
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	1	1	3	8	5	8	5	0	1	3	0	0	1	2	1	6	8	5	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)																					
1		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)									
POWER LEVEL (10)		20.405(a)(1)(ii)				50.38(c)(1)				50.73(a)(2)(v)				73.71(c)									
0		20.405(a)(1)(iii)				X 50.38(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)(ix)													
LICENSEE CONTACT FOR THIS LER (12)																							
NAME J. D. Woodard										TELEPHONE NUMBER AREA CODE 2 0 5 8 9 9 - 5 1 5 6													
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																							
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS				
SUPPLEMENTAL REPORT EXPECTED (14)																							
YES (If yes, complete EXPECTED SUBMISSION DATE)										XX		NO		EXPECTED SUBMISSION DATE (15)		MONTH		DAY		YEAR			

ABSTRACT (Limit to 1400 spaces, i.e. approximately fifteen single-space typewritten lines) (16)

At 0710 on 11-17-85, while reviewing Limiting Condition for Operation (LCO) forms, it was discovered that fire watch requirements had been determined incorrectly when the fire detectors on both sides of an inoperable fire barrier had been made inoperable at 0910 on 11-13-85. A continuous fire watch should have been established within one hour. Instead, an hourly fire watch had been established. Upon discovery of this event, the detectors on one side of the inoperable fire barrier were returned to operability.

This event was caused by personnel error in that the Shift Foreman failed to specify adequate fire watch requirements when the detectors on both sides of the penetrations were made inoperable on 11-13-85. To prevent recurrence of this type of event, the individuals involved have been counseled.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-3104  
EXPIRES: 3/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Joseph M. Farley - Unit 2	0 5 0 0 0 3 6 4 8 5	— 0	1 3	— 0	0 0 2 OF 0 2	

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

At 0710 on 11-17-85, while reviewing Limiting Condition for Operation (LCO) forms, it was discovered that fire watch requirements had been determined incorrectly when the fire detectors on both sides of an inoperable fire barrier had been made inoperable at 0910 on 11-13-85. A continuous fire watch should have been established within one hour. Instead, an hourly fire watch had been established.

At 0800 on 10-7-85, fire dampers between room 2201 (computer room) and room 2202 (hot shutdown panel room) were declared inoperable as described in Unit 1 LER 85-017-00. Technical Specification 3.7.12 states "within one hour either, establish a continuous fire watch on at least one side of the affected penetration, or verify the operability of fire detectors on at least one side of the non-functional fire barrier and establish an hourly fire watch patrol." The operability of fire detectors was determined and an hourly fire watch patrol was established as required. At 0915 on 11-5-85, the detectors in room 2201 were made inoperable to facilitate repair work on the fire dampers. A continuous fire watch patrol was not required since the detectors on the other side of the non-functional fire barrier (room 2202) remained operable. At 0910 on 11-13-85, the detectors in room 2202 were made inoperable to facilitate work on the fire dampers. Since detectors on both sides of the fire barrier penetration were then inoperable, a continuous fire watch should have been established. Instead, an hourly fire watch patrol was established in room 2202.

Upon discovery of this event, the detectors in room 2201 were returned to operability at 0715 on 11-17-85. At 0810 on 11-17-85, detectors in room 2202 were returned to operability. The existing hourly fire watch was maintained until the fire dampers were repaired and returned to service.

This event was caused by personnel error in that the Shift Foreman failed to specify adequate fire watch requirements when the detectors on both sides of the penetrations were made inoperable on 11-13-85. To prevent recurrence of this type of event, the individuals involved have been counseled.

**Mailing Address**  
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Telephone 205 783-6090

**R. P. McDonald**  
Senior Vice President  
Flintridge Building

December 16, 1985



Docket No. 50-364

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

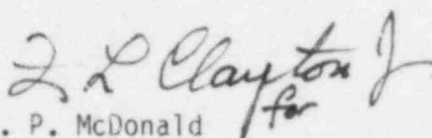
Joseph M. Farley Nuclear Plant - Unit 2  
Licensee Event Report No. LER 85-013-00

Dear Sir:

Joseph M. Farley Nuclear Plant, Unit 2, Licensee Event Report No. LER 85-013-00 is being submitted in accordance with 10CFR50.73.

If you have any questions, please advise.

Yours very truly,

  
R. P. McDonald

RPM/JAR:ddb-D30  
Enclosure

cc: IE, Region II

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