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ACCESSION NBR:9104080289 DOC.DATE: 91/04/01 NOTARIZED: NO DOCKET # FACIL:50-305 Kewaunee Nuclear Power Plant, Wisconsin Public Servic 05000305 AUTH.NAME AUTHOR AFFILIATION Wisconsin Public Service Corp. NALEPKA, D.S. Wisconsin Public Service Corp. NELSON, R.L. Wisconsin Public Service Corp. EVERS, K.H.

SUBJECT: LER 91-003-00:on 910303, discovery made re hourly fire watch insp resulting in Tech Spec violation. Caused by inattention to detail by two security officers involved. Reformatting of open/degraded fire penetration list.W/910401 ltr.

RECIPIENT AFFILIATION

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April 1, 1991

10 CFR 50.73

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Gentlemen:

Docket 50-305 Operating License DPR-43 Kewaunee Nuclear Power Plant Reportable Occurrence 91-003-00

The attached Licensee Event Report for reportable occurrence 91-003-00 is being submitted in accordance with the requirements of 10 CFR 50.73, "Licensee Event Report System."

Sincerely,

K. H. Evers

Manager-Nuclear Power

SLB/jms

Attach.

cc - INPO Records Center
Mr. Patrick Castleman, US NRC
US NRC, Region III

1/222

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ABSTRACT (Limit to 1400 speces, i.e., approximately fifteen single space typewritten lines) (15)

David S. Nalepka - Plant Licensing Supervisor

At 0245 on March 3, 1991, and at 0146 on March 4, 1991, with the plant at 95% power, it was discovered that hourly fire watch inspections had not been performed as required by Technical Specification 3.15.f. The specification requires that a hourly fire watch inspection be performed, on at least one side of a penetration, if the fire barrier is not intact. The non-performance of inspections was discovered by a contract Security Shift Captain during review of the security computer personnel access printouts.

The March 3, 1991, review revealed that an area in which a penetration fire barrier was not intact had not been inspected by the assigned Security Officer during the time periods of 1300-1500 on February 28, 1100-1300 on March 1. and 0900-1100 on March 2, 1991.

The March 4, 1991, review revealed that an area in which a penetration fire barrier was not intact had not been inspected during the time period of 1000-1100 on March 3, 1991.

The root cause of the event was determined to be inattention to detail by the two security officers involved.

Corrective actions will include reformatting of the open/degraded Fire Penetration List to group affected penetrations with the associated area; and performing a review of the Fire Watch Surveillance Procedure and revising the procedure as appropriate.

NRC	Form	366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVEO OMB NO 3150-0104 EXPIRES 8/31/85

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Oescription of Event

At 0245 on March 3, 1991, and at 0146 on March 4, 1991, with the plant at 95% power, it was discovered that hourly fire watch inspections had not been performed as required by Technical Specifications. The Kewaunee Technical Specification 3.15.f, requires that when a penetration fire barrier protecting safety-related areas is not intact, a hourly fire watch inspection shall be established for at least one side of the penetration within one hour. The non-performance of these inspections was discovered by a Security Shift Captain during a review of the security computer personnel access printouts.

The performance of fire watch inspections is a responsibility assigned to the contracted security force, and is implemented by the assignment of a security officer as the fire watch patrol, on a two hour rotational basis. The security officer is provided with a open/degraded Fire Penetration List which lists the degraded penetration number and designates the area which is required to be inspected.

The March 3, 1991, review revealed that an area, in which penetration [PEN] fire barrier No. 363 was not intact, had not been inspected by the Security Officer assigned fire watch patrol during the time periods of 1300-1500 on February 28, 1100-1300 on March 1, and 0900-1100 on March 2, 1991. Penetration fire barrier No. 363 provides a barrier between the Technical Support Center (TSC) and the Auxiliary Building. The Fire Penetration List designated the area above Door [DR] No. 442 in the TSC as the area to be inspected, however, the security computer personnel printout did not indicate that the TSC had been entered by the Security Officer assigned fire watch patrol during the above time periods. The same security officer was involved in the three events.

The March 4, 1991, review revealed that an area, in which penetration fire barrier No. 814 was not intact, had not been inspected by the assigned Security Officer during the time period of 1000-1100 on March 3, 1991. Penetration fire barrier No. 814 provides a barrier between the Control Room Air Conditioning Equipment Room (CR A/C ER) and the Auxiliary Building. The Fire Penetration List designated the CR A/C ER as the area to be inspected. This event involved a different security officer than that involved in the February 28-March 2, 1991 events.

Cause of Event

Failure to perform the fire watch inspections in accordance with the Fire Penetration List was caused by inattentiveness to detail by the Security Officers involved.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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Analysis of Event

This event is being reported in accordance with 10CFR50.73(a)(2)(i)(B) as a condition prohibited by the plant's technical specification.

There were no safety consequences as a result of the failure to perform the fire watch inspections. The scheduled inspections performed prior to and following the missed inspections did not reveal any condition or activity which would have compromised plant safety. The installed heat and smoke detectors, and fire suppression systems were operable during the time periods in which the inspections were not performed.

Corrective Actions

The following corrective actions have been taken to prevent a recurrence of these events:

- The Fire Penetration List has been reformatted to list the area requiring inspection immediately followed by a list of associated open/degraded penetrations, by identifying number. The previous list included the penetration number and associated area, however the penetrations were not grouped by area.
- 2. The Firewatch Inspection Surveillance Procedure will be reviewed by April 15, 1991, and revisions made to the procedure and associated checklist as determined to be appropriate.
- 3. Appropriate counseling, retraining, and disciplinary actions were administered to the Security Officers involved with the events.

Additional Information

Equipment Failures: None

Similar Event Reports: None